SUBCHAPTER PP. Out-of-Network Claim Dispute Resolution
Division 1. General Provisions
28 TAC §§21.5001 – 21.5003

Division 2. Mediation Process
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Division 3. Plan Administrator's Required Notice of Claims Dispute Resolution
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28 TAC §21.5030 and §21.5031

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts new Subchapter PP, §§21.5001 – 21.5003, 21.5010 – 21.5013, 21.5020, 21.5030, and 21.5031, concerning the out-of-network claim dispute resolution process, the plan administrator's required notice of the out-of-network claim dispute resolution process, the resolution of related complaints, and outreach efforts to inform consumers about the out-of-network claim dispute resolution process. Sections 21.5002, 21.5003, 21.5010, 21.5011, 21.5012, 21.5013, 21.5020 and 21.5030 are adopted with changes to the proposed text published in the May 14, 2010 issue of the *Texas Register* (35 TexReg 3760). Sections 21.5001 and 21.5031 are adopted without changes.

2. REASONED JUSTIFICATION. The new sections are necessary to implement SECTION 1 of House Bill (HB) 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009. HB 2256 enacts the Insurance Code Chapter 1467, requiring mandatory mediation at the request of the enrollee for certain out-of-network claims and requiring the collection of information on complaints relating to such claims. Under the

Insurance Code §1467.002, new Chapter 1467 applies to: (i) a preferred provider benefit plan issued under the Insurance Code Chapter 1301; and (ii) an administrator of a health benefit plan, other than a health maintenance organization plan, under the Insurance Code Chapter 1551. The Insurance Code Chapter 1551 is the Texas Employees Group Benefits Act, administered and implemented by the board of trustees established under the Government Code Chapter 815 to administer the Employees Retirement System of Texas (ERS). The Insurance Code §1467.003 authorizes the Commissioner to adopt rules as necessary to implement the Commissioner's powers and duties under Chapter 1467. The Insurance Code §1467.054 further provides that a request for mandatory mediation must be provided to the Department on a form prescribed by the Commissioner. This new subchapter is necessary to prescribe the process for requesting and initiating mandatory mediation of out-of-network claims as authorized in the Insurance Code Chapter 1467. This new subchapter is also necessary to implement the requirements of the Insurance Code §1467.151(a). Section 1467.151(a) requires the Commissioner to adopt rules to regulate the investigation and review of a filed complaint that relates to the settlement of an out-of-network health benefit claim subject to Chapter 1467. Section 1467.151(a) requires that these rules: (i) distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed medical care; (ii) develop a form for filing a complaint and establish an outreach effort to inform enrollees of the availability of the claims dispute resolution process under Chapter 1467; (iii) ensure that a complaint is not dismissed without appropriate consideration; (iv) ensure that enrollees are informed

of the availability of mandatory mediation; and (v) require the administrator to include a notice of the claims dispute resolution process available under Chapter 1467 with the explanation of benefits sent to an enrollee. This new subchapter implements these requirements.

The Department on August 31, 2009, posted an informal working draft of the proposed new rules on the Department's Internet website and invited public input. The Department held a stakeholder's meeting on September 9, 2009, to discuss implementation of SECTION 1 of HB 2256 and the informal working draft with interested parties. The Department received several written comments regarding the informal working draft of the proposed new rules, and these comments were taken into consideration in preparing the proposed rules. The proposed new rules were formally published in the May 14, 2010 issue of the *Texas Register* (35 TexReg 3760). The Department did not receive any requests for a public hearing on the rule proposal.

As a result of comments, the Department has made non-substantive changes to (i) proposed §21.5002 relating to the inclusion of a provision that a claim that is not covered under the terms of the health benefit plan coverage is not subject to mandatory mediation; (ii) proposed §21.5010(c)(2), relating to complete disclosures made by a hospital-based physician; (iii) proposed §21.5012, relating to the informal settlement teleconference; (iv) proposed §21.5030(b)(4) relating to specific information about a qualified claim; and (v) proposed Form No. LHL619 relating to the required information on the hospital-based physician. The Department has also made non-substantive changes to (i) proposed §21.5002 (1) and (2) (designated as §21.5002(a)(1) and (2) in

the rule text as adopted) relating to the change in the effective date of the rules from June 19, 2009 and September 1, 2010, respectively, to November 1, 2010; (ii) proposed §21.5003(11) relating to the definition of "preferred provider"; (iii) proposed §21.5011(b)(4) relating to online submission of Form No. LHL619; (iv) proposed §21.5013 relating to mediation participation; (v) proposed §21.5020 relating to the required notice of claims dispute resolution; and (vi) the certification statement, eligibility factors, and references to the terms "claim" and "claims" and "claim number" and "claim numbers" in proposed Form No. LHL619. None of the changes made to the proposed text or proposed form in this adoption materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

As a result of a comment, the Department added subsection (b) to proposed §21.5002, to clarify that this subchapter does not apply to a non-covered claim. The commenter requested that §21.5010, relating to qualified claim criteria, be revised to reflect that only *covered* claims are subject to the procedures mandated by Chapter 1467 and that proposed §21.5010(c), relating to ineligible claims, be revised to reflect that claims that are not covered by the enrollee's health insurance are ineligible for mediation. The commenter requested this clarification for consistency with Chapter 1467 of the Insurance Code, which, according to the commenter, requires that only certain *covered* claims are subject to mandatory mediation. The Department agrees that the requested clarification is needed but in lieu of revising proposed §21.5010(c), as requested by the commenter, the Department has added a new subsection (b) to §21.5002, relating to the scope of the subchapter. Section 21.5002(b) as adopted

reads: "This subchapter does not apply to a claim for health benefits, including medical and health care services and/or supplies, that is not a covered claim under the terms of the health benefit plan coverage."

Also, as a result of a comment, proposed §21.5010(c)(2)(D) was deleted to remove the requirement that a complete disclosure under §21.5010(c)(1) must otherwise comply with any rules promulgated by the Texas Medical Board under the Insurance Code §1467.003. A commenter requested that §21.5010(c)(2)(D) be deleted because Chapter 1467 of the Insurance Code does not require a complete disclosure to comply with rules promulgated by the Texas Medical Board and the statute does not confer any authority on the Texas Medical Board to promulgate standards for the content and procedures pertaining to the disclosure process. In response to this comment, the Department has deleted proposed §21.5010(c)(2)(D) in this adoption.

Additionally, as a result of comments, proposed §21.5012, relating to the informal settlement teleconference, is changed as adopted to require the insurer or administrator to use best efforts to coordinate the informal settlement teleconference. Two commenters objected to proposed §21.5012, because the insurer or administrator will not have control over the enrollee's or physician's actions, and failure by either the enrollee or the physician to cooperate or participate may affect the insurer or administrator's ability to comply with proposed §21.5012. The first commenter suggested that proposed §21.5012 be revised to state that neither an insurer nor an administrator should be subject to any sanction if the other parties to the teleconference fail to cooperate by not responding to the insurer/administrator's communications, by

not providing information necessary to set up the teleconference, or by not making themselves available to participate in the teleconference. The second commenter asserted that the Department has shifted the burden of scheduling the settlement conference on the insurer without making allowances for the availability of the parties and the timing of the receipt of the request by the insurer from the Department. The commenter states that the Texas Insurance Code §1467.054(d) obligates "all parties" to participate in a teleconference not later than the 30th day after the date of the request. According to the commenter, the proposed rule subjects the insurer to penalties for actions taken or not taken by the other parties. The commenter suggests that proposed §21.5012 be revised as follows: "An insurer or administrator that is subject to mandatory mediation requested by an enrollee under §21.5011 of this division (relating to Mediation Request Form and Procedure) shall coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by: (1) arranging a date and time when the insurer or administrator, the enrollee or the enrollee's representative if the enrollee or the enrollee's representative chooses to participate, and the hospital-based physician or the hospital-based physician's representative can participate in the informal settlement teleconference, [which shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation;] and (2) providing a toll-free number for participation in the informal settlement teleconference. *An insurer or administrator must use best efforts to schedule the informal settlement conference not later than the 30th day after the date on which the enrollee submits a request for mediation under this section."* The Department agrees with the commenters on the

necessity of clarification that best efforts must be used by insurers and administrators in scheduling the informal settlement conference. The Department, however, does not agree with one of the commenter's suggestions that the requested clarification should be made to §21.5012(2). Instead, the following change has been made to §21.5012 as adopted: "An insurer or administrator that is subject to mandatory mediation requested by an enrollee under §21.5011 of this division (relating to Mediation Request Form and Procedure) shall *use best efforts to* coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by: . . ." (emphasis added). This revision is very similar to that recommended by the commenter and has the same effect as the commenter's suggested language. This revision makes the commenter's suggestion to delete the requirement that the informal settlement teleconference "shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation" unnecessary. Therefore, this requirement is not deleted from §21.5012(1) as adopted because it reiterates the Insurance Code §1467.054(d) and is necessary for understanding §21.5012.

Also, as a result of a comment, proposed §21.5030(b)(4) is revised to add a subparagraph (D) to include the dollar amount of the disputed claim to the elements of specific information required on the qualified claim on the complaint form filed under §21.5030. A commenter suggested adding "(b)(4)(D) the dollar amount of the claim at dispute" to proposed §21.5030, stating that such language will give a better idea of the costs related to out-of-network claim disputes. Section 21.5030(b)(4)(D) as adopted incorporates the commenter's suggestion.

Finally, as a result of a comment, proposed Form No. LHL619 was revised to include the additional information of the amount billed by the physician under the "Hospital-Based Physician Information." A commenter stated that the request for mediation should include the "amount billed by the physician" because this information is important in determining whether or not the enrollee's request involves a qualified claim. The adopted Form No. LHL619 incorporates the commenter's suggestion.

In addition to the change made as a result of a comment to §21.5002, the Department made a change to proposed §21.5002(1) and (2) (designated as §21.5002(a)(1) and (2) in the rule text as adopted) to change the effective date of the rules from June 19, 2009 and September 1, 2010, respectively, to November 1, 2010. Section 21.5002 (a)(1) and (2) as adopted provide that the subchapter applies to a qualified claim filed under health benefit plan coverage: (1) issued by an insurer as a preferred provider benefit plan under the Insurance Code Chapter 1301, provided the claim is filed on or after *November 1, 2010*; or (2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under the Insurance Code Chapter 1551, provided the claim is filed on or after *November 1, 2010*. This change was made for compliance with the effective date requirements in the Government Code §2001.036. Section 2001.036 provides that a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State unless certain other statutorily specified conditions are met. The change is also necessary to avoid any retroactive effect of the rule.

The Department made a non-substantive change to proposed §21.5003(11), defining "Preferred provider" as "A hospital or hospital-based physician that contracts on a preferred benefit basis with an insurer issuing a preferred provider benefit plan under the Insurance Code Chapter 1301 to provide medical care or health care to *enrollees* [insureds] covered by a health insurance policy," replacing the term "insureds" with the term "enrollees." Although both terms refer to the same category of individuals, this change was made for consistency within the text and to avoid ambiguity or confusion. The Department also made a non-substantive change to §21.5011(b)(4), stating, "Upon the department's making [available] Form No. LHL619 (Health Insurance Mediation Request Form) *available to* [that may] be completed and submitted online, an enrollee may submit the request in this manner." This change was made for ease of readability.

The Department also made a non-substantive change to proposed §21.5013(a), stating that an insurer or administrator subject to mediation under Subchapter PP shall participate in mediation in good faith and *is subject to any* rules adopted by the chief administrative law judge pursuant to the Insurance Code §1467.003, instead of stating that the insurer or administrator *shall comply with* .any rules adopted by the chief administrative law judge. This change was made to clarify that the rule is intended to notify the insurer or administrator of the applicability of other rules adopted by the chief administrative law judge.

The Department also changed proposed §21.5020 to provide that a Chapter 1551 plan administrator must include a notification of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for

an out-of-network claim filed on or after *November 1, 2010*, for services and/or supplies furnished in a hospital that has a contract with the administrator. The November 1, 2010 change was necessary for compliance with the effective date requirements in the Government Code §2001.036. Section 2001.036 provides that a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State unless certain other statutorily specified conditions are met. The change is also necessary to avoid any retroactive effect of the rule.

In addition to the change made at the request of the commenter to add the "amount billed by the physician" as a required field to Form No. LHL619, the Health Insurance Mediation Request Form, the Department determined that it was necessary to change proposed Form No. LHL619, to provide that the enrollee submitting this completed form certifies that the claim(s) indicated on the form qualify for mandatory mediation pursuant to the requirements of Chapter 1467 of the Texas Insurance Code *and the rules in Title 28 Texas Administrative Code Chapter 21, Subchapter PP, adopted pursuant to Chapter 1467.* The certification in the form as proposed did not reference the Subchapter PP rules. This addition is necessary to ensure that the claim(s) for which mediation is requested by the enrollee on the form not only qualify for mandatory mediation pursuant to the requirements of Chapter 1467 of the Texas Insurance Code but also pursuant to the Subchapter PP rules. The Department also amended the Eligibility section of proposed Form No. LHL619 to include claims that are eligible under a Texas Employee Retirement System plan. The Eligibility section of Form No. LHL619 as adopted provides in pertinent part that under Chapter 1467 of the

Texas Insurance Code, an individual may request mediation if their claim(s) meets the eligibility criteria: “your claim(s) was filed with (i) a PPO on or after June 19, 2009; or (ii) a health benefit plan, other than an HMO, under Chapter 1551 of the Insurance Code (an Employee Retirement System of Texas plan) on or after September 1, 2010.” This change is necessary for consistency with §1467.002 of the Insurance Code and Section 6 of HB 2256. Additionally, the adopted Form No. LHL619 is revised to change the references throughout the form from the singular term “claim” to the plural term “claims” and the reference from the singular term “claim number” to the plural term “claim numbers.” The proposed form references both the term “claim” and “claims,” as well as the term “claim number.” This change is necessary for consistency with the adopted rules and for internal consistency of the form and to avoid ambiguity and confusion.

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

Section 21.5001 sets forth the purpose of the subchapter. Section 21.5002 describes the scope of the subchapter. As contemplated in the Insurance Code §1467.002 and §1467.051 and HB 2256, SECTION 6, the new subchapter applies to a qualified claim filed under health benefit plan coverage that is: (i) issued by an insurer as a preferred provider benefit plan under the Insurance Code Chapter 1301, provided the claim is filed on or after November 1, 2010; or (ii) administered by the administrator of a health benefit plan, other than a health maintenance organization plan, under the Insurance Code Chapter 1551, provided the claim is filed on or after November 1, 2010. The new subchapter does not apply to a claim for health benefits, including medical and

health care services and/or supplies, that is not a covered claim under the terms of the health benefit plan coverage.

Section 21.5003 specifies definitions for words and terms when used in the new subchapter. Included in the defined terms is the term “hospital-based physician” at §21.5003(6), which the Department defines as “a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist: (A) to whom the hospital has granted clinical privileges; and (B) who provides services to patients of the hospital under those clinical privileges.” This definition is generally consistent with the statutorily-defined term “facility-based physician,” set forth at the Insurance Code §1467.001(4). The definition, however, provides additional clarity by eliminating any ambiguity associated with the use of the term “facility” by substituting the word “hospital” for the term “facility.” This clarification is consistent with the statutory requirement in the Insurance Code §1467.051(a)(2) that an enrollee may request mediation of a settlement of an out-of-network health benefit claim if it is for a medical service or supply provided by a facility-based physician in a “hospital” that is a preferred provider or that has a contract with the ERS administrator.

Section 21.5010 establishes the criteria for a claim to be eligible for mediation and provides that a claim that meets such criteria is referred to as a “qualified claim.” In accordance with the Insurance Code §1467.051(a)(2), §21.5010(a)(1) provides that an enrollee may request mandatory mediation of an out-of-network claim if the claim is for medical services and/or supplies provided by a hospital-based physician in a hospital that is a preferred provider with the insurer or that has a contract with the administrator.

New §21.5010(a)(2) is consistent with the intent of the Insurance Code §1467.051(a)(1), but §21.5010(a)(2) has clarifying language that is necessary to eliminate ambiguity and ensure uniform claims-handling standards. Without these clarifications, there would be ambiguity concerning whether a particular request for payment of health benefits meets the $1,000 threshold of enrollee responsibility described in the Insurance Code §1467.051(a)(1) as necessary to eligibility for mandatory mediation. Section 21.5010(a)(2) provides that the *aggregate* amount for which the enrollee is responsible to the hospital-based physician for an out-of-network claim, *not including* copayments, deductibles, coinsurance, *or amounts paid by an insurer or administrator directly to the enrollee, must be* greater than $1,000 to be eligible for mandatory mediation. This provision incorporates the eligibility criteria described in the Insurance Code §1467.051(a)(1) with necessary clarification (as indicated by italics) to reduce possible ambiguity and to facilitate uniform handling of out-of-network claims. Section 1467.051(a) of the Insurance Code provides that an enrollee may request mediation of a settlement of an out-of-network health benefit claim if "(1) the amount for which the enrollee is responsible to a facility-based physician, *after* copayments, deductibles, and coinsurance, *including the amount unpaid by the administrator or insurer, is* greater than $1,000; . . . ." Section 21.5010(a)(2) clarifies the Insurance Code §1467.051(a)(1) in three ways. First, the use of the term "aggregate," when read together with §21.5010(b) and §21.5003(3), clarifies that individual units of a claim may be aggregated to reach the threshold $1,000 amount necessary to eligibility for mandatory mediation under the Insurance Code §1467.051(a)(1), as opposed to each individual line item of a claim

having to reach the $1,000 threshold in order to be eligible for mandatory mediation. Without this clarification, different interpretations could be given to §1467.051(a)(1). Some enrollees, insurers, and physicians could interpret §1467.051(a)(1) to mean that each line item of a claim for a medical service or supply has to meet the $1,000 threshold in order for that line item to be eligible for mandatory mediation while other enrollees, insurers, and physicians could interpret it to mean that line items of a claim for a medical service or supply could be aggregated to meet the $1,000 threshold in order for the claim to be eligible for mandatory mediation. Second, the use of the phrase “not including” in §21.5010(a)(2) rather than the term “after” in §1467.051(a)(1) clarifies the Department’s interpretation of the statutory provision and enhances readability thereby aiding in uniform compliance. Third, the use of the language in §21.5010(a)(2) reading “or amounts paid by an insurer or administrator directly to the enrollee, must be. . . .” in lieu of the language in §1467.051(a)(1) of the Insurance Code reading “including the amount unpaid by the administrator or insurer, is. . . .” clarifies the Department’s interpretation of the statutory provision and enhances readability thereby aiding in uniform compliance. Consistent with §1467.051(a)(1) of the Insurance Code, under §21.5010(a)(2), when an insurer makes payment on a claim directly to the enrollee, the amount of such payment should not be included in determining whether the claim meets the $1,000 threshold for eligibility for mediation. This clarification is necessary to ensure uniform handling of similar claims for which the only variation is whether payment was issued directly to the enrollee or instead to the hospital-based physician.

Section 21.5010(b) provides that the use of more than one form in the submission of a claim does not preclude eligibility of a claim for mandatory mediation if the claim otherwise meets the requirements of §21.5010. Section 21.5003(3) defines the term "claim" as "a request to a health benefit plan for payment for health benefits under the terms of the health benefit plan coverage, including medical and health care services and/or supplies, provided that such services or supplies: (A) are furnished pursuant to a single date of service; or (B) if furnished pursuant to more than one date of service, are provided as a continuing and/or related course of treatment over a period of time for a specific medical problem or condition or in response to the same initial patient complaint." This definition of "claim" and the provision under §21.5010(b) that the use of more than one form in the submission of a claim does not preclude eligibility of the claim for mandatory mediation are necessary because the term "claim" is not defined in the Insurance Code Chapter 1467. These clarifications in §21.5003(3) and §21.5010(b) are also necessary to ensure uniform handling of similar claims. Similar claims could otherwise be treated differently because of differences in how the medical services and/or supplies were billed or furnished. These clarifications will prevent disparate handling of similar claims that vary based only on certain features not related to the nature or substance of the claims. For example, these clarifications will prevent disparate handling of similar claims that vary based upon whether the medical and health care services and/or supplies were included on a single or multiple claim forms. The clarifications will also prevent disparate handling of similar claims that vary based upon whether the services and/or supplies were provided as a single treatment or as

part of a continuing and/or related course of treatment over a period of time. Absent these clarifications, there would be ambiguity concerning whether a particular request for payment of health benefits meets the $1,000 threshold of enrollee responsibility described in the Insurance Code §1467.051(a)(1) as necessary to eligibility for mandatory mediation. The Department has determined that any approach that does not include these particular clarifications would be insufficient to comply with the intent of HB 2256, which is to protect the economic welfare of all enrollees who have been charged large and unanticipated medical bills resulting from balance billing.

Section 21.5010(c) provides that a claim is not eligible for mandatory mediation under this new subchapter if the hospital-based physician has provided a complete disclosure as described in the Insurance Code §1467.051. This provision is necessary to reflect the statutory provision under the Insurance Code §1467.051(d), which states that a facility-based physician who makes a disclosure under the Insurance Code §1467.051(c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under Subchapter B of Chapter 1467 of the Insurance Code if the amount billed is less than or equal to the maximum amount projected in the disclosure.

Section 21.5011(a) adopts by reference Form No. LHL619 (Health Insurance Mediation Request Form) and identifies information elements that the mediation request form requires in accordance with the Insurance Code §1467.054(b). These information elements include: (i) the name and contact information, including a telephone number, of the enrollee requesting mediation; (ii) a brief description of the qualified claim to be

mediated; (iii) the name and contact information, including a telephone number, for the requesting enrollee's counsel, if applicable; (iv) the names of the hospital-based physician and insurer or administrator; and (v) the name and address of the hospital where services were rendered. Section 21.5011(a) also provides a web address for accessing the form to request mediation. Section 21.5011(b)(1) – (3) provides that an enrollee may submit a request for mediation by completing and submitting Form No. LHL619 by mail, fax, or e-mail. Section 21.5011(b)(4) provides that upon the Department's making Form No. LHL619 available to be completed and submitted online, an enrollee may submit the request in this manner. Section 21.5011(c) provides the toll-free telephone number for assistance with submitting a request for mediation.

Section 21.5012 imposes requirements regarding the coordination of the informal settlement teleconference, requiring the insurer or administrator that is subject to the mandatory mediation request to use best efforts to coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by: (i) arranging a date and time when the parties can participate in the teleconference, to occur no later than the 30th day after the date on which the enrollee submitted the request for mediation; and (ii) providing a toll-free number for participation in the informal settlement conference. The purpose of §21.5012 and the Insurance Code §1467.054(d) is to provide a forum for settlement of eligible enrollee claims before mediation commences. This purpose is a necessary element in protecting the economic welfare of all enrollees who have been charged large and unanticipated medical bills resulting from balance billing. "Balance billing" is the discrepancy between the dollar amount of reimbursement

allowed for the service by the insurer and the dollar amount of reimbursement charged by the hospital-based physician. The Department anticipates that the insurer will be the most frequent participant in the mediation process. The requirements under §21.5012 are necessary to provide for more uniform implementation of the statutory teleconference requirement, reduce potential confusion for all participants in the informal settlement teleconference, and provide for more efficient regulation by the Department of the teleconference requirement.

Section 21.5013 incorporates the statutory requirements described in the Insurance Code §1467.051 and §1467.101 with respect to participation of an insurer or administrator subject to mediation under Chapter 1467 by requiring good faith participation in mediation. The new section also notifies such insurers or administrators that they are also subject to any rules adopted by the chief administrative law judge under the Insurance Code §1467.003 and restates the conduct specified in the Insurance Code §1467.101 that constitutes bad faith mediation.

Section 21.5020 requires an administrator of a plan under the Insurance Code Chapter 1551 (ERS plans) to include a notification of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after November 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator. This rule is required in the Insurance Code §1467.151(a).

Section 21.5030 describes the process for resolution of complaints regarding a qualified claim or a mediation that has been requested under §21.5010. Section

21.5030(a) specifies the web address from which the recommended complaint form may be accessed, the manner in which a complaint may be submitted, and the Department's toll-free number for assistance with filing a complaint. Section 21.5030(b) specifies information elements on the form for filing the complaint, including: (i) whether the complaint falls within the scope of the Insurance Code Chapter 1467; (ii) whether medical care has been delayed or has not been given; (iii) whether the medical service and/or supply that is the subject of the complaint was for emergency care; (iv) the type and specialty of the hospital-based physician; (v) the type of service performed or supply provided; (vi) the city and county where the service was performed; and (vii) the dollar amount of the disputed claim. Section 21.5030(b) is necessary to comply with the §1467.151(a)(1) and (2) requirements that the rules adopted pursuant to §1467.151 of the Insurance Code must distinguish among complaints for out-of-network coverage or payment, give priority to investigating allegations of delayed medical care, and develop a form for filing a complaint. Additionally, the information provided pursuant to these requested information elements will facilitate the Department's maintenance of such information as required under the Insurance Code §1467.151(b).

Section 21.5030(c) specifies the steps that the Department will undertake in resolving a complaint under this section. New §21.5030(c) is necessary to comply with the §1467.151(a)(3) requirement that the rules adopted pursuant to §1467.151, relating to consumer protection, ensure that a complaint is not dismissed without appropriate consideration.

Section 21.5031 describes outreach efforts that the Department will undertake to inform consumers of the availability of mandatory mediation. This new section is necessary to comply with the §1467.151(a)(2) requirement that the rules adopted pursuant to §1467.151, relating to consumer protection, establish an outreach effort to inform enrollees of the availability of the claims dispute resolution process under Chapter 1467 of the Insurance Code. This new section is also necessary to comply with the §1467.151(a)(4) requirement that the rules adopted pursuant to §1467.151, relating to consumer protection, ensure that enrollees are informed of the availability of mandatory mediation.

3. HOW THE SECTIONS WILL FUNCTION.

§21.5001. Purpose. Section 21.5001 sets forth the purpose of the subchapter, which is to prescribe the process for requesting and initiating mandatory mediation of claims as authorized in the Insurance Code Chapter 1467 and to facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under the Insurance Code Chapter 1467.

§21.5002. Scope. Section 21.5002 establishes the scope of the subchapter. The new subchapter applies to a qualified claim filed under health benefit plan coverage that is: (i) issued by an insurer as a preferred provider benefit plan under the Insurance Code Chapter 1301, provided the claim is filed on or after November 1, 2010; or (ii) administered by the administrator of a health benefit plan, other than a health maintenance organization plan, under the Insurance Code Chapter 1551, provided the

claim is filed on or after November 1, 2010. The subchapter does not apply to a claim for health benefits, including medical and health care services and/or supplies, that is not a covered claim under the terms of the health benefit plan coverage.

§21.5003. Definitions. Section 21.5003 contains definitions for words and terms when used in the adopted new subchapter.

§21.5010. Qualified Claim Criteria. Section 21.5010 establishes the criteria for a claim to be eligible for mediation and provides that a claim that meets such criteria is referred to as a "qualified claim." Section 21.5010(a) sets forth the required criteria for what constitutes a "qualified claim," requiring (i) the claim to be an out-of-network claim for medical services and/or supplies provided by a hospital-based physician in a hospital that is a preferred provider with the insurer or that has a contract with the administrator; and that (ii) the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $1,000. Section 21.5010(b) provides that the use of more than one form in the submission of a claim does not preclude eligibility of a claim for mandatory mediation if the claim otherwise meets the requirements of §21.5010.

Section 21.5010(c) provides that a claim is not eligible for mandatory mediation under this new subchapter if the hospital-based physician has provided a complete disclosure as described in the Insurance Code §1467.051.

§21.5011. Mediation Request Form and Procedure. Section 21.5011(a) adopts by reference Form No. LHL619 (Health Insurance Mediation Request Form) and

identifies information elements that the mediation request form requires in accordance with the Insurance Code §1467.054(b). These information elements include: (i) the name and contact information, including a telephone number, of the enrollee requesting mediation; (ii) a brief description of the qualified claim to be mediated; (iii) the name and contact information, including a telephone number, for the requesting enrollee's counsel, if applicable; (iv) the names of the hospital-based physician and insurer or administrator; and (v) the name and address of the hospital where services were rendered. Section 21.5011(a) also provides a web address for accessing the form to request mediation. Section 21.5011(b)(1) – (3) provides that an enrollee may submit a request for mediation by completing and submitting Form No. LHL619 by mail, fax, or e-mail. Under §21.5011(b)(4), an enrollee may submit the request for mediation online when this means of completing and submitting the request becomes available. Section 21.5011(c) provides the toll-free telephone number for assistance with submitting a request for mediation.

§21.5012. Informal Settlement Teleconference. Section 21.5012 imposes requirements regarding the coordination of the informal settlement teleconference, requiring the insurer or administrator that is subject to the mandatory mediation request to use best efforts to coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by: (i) arranging a date and time when the parties can participate in the teleconference, to occur no later than the 30th day after the date on which the enrollee submitted the request for mediation; and (ii) providing a toll-free number for participation in the informal settlement conference.

§21.5013. Mediation Participation. Section 21.5013 incorporates the statutory requirements described in the Insurance Code §1467.051 and §1467.101 with respect to participation of an insurer or administrator subject to mediation under Chapter 1467 by requiring good faith participation in mediation. The section also notifies such insurers or administrators that they are subject to any rules adopted by the chief administrative law judge under the Insurance Code §1467.003 and restates the types of conduct specified in the Insurance Code §1467.101 that constitutes bad faith mediation.

§21.5020. Required Notice of Claims Dispute Resolution. Section 21.5020 requires an administrator of a plan under the Insurance Code Chapter 1551 (ERS plans) to include a notification of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after November 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator.

§21.5030. Complaint Resolution. Section 21.5030 describes the process for resolution of complaints regarding a qualified claim or a mediation that has been requested under §21.5010. Section 21.5030(a) specifies the web address for accessing the recommended complaint form, the manner in which a complaint may be submitted, and the toll-free number for obtaining Department assistance with filing a complaint. Section 21.5030(b) specifies information elements on the form for filing the complaint, including: (i) whether the complaint is within the scope of the Insurance Code Chapter 1467; (ii) whether medical care has been delayed or has not been given; (iii) whether the medical service and/or supply that is the subject of the complaint was for emergency

care; (iv) the type and specialty of the hospital-based physician; (v) the type of service performed or supply provided; (vi) the city and county where the service was performed; and (vii) the dollar amount of the disputed claim. Section 21.5030(c) specifies the steps that the Department will undertake in resolving a complaint under this section.

§21.5031. Department Outreach. Section 21.5031 describes outreach efforts that the Department will undertake to inform consumers of the availability of mandatory mediation.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comment

Comment: One commenter expresses appreciation for the work the Department staff has done to draft rules relating to mediation, complaint resolution and outreach. The commenter states that the rules as proposed adequately implement HB 2256 as passed by the 81st Texas Legislature and will provide an important consumer protection for enrollees who have claim disputes when they access out-of-network services.

Agency Response: The Department appreciates the supportive comment.

§21.5003(3). Proposed definition of claim

Comment: Two commenters state that the definition of "claim" in §21.5003(3) is inconsistent with statutory language. The first commenter requests that part (B) of the definition of "claim" be revised to read: "(B) if furnished pursuant to more than one date

of service, are provided as a continuing [and/or related] course of treatment [over a period of time] for a specific medical problem or condition, *and would typically be considered one claim in the normal course of business for an insurance company.* [or in response to the same initial patient complaint.]" A second commenter requests that at a minimum, subsection (B) should be revised to apply to services or supplies provided during the course of a single hospital admission because the reference to "in response to the same initial patient complaint" in the proposed definition is vague and too broad.

The first commenter asserts the following reasons for the requested change: (i) the proposed §21.5003(3) definition of "claim" appears overly broad, vague and beyond the scope of Chapter 1467 of the Insurance Code; (ii) the definition construes the term "claim" to include requests for health insurance benefits that would normally constitute more than one claim; (iii) the Insurance Code Chapter 1467 does not reference the aggregation of claims in order to meet the statutory $1,000 minimum requirement for mandatory mediation under the statute; (iv) as used in the statute, a "claim" in the amount of $1,000 is consistently stated in the singular and not plural; (v) since "claim" is not defined in the statute, the term should be given its ordinary meaning as commonly understood and applied in the business of processing and adjudicating a claim for health insurance benefits; (vi) the statute speaks in terms of a single discrete claim in connection with the $1,000 minimum, and not an aggregation of claims as contemplated by the Department's proposed rule; (vii) the scope of the definition appears particularly unreasonable and overly broad in permitting multiple requests for health benefits, not only for a specific medical procedure, but for subsequent procedures so long as they

are “related to” the initial treatment; (viii) the definition is inconsistent with the terms of the statute to the extent the definition encompasses as one claim requests arising from both an original procedure and the treatment of a complication “related to” the earlier procedure; (ix) if the definition would treat as one “claim” both an underlying treatment and a subsequent “related” medical procedure that occurred two, four or more than four years after the original procedure, such a construction would plainly exceed the bounds set by the statute, and allowing an enrollee to aggregate claims in this manner to reach the $1,000 threshold violates the plain language and intent of the statute.

The second commenter asserts the following reasons for the requested change: (i) the Texas Insurance Code §1467.051(a)(2) provides that an enrollee may request mediation if “*the* health benefit claim is for *a* medical service or supply provided by a facility based physician…” (emphasis added), and the proposed definition of “claim” in §21.5003(3) conflicts with the statute; (ii) the proposed definition of “claim” exceeds the Department’s statutory authority; and (iii) the proposed definition of “claim” conflicts with the Department’s own form regarding a request of mediation (LHL619), which provides that an enrollee may request mediation if “your claim is for a medical service or supply. . . .”

Agency Response: The Department declines to make the requested changes for the following reasons: (i) the Department disagrees that the definition of “claim” in proposed §21.5003(3), which is adopted without changes, is overly broad, vague, or exceeds the scope of the statute; an individual or entity will be able to determine what constitutes a “claim” by a plain reading of the rules; (ii) the definition of “claim” in

proposed §21.5003(3), which is adopted without changes, is consistent with the Department's rulemaking authorization in the Insurance Code §1467.003 to adopt rules as necessary to implement the Department's powers and duties under Chapter 1467 of the Insurance Code; (iii) the definition is consistent with the statutory provisions of the Insurance Code Chapter 1467, including but not limited to the statutory right for an enrollee to request mediation of a settlement of certain out-of-network health benefit claims under §1467.051; (iv) the inclusion of the definition of "claim" does not impose any additional burdens, conditions, or restrictions on a person, including an administrator or insurer, beyond or inconsistent with the Insurance Code Chapter 1467; to the contrary, as previously stated, the term "claim" in these rules is applied consistently with the provisions of the Insurance Code Chapter 1467; (v) the use of the term "claim" is also consistent with the general objectives of Chapter 1467, as enacted by HB 2256. The primary purpose of Chapter 1467 of the Insurance Code is to create a remedy for enrollees who have been billed for covered services because of a discrepancy between the dollar amount of reimbursement allowed for the service by the insurer and the dollar amount of reimbursement charged by the hospital-based physician ("balance billing"). According to the Senate Committee on State Affairs Bill Analysis for HB 2256, balance billing most commonly occurs when a facility-based physician does not have a contract with a certain health benefit plan, but the facility at which the physician practices has a contract with that health benefit plan. TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report), HB 2256, 81st Leg., R.S. (May 22, 2009). The Bill Analysis further explains, "An enrollee who is

admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill. Currently, there is no remedy for this bill other than the patient attempting to set up a payment plan with the facility-based physician." HB 2256 provides an alternative remedy for these unexpected medical bills that result from balance billing (subject to certain minimum amounts) by creating an out-of-network claim dispute resolution process. Sections 21.5010(a)(2), 21.5010(b), and 21.5003(3) clarify how to calculate whether a claim is qualified for mandatory mediation. The Department has determined that any approach that does not include these particular clarifications would be insufficient to comply with the intent of HB 2256, which is to protect the economic welfare of all enrollees who have been charged large and unanticipated medical bills resulting from balance billing.

Additionally, as noted in the Department's rule proposal, few requests for mediation had been received as of April 1, 2010, and few such requests have been received to date. Even if the number of mediations were to increase, however, the Department is of the opinion that it would be a relatively rare occurrence for an enrollee to have multiple services on separate dates by the same out-of-network facility based physician at a network hospital as part of a "related" but not "continuing" course of treatment. The Department's reason for adopting the definition of "claim," in §21.5003 is to provide a clear, broad standard to guide all affected parties. This type of standard will eliminate much of the potential for manipulation of the process by these parties and eliminate difficult disputes over whether claims qualify for mediation. Further, the Department is of the opinion that this standard will not have a significant impact on the

number of mediations that will actually occur. Because all mediations will be requested through the Department, the Department staff will also be able to continue to monitor this issue to determine if problems arise.

§21.5010. Qualified Claim Criteria

Comment: A commenter requests that §21.5010 be revised to reflect that only *covered* claims are subject to the procedures mandated by Chapter 1467 and that proposed §21.5010(c) be revised to reflect that claims that are not covered by the enrollee's health insurance are ineligible for mediation. The commenter asserts the following reason for the requested changes: (i) the statute reflects that its requirements are not intended generally to supplant or substitute ERS' and the ERS Board of Trustees' exclusive authority under Texas Insurance Code §§1551.051, 1551.052, 1551.055, 1551.201, 1551.202, and Subchapter H of Chapter 1551, to define the terms of health insurance coverage under the Texas Employees Group Benefits Program, administer claims and process administrative appeals arising from the denial of claims; (ii) the disclosure provisions of §1467.051 state that if an out-of-network facility-based physician makes a proper disclosure identifying his or her status, the projected amounts for which the enrollee may be responsible, and the circumstances in which the enrollee would be responsible, then neither the mediation nor special trial provisions of the statute would apply; (iii) the disclosure provisions reflect that the requirements of Chapter 1467 apply to issues regarding an enrollee's share of a covered claim, not to whether or not a particular medical service or good is covered; such issues remain

subject to the provisions of Chapter 1551 of the Insurance Code and ERS' rules and plan provisions regarding those issues; (iv) the complaint provisions of §1467.054(d) further reflect that the statute is intended as a vehicle to resolve disputes over improper billing by an out-of-network facility-based physician and for unfair claim settlement practices; (v) §1467.054(i) provides that the subsection does not require an insurer or administrator to pay for an uncovered service; (vi) the Insurance Code §1467.056 specifies the issues that are the proper subject of mediation and include: (a) whether the amount charged by the facility-based physician for the medical service or supply is excessive; (b) whether the amount paid by the insurer or administrator represents the usual and customary rate for the medical service or supply or is unreasonably low; and (c) a determination of the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based physician; and (vii) §1467.056(d) further states that the goal of the mediation is to reach an agreement among the parties as to the amount paid by the insurer or administrator to the facility-based physician, the amount charged by the physician, and the amount paid to the physician by the enrollee.

The commenter emphasizes that the scope of Chapter 1467 of the Insurance Code is limited to the procedures that apply to disputes regarding an enrollee's share of the costs for medical goods and services. The commenter also points out that §1467.057(c) states that "a special judge's verdict is not relevant or material to *any other balance bill dispute* and has no precedential value." Disputes regarding the scope of coverage are not addressed other than to state that a service by a facility-based

physician may not be summarily disallowed. Chapter 1551, the Master Benefit Plan Document for HealthSelect and ERS' rules provide for multiple levels of review before a claim is disallowed for lack of coverage.

Agency Response: The Department agrees that only covered claims are subject to the mandatory mediation prescribed by Chapter 1467 of the Insurance Code but does not agree with the commenter's suggestion to amend §21.5010 in order to clarify this fact. While the Department is of the opinion that the proposed rules provide that only covered claims are subject to mandatory mediation, the Department also agrees that the rules could more explicitly state that only "covered" claims are within the scope of the rules. Therefore, the Department has made the clarification in §21.5002, relating to the scope of the rule. The following discusses the Department's reasoning and the changes made to the proposed text in response to the comments. The proposed definition of "claim," which is adopted without change, already clarifies that only covered claims are subject to mandatory mediation. Proposed new §21.5003(3), which is adopted without change, defines "claim" as "a request to a health benefit plan for payment *for health benefits under the terms of the health benefit plan coverage*, including medical and health care services and/or supplies. . ." (emphasis added). Proposed §21.5010 discusses criteria for an "out-of-network claim" to be a "qualified claim." Proposed §21.5003(10), which is adopted without change, defines "out-of-network claim" as "a *claim* for payment for medical or health care services and/or supplies that are furnished by a hospital-based physician that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an

administrator." Thus, a "qualified claim" under proposed §21.5010 is a type of "out-of-network claim," and an "out-of-network claim" is a type of "claim." Because the definition of "claim" is therefore incorporated into proposed §21.5010, the limitation of "covered" claims also already applies. However, because of the concerns raised by the commenter, the Department has revised proposed §21.5002 relating to the scope of the rule, adding the following language: "(b) This subchapter does not apply to a claim for health benefits, including medical and health care services and/or supplies, that is not a covered claim under the terms of the health benefit plan coverage." This revision makes it unnecessary to revise proposed §21.5010 as the commenter requests.

Comment: A commenter requests the deletion of §21.5010(c)(2)(D), which requires a complete disclosure under §21.5010(c)(1) to otherwise comply with any rules promulgated by the Texas Medical Board under the Insurance Code §1467.003. The commenter asserts the following reasons for the requested change: (i) proposed §21.5010(c) appears to exceed the scope of Chapter 1467 with respect to the requirements for a disclosure by an out-of-network facility-based physician that will forestall an enrollee's recourse to mandatory mediation; (ii) §21.5010(c)(2)(D) provides that in order for the disclosure to be "complete," it must comply with any rules promulgated by the Texas Medical Board under Insurance Code §1467.003; however, §1467.051 provides the specific requirements for a disclosure to be effective, and it does not mention compliance with any rules promulgated by the Texas Medical Board; (iii) although §1467.003 provides that the Texas Medical Board may promulgate rules to implement its respective powers and duties under Chapter 1467, the statute does not

confer any authority on the Board with respect to the content and procedures pertaining to the disclosure process; on the contrary, the Texas Medical Board's authority under Chapter 1467 appears to include: (a) addressing complaints of bad faith mediation by physicians subject to the mediation process; (b) adopting rules regulating the investigation and review of complaints relating to the settlement of an out-of-network health benefit claim that is subject to the chapter; (c) distinguishing between complaints for out-of-network coverage or payment and giving priority to investigating allegations of delayed medical care; (d) developing forms relating to such complaints and ensuring that complaints are given appropriate consideration; and (e) maintaining information regarding complaints as specified in §1467.151(b); and (iv) the Insurance Code §1467.151(d) provides that a facility-based physician who fails to provide disclosure under that section is not subject to discipline by the Texas Medical Board; given this statutory context, there appears to be no authority for proposed §21.5010(c)(2)(D) requiring that an out-of-network facility-based physician's disclosure comply with unspecified rules promulgated by the Texas Medical Board.

Agency Response: The Department agrees to delete the requirement in §21.5010(c)(2)(D) and has made the requested deletion in §21.5010(c)(2)(D) as adopted.

§21.5011. Mediation Request Form and Procedure

Comment: Two commenters assert that the Health Insurance Mediation Request Form should include additional required fields. One commenter states that a

request for mediation should include (i) the date(s) of service by the out-of-network facility-based physician; (ii) whether or not the physician is a hospital-based radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist; and (iii) the amount billed by the physician. This information is important in determining whether or not the enrollee's request involves a qualified claim and meets the $1,000 minimum requirement and/or constitutes an aggregation of claims not permitted by statute. This commenter also requests that the enrollee be required to state whether a proper disclosure has been received by the physician, as the Department will not otherwise be able to make an informed decision as to whether or not mandatory mediation is appropriate as requested by the enrollee.

Another commenter states that §21.5011 should require the enrollee to include a copy of the bill from the out-of-network provider. The commenter asserts that it is unclear how the Department would make a determination regarding the eligibility of the claim for mediation without obtaining a copy of the bill from the out-of-network provider.

Agency Response: The Department agrees that the request for mediation should include the amount billed by the physician and has updated the Health Insurance Mediation Request Form, as adopted, accordingly. While the Department agrees that this information is important in determining whether or not the enrollee's request involves a qualified claim and meets the $1,000 minimum requirement, the Department does not agree with the commenter's assertion that an aggregation of claims is not permitted by statute. It is the Department's position that the term "claim" as used in Chapter 1467 of the Insurance Code may in some instances include an aggregation of

claims as provided by the use of the term “aggregate” in §21.5010(a)(2) when read together with §21.5010(b) and §21.5003(3). Section 21.5010(b) provides for the use of more than one form in the submission of a claim and §21.5003(3) defines the term “claim.” The Department, however, does not agree that the other requested additional elements should be required for the following reasons: (i) the date of service is already an optional field in the Health Insurance Mediation Request Form; (ii) the name of the hospital-based physician is a required element for submitting a request, which enables the Department to easily determine whether the physician is a radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist; (iii) the “Eligibility” section of the form specifically informs the potential requestor that the claim must be for “a medical service or supply provided by an out-of-network hospital-based physician (such as a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist)”; (iv) the “Eligibility” section informs the potential requestor that he or she would be ineligible to request mandatory mediation if the hospital-based physician provided a complete and accurate disclosure before providing a medical service or supply that (a) explained that the facility-based physician did not have a contract with the individual’s health benefit plan; (b) disclosed projected amounts for which the individual may be responsible; and (c) disclosed the circumstances under which the individual would be responsible for those amounts; a hospital-based physician would also have the opportunity to produce documentation that such a disclosure had been made once notified that a request for mediation has been made; and (v) the “Eligibility” section also states that the amount owed to the

hospital-based physician (not including copayments, deductibles, coinsurance, and amounts paid by the insurer or administrator directly to the enrollee) must be more than $1,000; the individual, by submitting a request for mediation, certifies that the claim qualifies for mandatory mediation pursuant to the requirements of Chapter 1467 of the Texas Insurance Code.

Therefore, additional documentation, such as a copy of the bill, is unnecessary at the initial request. While the Department sets forth the eligibility criteria in the Health Insurance Mediation Request Form, it is the responsibility of the enrollee to determine whether his or her claim is eligible. Chapter 1467 of the Insurance Code does not require the Department to make determinations on whether claims are eligible for mediation.

Comment: A commenter suggests that the Department should be required to review each request for mediation and to determine whether or not it meets the statutory requirements for mediation. Such review and determination by the Department will be important to ensure that the parties are not improperly subjected to the time and expense of mediation, and possible special trial, when the statutory prerequisites for those procedures have not been met.

Agency Response: The Department disagrees. Chapter 1467 of the Insurance Code does not require the Department to make determinations on whether claims are eligible for mediation. The Insurance Code §1467.051(a) and §1467.054(b) are the relevant statutes, and none of these statutes require the Department to make determinations on whether claims are eligible for mediation. The Insurance Code

§1467.051(a) states, “An enrollee may request mediation of a settlement of an out-of-network health benefit claim if: (1) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000; and (2) the health benefit claims is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator.” The Insurance Code §1467.054(b) states, “A request for mandatory mediation must be provided to the department on a form prescribed by the commissioner and must include: (1) the name of the enrollee requesting mediation; (2) a brief description of the claim to be mediated; (3) contact information, including a telephone number, for the requesting enrollee and the enrollee’s counsel, if the enrollee retains counsel; (4) the name of the facility-based physician and name of the insurer or administrator; and (5) any other information the commissioner may require by rule.” To assist in ensuring that the statutory process is followed, the Department’s Health Insurance Mediation Request Form requires that the enrollee certify that the claim indicated in the form qualify for mandatory mediation pursuant to the requirements of Chapter 1467 of the Texas Insurance Code and the rules in Title 28 Texas Administrative Code Chapter 21, Subchapter PP, adopted pursuant to Chapter 1467. Therefore, it is the responsibility of the enrollee under both the statute and the adopted rules to determine whether his or her claim is eligible. However, if a request for mandatory mediation clearly does not meet the eligibility requirements, the Department may inform the requestor and appropriately reclassify the request as a complaint.

Alternatively, the assigned mediator and/or special judge, with the ability to request additional information from the parties, may be in the best position to quickly determine whether a claim is eligible under the statute.

§21.5012. Informal Settlement Teleconference

Comment: Two commenters object to §21.5012 as proposed because the insurer or administrator will not have control over the enrollee's or physician's actions, and failure by either enrollee or physician to cooperate or participate may affect the insurer or administrator's ability to comply with proposed §21.5012. The first commenter contends that proposed §21.5012 does not address the obligation of the enrollee and out-of-network physician to cooperate in the informal settlement teleconference process or the consequences of any failure in that regard. The commenter suggests that proposed §21.5012 be revised to state that neither an insurer nor an administrator should be subject to any sanction if the other parties to the teleconference fail to cooperate by not responding to the insurer/administrator's communications, by not providing information necessary to set up the teleconference, or by not making themselves available to participate in the teleconference.

The second commenter asserts that the Department has shifted the burden of scheduling the settlement conference on the insurer without making allowances for the availability of the parties and the timing of the receipt of the request by the insurer from the Department. The Insurance Code §1467.054(d) obligates "all parties" to participate in a teleconference not later than the 30th day after the date of the request. According

to the commenter, the proposed rule subjects the insurer to penalties for actions taken or not taken by the other parties. The commenter suggests that proposed §21.5012 be revised as follows: "An insurer or administrator that is subject to mandatory mediation requested by an enrollee under §21.5011 of this division (relating to Mediation Request Form and Procedure) shall coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by: (1) arranging a date and time when the insurer or administrator, the enrollee or the enrollee's representative if the enrollee or the enrollee's representative chooses to participate, and the hospital-based physician or the hospital-based physician's representative can participate in the informal settlement teleconference, [which shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation;] and (2) providing a toll-free number for participation in the informal settlement teleconference. *An insurer or administrator must use best efforts to schedule the informal settlement conference not later than the 30th day after the date on which the enrollee submits a request for mediation under this section."*

Agency Response: The Department agrees with the commenters on the necessity of clarification that best efforts must be used by insurers and administrators in scheduling the informal settlement conference. The Department, however, does not agree with one of the commenter's suggestions that the requested clarification should be made to §21.5012(2). Instead, the following change has been made to §21.5012 as adopted: "An insurer or administrator that is subject to mandatory mediation requested by an enrollee under §21.5011 of this division (relating to Mediation Request Form and

Procedure) shall *use best efforts to* coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by . . . ." This revision is very similar to that recommended by the commenter and has the same effect as the commenter's suggested language. This revision makes the commenter's suggestion to delete the requirement that the informal settlement teleconference "shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation" unnecessary. Therefore, this requirement is not deleted from §21.5012(1) as adopted because it reiterates the Insurance Code §1467.054(d) and is necessary for understanding §21.5012.

Comment: A commenter requests that proposed §21.5012 be revised to specify that if the enrollee fails to cooperate or attend the teleconference, he or she waives the right to mediation. The commenter's reasons are: (i) §1467.054(d) provides, "In an effort to settle the claim before mediation, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation under this section"; (ii) unlike the actual mediation session in which the enrollee's attendance is optional, the statute requires his or her participation in the teleconference proceeding; and (iii) the enrollee's participation is mandatory and necessary to explore the possibility of resolving the dispute without the expense and time involved in preparing for and attending mediation.

Agency Response: The Department disagrees that the enrollee is required by statute to participate in the informal teleconference. Section 1467.054(d) provides, "In an effort to settle the claim *before mediation*, all *parties* must participate in an informal

settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation under this section" (emphasis added). Section 1467.001(7) defines "party" as "an insurer offering a preferred provider benefit plan, an administrator, or a facility-based physician or the physician's representative who participates in a mediation conducted under this chapter. The enrollee is also considered a party *to the mediation*" (emphasis added). Thus, it is the Department's position that the informal settlement teleconference is not considered part of the mediation and also that the enrollee is not defined in §1467.001(7) as a "party" whose participation is required in the informal settlement teleconference under the Insurance Code §1467.054(d).

§21.5013. Mediation Participation

Comment: A commenter notes that although proposed §21.5013 requires insurers and administrators to mediate in good faith, the rule is silent regarding such obligation with respect to enrollees and out-of-network facility-based physicians. Chapter 1467 clearly requires that all parties to mediation attend in good faith, and the proposed rule should be revised to reflect that the duty of good faith applies to all parties to the mediation.

Agency Response: The Insurance Code §1467.101 describes the conduct that constitutes bad faith mediation for purposes of Chapter 1467. The Insurance Code §1467.102(a) states, "Bad faith mediation, by a party other than the enrollee, is grounds for imposition of an administrative penalty *by the regulatory agency that issued a license*

or certificate of authority to the party who committed the violation" (emphasis added). As a result, the Department's rules address only those parties, i.e., insurers and administrators, that are subject to the Department's regulatory authority.

Comment: A commenter suggests that proposed §21.5013 could be improved to clarify the limits of the mediator's right to request information from the parties. Proposed §21.5013 should be revised to (i) provide that any confidential information provided to the mediator must remain confidential unless the providing party consents to its disclosure to the other party(s); (ii) reflect that the mediator's request for information must be objectively reasonable in terms of facilitating an agreement between the parties; and (iii) emphasize the requirement of §1467.055 that, except as otherwise provided by the statute, the mediator shall hold in strict confidence all information provided to him or her by a party and all his or her communications with each party. The commenter asserts the following reasons for the suggested change: (i) to the extent that it would permit the mediator to share, without consent, confidential or privileged information with other parties to the mediation, proposed §21.5013 exceeds both the scope of Chapter 1467 and conflicts with the accepted common and best practices used in mediations generally; (ii) the Texas Civil Practice and Remedies Code Chapter 154 addresses general statutory procedures for mediation, including the parties' control over information provided to the mediator; (iii) currently, proposed §21.5013 places no limits on the kind of information the mediator may request, leaving entirely to his or her discretion the determination of what information is necessary to facilitate the agreement; and (iv) much of the information relevant to mediation may be

considered important privileged and confidential information, and the proposed rules should recognize the parties' legitimate rights and expectations regarding its protected nature.

Agency Response: The Department does not have the statutory authority to make the suggested changes. Chapter 1467 of the Insurance Code does not delegate any authority to the Department to regulate mediators for purposes of Chapter 1467. Therefore, the Department is not involved in oversight of the mediators participating in the mediation process. Pursuant to the Insurance Code §1467.053, the chief administrative law judge shall appoint the mediator through a random assignment from a list of qualified mediators maintained by the State Office of Administrative Hearings. For purposes of mandatory mediation under Chapter 1467, mediators are regulated pursuant to rules promulgated by the State Office of Administrative Hearings under Title 1 of the Texas Administrative Code, Chapter 167, Subchapters A - E.

§21.5030. Complaint Resolution

Comment: A commenter recommends that proposed §21.5030(c) be revised to require that the enrollee be notified of available administrative remedies provided pursuant to Chapter 1551 of the Texas Insurance Code and ERS' rules, in addition to the Department's procedures for addressing complaints pursuant to Chapter 1467. The scope of Chapter 1467 is limited to disputes between an enrollee and out-of-network facility-based physician and an insurer or administrator regarding the enrollee's share after benefits have been paid on a covered claim. To the extent that the enrollee's

complaint relates to matters outside the scope of Chapter 1467, Chapter 1551 provides exclusive administrative remedies through ERS, its administrator and/or through judicial review as provided by the statute. Enrollees will need the Department's guidance so that their complaints are directed appropriately as required by either Chapter 1467 or Chapter 1551 of the Insurance Code. Accordingly, the commenter proposes that subsection (c) be revised to include a part (5) stating: "(5) Notification to the enrollee of administrative remedies available under Chapter 1551 of the Insurance Code if a complaint by a participant in the Texas Employees Group Benefits Program does not fall within the scope of Chapter 1467."

Agency Response: The Department declines to make the requested change because rulemaking on this issue is not required under Chapter 1467 of the Insurance Code, and the Department disagrees that such a change is required or necessary. The Department will provide the recommended notice on its website to enable ERS enrollees to have access to such information. Additionally, the ERS has the option, without any such rule, to provide the notice on the enrollees' explanations of benefits at the same time that the required notice of the availability of mediation is provided.

Comment: A commenter suggests adding a part (b)(4)(D) to proposed §21.5030 to address additional specific information to be included about the qualified claim that is the basis of the complaint. According to the commenter, it will further strengthen the rules and give a better idea of the costs related to out-of-network claim disputes. The commenter recommends that it read: "(b)(4)(D) the dollar amount of the claim at dispute."

Agency Response: The Department agrees and §21.5030 as adopted includes "(b)(4)(D) the dollar amount of the disputed claim."

Fiscal Note—Cost of mediation

Comment: One commenter states disagreement with the Department's published Fiscal Note for mediation costs for the Employees Retirement System (ERS). This disagreement is based on: (i) legislative cost information provided to the Department and to the Legislative Budget Board during the 81st Legislative session (ERS Cost Estimate); and (ii) a potentially higher estimate of the number of mediations that will be requested. The commenter anticipates that ERS' likely average costs for each mediation, including travel, would be $2,000. The language and context of the ERS Cost Estimate shows that the focus was on the cost of mediation to ERS and not to all parties, and that the likely average cost to ERS would be $2,000. The ERS Cost Estimate states, "While this additional [mediation] cost, estimated at about $2,000 per case including associated travel expenses, would initially be paid by the HealthSelect administrator, it would ultimately be passed through to HealthSelect as an increase in the administrative fee." The commenter, referencing the Department's Fiscal Note, asserts that "this analysis appears reasonably clear that ERS' estimate of its average cost per mediation is $2,000, not the $1,000 figure referenced in TDI's fiscal analysis." The commenter further asserts that actual costs for representation and travel to the location of the mediation may substantially exceed the Department's estimate in the Fiscal Note. If ERS staff and/or its attorneys are required to travel across the state to

attend a mediation, then the travel costs would increase substantially beyond the Department's estimate. The commenter also states that the estimated cost for mediation does not appear to reflect costs associated with lost productivity of staff and attorney time during prolonged travel.

The commenter states that the ERS Cost Estimate reflected that as many as 2,500 claims of participants in HealthSelect may be subject to mediation per plan year. Reliance on initial experience for claims for mediation may be misleading, since increased awareness of the right to mediation may increase the number of requests. If 2,500 ERS cases were mediated, ERS' likely cost would be approximately $5 million. Further, according to the commenter, that estimate does not reflect the Department's proposed definition of "claim" allowing the aggregation of claims that otherwise would not meet the mandatory $1,000. As more claims would qualify for mediation through the process of aggregation, the costs to the HealthSelect plan would increase accordingly.

Agency Response: The Department acknowledges the difference in cost estimates, which are a result of the Department's reliance on additional sources of information and a different methodology that does not result in a figure analogous to the commenter's estimated $5 million cost. However, based on the following reasons, the Department is of the opinion that the Fiscal Note is not incorrect nor does it fail to substantially comply with the requirements of the Government Code §2001.024. The Department estimated in its Fiscal Note a potential range of fiscal cost to ERS of between $81.26 and $1,936.18 per mediation, but noted additional factors that might

increase this cost, such as: (i) the parties' agreement to participate in additional hours of mediation under the Insurance Code §1467.058; (ii) the amount of time required to coordinate the informal settlement teleconference; (iii) whether a staff representative or attorney is used; and (iv) the amount of time required for litigation before a special judge. The Fiscal Note further explained that an estimate of the total fiscal impact resulting from the Department's proposed rule was not possible. Consistent with the Government Code §2001.024, the Fiscal Note did not address fiscal impact resulting from the statute. The Department relied on the ERS Cost Estimate in conjunction with more recent correspondence with ERS' in its methodology to develop the Fiscal Note for mediation costs to the ERS. The ERS Cost Estimate, 81st Legislature, HB 2256, to which the commenter refers, states, "The As Passed Second House version continues to require the cost of mediation *to be split evenly between the facility-based physician and the HealthSelect administrator* [emphasis added]. While this additional cost, estimated at about $2,000 per case including associated travel expenses, would initially be paid by the HealthSelect administrator, it would ultimately be passed through to HealthSelect as an increase in the administrative fee. This would eventually lead to higher contributions for the state and the members." In addition to the information provided to the Department in the ERS Cost Estimate, the Department also solicited information from ERS through written correspondence during the development of the proposal. The Department submitted a question to the ERS asking, "If the ERS administrator has to arrange for the telephone conferences, is ERS anticipating a separate charge from the administrator for this, or can you estimate what the cost for

this would be?" ERS, in correspondence dated September 28, 2009, answered to the Department, "Initially no but if the volume emerges as anticipated, eventually they will have to charge for this service. *The cost of the actual mediator charge we believe will be passed on to ERS. We estimate our portion of the mediator charge at $1,000 per mediation*" (emphasis added). The Department read the ERS Cost Estimate in conjunction with the ERS' correspondence and interpreted the "$2,000 per case including associated travel expenses" as describing the entire cost of the case, which was to be split between the facility-based physician and the HealthSelect administrator for a resulting cost of $1,000 per party. This figure was consistent with the $1,000 estimate in the September 28, 2009 ERS correspondence. In the Fiscal Note discussion titled "Cost of Mediation," the Department estimates mediator fees will range from $325 to $1,000 per party for a half-day of mediation. This estimated range was based on the following factors: (i) ERS' statement in its September 28, 2009 correspondence that its estimated mediator charge was $1,000 per mediation, and (ii) other mediation cost estimates provided by the Texas Medical Association, Texas Society of Anesthesiologists, and Burdin Mediators. Significantly, the Department acknowledges in the Fiscal Note that such costs for mediator fees and travel expenses may exceed the $325 to $1,000 estimate.

With regard to the commenter's estimated total cost of $5 million for mediations each plan year, the Department disagrees that it should be addressed in the Fiscal Note. According to the commenter, ERS' likely cost for mediations per plan year would be approximately $5 million if 2,500 cases were mediated annually and indicated that

such cost does not reflect the Department's proposed definition of "claim." Therefore, the $5 million estimate is projected independent of the Department's rules and reflects only the costs for compliance with the statutory requirements for mandatory mediation. As such, this type of total estimate that includes compliance with statutory requirements would not be included in the Fiscal Note. The Government Code §2001.024 requires that the Fiscal Note in a proposal must address, inter alia, "the additional estimated cost to the state and to local governments expected *as a result of enforcing or administering the rule*" (emphasis added). It does not require the Fiscal Note to address estimated costs to the state and to local governments expected as a result of statute.

Additionally, the Department did not compute an estimate analogous to the $5 million. In contrast to the Department's methodology, the commenter's methodology multiplies (i) the estimated number of mediations (2,500) by (ii) the estimated cost of mediation, including travel ($2,000) for a resulting total estimate of $5 million. The Department's methodology did not include an estimated number of claims eligible for mediation, stating, "It is not possible for the Department to estimate the total number of requests for mediation because that number will be determined by numerous factors not suitable to reliable quantification. . . ." Therefore, the Department does not have a computed estimate analogous to the commenter's total estimate of $5 million, because, unlike the commenter, the Department determined that it was not able to estimate the total number of claims.

With regard to the comment that the estimated cost for mediation does not appear to reflect costs associated with lost productivity of staff and attorney time during

prolonged travel, the election of any entity required to comply with these rules to use existing staff to represent the entity in the mediation is the result of a business decision by that entity and not a requirement of these rules. Additionally, the Fiscal Note, which is based on the Department's interpretation of the ERS Cost Estimate and ERS' correspondence, states, "ERS estimates its portion of the mediator charge at $1,000 per mediation, including travel to the county which has jurisdiction." In addition, the Fiscal Note stated that "The Insurance Code §1467.054(e) requires that mediation take place in the county in which the medical services were rendered." Therefore, although the Fiscal Note did not specifically include a separate estimate of the costs of compensating staff or attorneys for travel time as a separate cost component, these two statements clearly indicate that travel may be required. Additionally, under the discussion titled "Cost of representation," the Fiscal Note states an estimate of a mean hourly wage of $64.05 for a general and operations manager in the insurance industry in Texas, i.e., staff, and a mean hourly wage of $59.91 for a lawyer in Texas. These estimated hourly wages could be used by entities required to comply with these rules to compute estimated costs of an employee's lost productivity or estimated costs of an attorney's time for travel to the mediation. If the $64.05 estimated hourly wage for staff or the $59.91 estimated hourly wage for an attorney is not appropriate for any entity required to comply with the rules, such entities have the necessary information to compute estimated costs associated with lost productivity of their own staff and estimated costs associated with the time for their attorneys during prolonged travel. Further, if any entity required to comply with these rules chooses to use existing staff to represent them in

the mediation, such a choice is a result of a business decision and not a requirement of these rules.

In addition, the Department's assessment in the published Fiscal Note was that because the Department had received no qualified request for mediation as of April 1, 2010, that this lack of requests could indicate that there would be relatively few requests for mediation involving the ERS on or after September 1, 2010, when the mediation process becomes effective for ERS enrollees. Therefore, as a result of this assessment, the Department is of the opinion that any fiscal impact associated with lost productivity of staff and attorney time during prolonged travel for any entity required to comply with these rules will likely be minimal.

Comment: A commenter requests that the Fiscal Note be revised because it does not reflect certain additional cost factors. These additional cost factors are the costs associated with (i) responding to document requests by the mediator; (ii) responding to discovery and other prehearing matters in the special trial process; (iii) addressing disputes and legal questions relating to implementation of Chapter 1467 and the proposed rules; and (iv) increased costs to the group benefits program if the requirements of Chapter 1467 result in substantial provider reimbursement increases. According to the commenter, the aggregate estimated costs to ERS to comply with Chapter 1467 and the proposed rules may exceed $8.25 million per plan year.

Agency Response: The Department declines to revise its Fiscal Note for the following reasons: (i) the Department disagrees that the estimates do not take into account the costs associated with (a) responding to document requests by the mediator

and (b) responding to discovery and other prehearing matters in the special trial process; the Department included estimated costs for representation hours, including legal preparation time, and the Department anticipated that this preparation time would include such responses; (ii) the Department disagrees that the Fiscal Note should discuss increased costs to the group benefits program due to potential provider reimbursement increases because the proposed rules do not specifically require any increases in reimbursements to providers; and (iii) the Department does not agree that the costs of addressing disputes and legal questions relating to the implementation of Chapter 1467 and the proposed rules should be addressed in the Fiscal Note; these costs result from the enactment of Chapter 1467 of the Insurance Code. Further, it is the experience of this agency that there are no legal requirements to estimate cost for purposes of a Fiscal Note or a Cost Note for responding to questions relating to adopted rules.

With respect to the commenter's estimated cost of $8.25 million per plan year, the commenter does not distinguish between estimated costs imposed by Chapter 1467 of the Insurance Code and those imposed by the rules. The commenter did not identify any new costs specifically imposed by the proposed rules that were not included in the Department's Fiscal Note.

Fiscal Note—Cost for special judges' fees

Comment: One commenter asserts that the cost for special judges' fees would be substantially more than is reflected in the Fiscal Note. According to the commenter,

Administrative Law Judges (ALJs) spend an average of 16 hours per ERS case rather than the four hours estimated by the Department and substantially more time on aggressively litigated cases heard on the merits. In addition, the commenter argues that the estimated rate of $28.17 per hour for special judges appears unrealistically low. According to the commenter, information from SOAH indicated a rate of $100 per hour for an ALJ hearing an ERS case. If a judge qualifying as a special judge under Chapter 151 of the Texas Civil Practice and Remedies Code who has expertise in dealing with patient share insurance issues can be found, the commenter anticipates that his or her fee rate would probably be in the range of $400 to $500 per hour. The commenter opines that a more reasonable estimate of the special trial judge's cost is approximately $8,000 per case. This estimate would result in a cost of $2,600 for the judge's fee for each party, assuming that the ERS, the provider and the enrollee each bear a proportionate share of the cost. This cost would be in addition to the costs for any court reporting services used in the proceeding and other incidental expenses. According to the commenter, if half of the estimated 2,500 mediations continued to the special trial process, the ERS portion of the special judges' fees alone would exceed $3.25 million per plan year.

Agency Response: While the Department's Fiscal Note estimated $28.17 per hour for special judges' fees and a four-hour period of time for a case, the Fiscal Note also stated that the cost for special judges' fees could be a higher rate and that the average case may take longer than the anticipated four hours. The Department's estimated $28.17 per hour for special judges' fees was based on the latest DOL Wage

Report average for Texas, full-time judges, magistrate judges, and magistrates. The Fiscal Note specifically allowed for fee variance, stating that "the salary, however, of a special judge working on a contract basis, as in this instance, will vary from and may exceed the full-time salaried hourly wage." Additionally, the Fiscal Note indicated that the length of a case before a special judge may vary. The four-hour estimate is based on the fact that §1467.055(f) of the Insurance Code provides that a mediation will last no more than four hours except by agreement of the participating parties. Based on the length of the mediation, the Fiscal Note assumed a similar timeframe for the litigation before a special judge. The Fiscal Note stated: "Costs for special judge fees and court reporter fees will be higher if the process takes longer than the estimated four hours." With regard to the average 16 hours per ERS case, it is possible that mediation pursuant to Chapter 1467 of the Insurance Code may not take as long as the average ERS case. Under Chapter 1467 of the Insurance Code, the scope of the mediation before the special judge is limited to the dispute about the amount paid by the insurer or administrator to the facility-based physician, the amount charged by the facility-based physician, and the amount paid to the facility-based physician by the enrollee.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: Office of Public Insurance Counsel

Neither for nor against, with recommended changes: Texas Association of Health Plans, Employees Retirement System of Texas

6. STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code §§1467.003, 1467.054(b), 1467.151(a), 1467.151(b) and 36.001 and HB 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009, SECTION 7. Section 1467.003 requires the Commissioner to adopt rules as necessary to implement the Commissioner's respective powers and duties under Chapter 1467 of the Insurance Code (Out-of-Network Claim Dispute Resolution). Section 1467.054(b) provides that a request for mandatory mediation must be provided to the Department on a form prescribed by the Commissioner. Section 1467.151(a) requires that the Commissioner, as appropriate, adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467 of the Insurance Code. Section 1467.151(b) requires the Department to maintain certain information on each complaint filed that concerns a claim or mediation subject to the Insurance Code Chapter 1467 and to related claims, including any information about the insurer or administrator that the Commissioner by rule requires. Section 36.001 provides that the Commissioner may 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. HB 2256, SECTION 7 provides that, as soon as practicable after the effective date of HB 2256, the Commissioner shall adopt rules as necessary to implement and enforce HB 2256.

7. TEXT.

Division 1. General Provisions

§21.5001. Purpose. As authorized under the Insurance Code §1467.003, the purpose of this subchapter is to:

(1) prescribe the process for requesting and initiating mandatory mediation of claims as authorized in the Insurance Code Chapter 1467; and

(2) facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under the Insurance Code Chapter 1467.

§21.5002. Scope.

(a) This subchapter applies to a qualified claim filed under health benefit plan coverage:

(1) issued by an insurer as a preferred provider benefit plan under the Insurance Code Chapter 1301, provided the claim is filed on or after November 1, 2010; or

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under the Insurance Code Chapter 1551, provided the claim is filed on or after November 1, 2010.

(b) This subchapter does not apply to a claim for health benefits, including medical and health care services and/or supplies, that is not a covered claim under the terms of the health benefit plan coverage.

§21.5003. Definitions. The following words and terms when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

(1) Administrator--An administering firm or a claims administrator for a health benefit plan, other than an HMO plan, providing coverage under the Insurance Code Chapter 1551.

(2) Chief administrative law judge--The chief administrative law judge of the State Office of Administrative Hearings.

(3) Claim--A request to a health benefit plan for payment for health benefits under the terms of the health benefit plan coverage, including medical and health care services and/or supplies, provided that such services or supplies:

(A) are furnished pursuant to a single date of service; or

(B) if furnished pursuant to more than one date of service, are provided as a continuing and/or related course of treatment over a period of time for a specific medical problem or condition, or in response to the same initial patient complaint.

(4) Enrollee--An individual who is eligible to receive benefits through a health benefit plan.

(5) Health benefit plan--A plan that provides coverage under:

(A) a preferred provider benefit plan offered by an insurer under the Insurance Code Chapter 1301; or

(B) a plan, other than a health maintenance organization plan, under the Insurance Code Chapter 1551.

(6) Hospital-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom the hospital has granted clinical privileges; and

(B) who provides services to patients of the hospital under those clinical privileges.

(7) Insurer--A life, health, and accident insurance company, health insurance company, or other company operating under the Insurance Code Chapters 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state a preferred provider benefit plan under the Insurance Code Chapter 1301.

(8) Mediation--A process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan or the administrator and a hospital-based physician or the physician's representative to settle a qualified claim of an enrollee.

(9) Mediator--An impartial person who is appointed to conduct mediation under the Insurance Code Chapter 1467.

(10) Out-of-network claim--A claim for payment for medical or health care services and/or supplies that are furnished by a hospital-based physician that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator.

(11) Preferred provider--A hospital or hospital-based physician that contracts on a preferred benefit basis with an insurer issuing a preferred provider

benefit plan under the Insurance Code Chapter 1301 to provide medical care or health care to enrollees covered by a health insurance policy.

Division 2. Mediation Process

§21.5010. Qualified Claim Criteria.

(a) Required Criteria. An enrollee may request mandatory mediation of an out-of-network claim under §21.5011 of this division (relating to Mediation Request Form and Procedure) if the claim complies with the criteria specified in paragraphs (1) and (2) of this subsection. An out-of-network claim that complies with such criteria is referred to as a "qualified claim" in this subchapter.

(1) The out-of-network claim must be for medical services and/or supplies provided by a hospital-based physician in a hospital that is a preferred provider with the insurer or that has a contract with the administrator.

(2) The aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $1,000.

(b) Submission of Multiple Claim Forms. The use of more than one form in the submission of a claim, as defined in §21.5003(3) of this subchapter (relating to Definitions), does not preclude eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible Claims.

(1) An out-of-network claim is not eligible for mandatory mediation under this subchapter if:

(A) the hospital-based physician has provided a complete disclosure to an enrollee under the Insurance Code §1467.051 and this subsection before providing the medical service and/or supply and has obtained the enrollee's written acknowledgment of that disclosure; and

(B) the amount billed by the hospital-based physician is less than or equal to the maximum amount specified in the disclosure.

(2) A complete disclosure under paragraph (1) of this subsection must:

(A) explain that the hospital-based physician does not have, as applicable, either a contract with the enrollee's health benefit plan as a preferred provider or a contract with the administrator of the plan, other than an HMO plan, provided under the Insurance Code Chapter 1551;

(B) disclose projected amounts for which the enrollee may be responsible; and

(C) disclose the circumstances under which the enrollee would be responsible for those amounts.

§21.5011. Mediation Request Form and Procedure.

(a) Mediation Request Form. The commissioner adopts by reference Form No. LHL619 (Health Insurance Mediation Request Form), which is available at http://www.tdi.state.tx.us/consumer/cpmmediation.html. Form No. LHL619 (Health

Insurance Mediation Request Form) requires information necessary for the department to properly identify the qualified claim, including:

(1) the name and contact information, including a telephone number, of the enrollee requesting mediation;

(2) a brief description of the qualified claim to be mediated;

(3) the name and contact information, including a telephone number, of the requesting enrollee's counsel, if the enrollee retains counsel;

(4) the name of the hospital-based physician;

(5) the name of the insurer or administrator; and

(6) the name and address of the hospital where services were rendered.

(b) Submission of Request. An enrollee may submit a request for mediation by completing and submitting Form No. LHL619 (Health Insurance Mediation Request Form) as provided in paragraphs (1) - (4) of this subsection.

(1) The request may be submitted via mail, to the Texas Department of Insurance, Consumer Protection Division, Mail Code 111-1A, P.O. Box 149091, Austin, Texas 78714-9091.

(2) The request may be submitted via fax, to (512) 475-1771.

(3) The request may be submitted via e-mail, to ConsumerProtection@tdi.state.tx.us.

(4) Upon the department's making Form No. LHL619 (Health Insurance Mediation Request Form) available to be completed and submitted online, an enrollee may submit the request in this manner.

(c) Assistance. Assistance with submitting a request for mediation is available at the department's toll-free telephone number, 1-800-252-3439.

§21.5012. Informal Settlement Teleconference. An insurer or administrator that is subject to mandatory mediation requested by an enrollee under §21.5011 of this division (relating to Mediation Request Form and Procedure) shall use best efforts to coordinate the informal settlement teleconference required by the Insurance Code §1467.054(d) by:

(1) arranging a date and time when the insurer or administrator, the enrollee or the enrollee's representative if the enrollee or the enrollee's representative chooses to participate, and the hospital-based physician or the hospital-based physician's representative can participate in the informal settlement teleconference, which shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation; and

(2) providing a toll-free number for participation in the informal settlement teleconference.

§21.5013. Mediation Participation.

(a) An insurer or administrator subject to mediation under this subchapter shall participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge pursuant to the Insurance Code §1467.003.

(b) Under the Insurance Code §1467.101, conduct that constitutes bad faith mediation includes:

(1) failing to participate in the mediation;

(2) failing to provide information that the mediator believes is necessary to facilitate an agreement; or

(3) failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

Division 3. Plan Administrator's Required Notice of Claims Dispute Resolution

§21.5020. Required Notice of Claims Dispute Resolution. An administrator of a plan under the Insurance Code Chapter 1551 shall include a notification of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after November 1 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator.

Division 4. Complaint Resolution and Outreach

§21.5030. Complaint Resolution.

(a) Written Complaint.

(1) An individual may submit to the department a written complaint regarding a qualified claim or a mediation that has been requested under §21.5010 of

this subchapter (relating to Qualified Claim Criteria). A recommended form for filing a complaint under this subsection is available at http://www.tdi.state.tx.us/consumer/cpportal.html. The complaint may be submitted by:

(A) mail, to the Texas Department of Insurance, Consumer Protection Division, Mail Code 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(B) fax, to (512) 475-1771;

(C) e-mail, to ConsumerProtection@tdi.state.tx.us; or

(D) online submission.

(2) Assistance with filing a complaint is available at the department's toll-free telephone number, 1-800-252-3439**.**

(b) Complaint Form. The recommended form for filing a complaint under subsection (a) of this section requests that certain information concerning the complaint be provided, including:

(1) whether the complaint is within the scope of the Insurance Code Chapter 1467;

(2) whether medical care has been delayed or has not been given;

(3) whether the medical service and/or supply that is the subject of the complaint was for emergency care; and

(4) specific information about the qualified claim, including:

(A) the type and specialty of the hospital-based physician;

(B) the type of service performed or supplies provided;

(C) the city and county where service was performed; and

(D) the dollar amount of the disputed claim.

(c) Department Processing. The department shall maintain procedures to ensure that a written complaint made under this section is not dismissed without appropriate consideration, including:

(1) review of all of the information submitted in the written complaint;

(2) contact with the parties that are the subject of the complaint;

(3) review of the responses received from the subjects of the complaint to determine if and what further action is required, as appropriate; and

(4) notification to the enrollee of the mediation process, as described in the Insurance Code Chapter 1467, Subchapter B.

§21.5031. Department Outreach. In addition to the notice provided to consumers regarding the availability of mandatory mediation as described in §21.5030(c) of this division (relating to Complaint Resolution), the department will provide outreach as required by the Insurance Code §1467.151(a)(2) by making information concerning the availability of this mandatory mediation process available:

(1) on the department's website; and

(2) via consumer publications.

CERTIFICATION. This agency hereby certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on September 17, 2010.

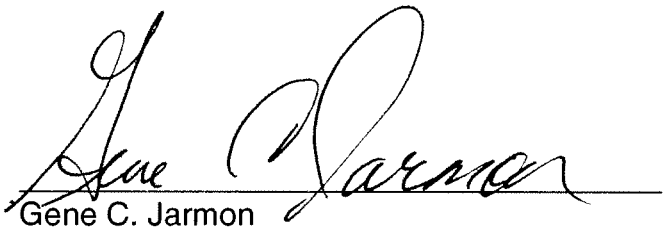
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that new Subchapter PP, §§21.5001 – 21.5003, 21.5010 – 21.5013, 21.5020, 21.5030 and 21.5031 specified herein, concerning the out-of-network claim dispute resolution process, the plan administrator's required notice of the out-of-network claim dispute resolution process, the resolution of related complaints, and outreach efforts to inform consumers about the out-of-network claim dispute resolution process, is adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:



Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. 10-0861
SEP 28 2010