Chapter 21. Trade Practices
Subchapter KK. Health Care Reimbursement Rate Information
28 TAC §§21.4501 - 21.4507

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC §§21.4501 - 21.4507, concerning health care reimbursement rate information. The amendments are adopted with changes to the proposed text published in the November 20, 2015, issue of the *Texas Register* (40 TexReg 8158).

TDI modified "§21.4705" to "§21.4505" in §21.4507(c)(1)(C), (c)(2)(B), (c)(3), (c)(4)(C), (c)(5)(B), (c)(6)(B), (c)(6)(C), and (d)(1) of the proposal text to correct the citation. The adopted rules reference the correct citation.

TDI modified "subchapter" to "title" in §§ 21.4502(a), 21.4505(b), 21.4507 (c)(1)(C), 21.4507(c)(2)(C), 21.4507(c)(3), 21.4507(c)(4)(C), 21.4507(c)(5)(B), 21.4507(C)(6)(B) - (C), and 21.4507(d)(1).

In response to a comment, TDI removed §21.4502(e). TDI will explain issuers' ability to include self-funded data in data collection instructions provided to issuers prior to the due date of each annual data call, instead of including it in the rule text. Because of the removal of subsection (e), TDI changed §21.4502(f) to §21.4502(e) and §21.4502(g) to §21.4502(f).

In response to a comment, TDI modified the definition of "allowed amount" at §21.4503(1) to use the term "payment" instead of "reimbursement."

TDI added the words "and §38.353, which is" and "or a state employee health plan under Insurance Code Chapters 1551, 1575, 1579, and 1601" to the definition of applicable health benefit plan at §21.4503(3). These plans are included in the applicability section of Insurance Code §38.353, and including them in the definition adds clarity.

In response to a comment, TDI modified the definition of "freestanding emergency medical care facility" at §21.4503(6) as one that is "required to be licensed under Health and Safety Code Chapter 254."

In response to a comment, TDI modified the definition of "in-network claims" under §21.4503(10) to clarify that the provider must be contracted "under the plan."

TDI made minor changes to terminology in order to consistently use the term, "applicable health benefit plan issuer" in §21.4503(18) and §21.4506(a).

In response to a comment, TDI made minor changes to terminology in order to consistently use the term, "health care services" in §§21.4503(4), 21.4503(10), 21.4503(12), and 21.4505(b).

In response to a comment, TDI made minor changes to terminology in order to consistently use the term "provider" in §21.4503(16) and §21.4504.

TDI removed the words "in §21.4506 of this subchapter" from §21.4505(a).

TDI removed the words "for in-network and out-of-network claims" from §21.4507(b).

TDI reordered the list of services at §21.4507(c)(1)(C) by moving "back surgery - laminectomy" from §21.4507(c)(1)(C)(vi) to §21.4507(c)(1)(C)(vii) in order to group services together that are collected for both inpatient and outpatient.

TDI added the words "pathology claims" and "as applicable" to §21.4507(c)(2)(B). The changes modify specifications for outpatient professional claims data in order to align the requirements for professional outpatient claims with those for professional inpatient claims.

TDI removed the words "free-standing clinic" from §21.4507(c)(2)(B) because the place-of-service codes used for professional claims data do not include a code for free-standing clinics.

TDI reordered and renumbered the list of outpatient services at §21.4507(c)(2)(C) and added "back surgery - laminectomy" to the list at §21.4507(c)(2)(C)(i). TDI reordered and renumbered the list of services to accommodate the additional service and to group the services by those collected in both inpatient and outpatient settings. "Back surgery - laminectomy" was added because it is on the list of procedures collected for inpatient, but the procedure is also commonly performed on an outpatient basis.

TDI renamed "myringotomy" to "tympanostomy" and renumbered it from §21.4507(c)(2)(C)(vii) to §21.4507(c)(2)(C)(ix). The term tympanostomy provides a more accurate description of the service for which data is collected.

TDI added a space between (ii) and "evocative suppression testing" at §21.4507(c)(5)(B)(ii).

TDI removed the word "lab" at §21.4507(c)(6) to clarify data for rural health clinic office visits is not limited to laboratory services.

TDI added the words "by time or complexity" to the description of office visits under §21.4507(c)(6)(B)(i) - (iii). The change clarifies that data for office visits should be specific to the level of time or complexity involved.

TDI changed §21.4507(b) and §21.4507(c)(1)(C) to insert the words "of this title" following a references to other sections.

TDI changed capitalization in the introductory phrases in §§21.4507(c)(2) - (6), 21.4503(1) - (5), 21.4503(7) - (16), and 21.4507 for consistency with TDI rule drafting style for introductory phrases.

TDI removed the introductory phrase "Data submission requirements" in §21.4507(d) for consistency within the section.

In response to a comment, TDI deleted §21.4507(d)(4)(C) to remove reference to "self-funded employer group plans." As a result of this change, §21.4507(d)(4)(D) was changed to §21.4507(d)(4)(C) and §21.4507(d)(4)(E) was changed to §21.4507(d)(4)(D).

These changes do not introduce new subject matter, create additional costs, or affect persons other than those previously on notice from the proposal.

REASONED JUSTIFICATION. The amendments to §§21.4501 - 21.4507 are necessary because data collected under the previously adopted rules do not produce a consistent and accurate representation of average market prices for health care services.

In 2007, the Legislature adopted Insurance Code Chapter 38, Subchapter H, which authorized TDI to collect annually data concerning health benefit plan reimbursement rates. On January 9, 2011, TDI adopted rules that created a data collection methodology to collect certain information related to reimbursement rates, and TDI annually published the information collected in a Reimbursement Rate Guide on its website. The purpose of the guide is to help consumers estimate costs in advance of planned procedures and mitigate balance billing.

TDI found that much of the data submitted by carriers under the rules adopted in 2011 did not accurately reflect costs that consumers are likely to face. In collaboration with the University of Texas School of Public Health, TDI improved the data collection methodology, which is adopted in these rules. The methodology will improve the quality and relevance of data provided to consumers through the Reimbursement Rate Guide.

Past data was orientated around single medical billing codes, which could not provide consumers with a clear picture of treatment event costs because the full cost of a procedure may include multiple claims, each including multiple lines of billing codes. The adopted methodology presents more accurate procedure costs by using key target codes. For any claim that includes a target code, the issuer will provide the full cost of the claim, inclusive of the target code and other services provided.

In addition to collecting a more comprehensive set of claims costs, the adopted amendments also include an explicit method for grouping different claims related to the same medical service into a treatment event. This will allow TDI to present cost estimates to consumers that represent the total cost of care, rather than separately presenting facility costs, physician costs, and anesthesiologist costs.

The adopted methodology: (i) improves accuracy of price estimates for inpatient and outpatient procedures by collecting data at the claim level (rather than the line level); (ii) makes data more meaningful by grouping separate cost components by treatment event; (iii) mitigates the influence of outliers by collecting median amounts; and (iv) allows TDI to present a likely range of costs by collecting minimum/maximum and 25th/75th percentiles.

TDI hosted stakeholder meetings on April 15, 2014, and November 13, 2014, to discuss changes to the data collection methodology and potential changes to TDI's data collection rules at 28 TAC §§21.4501 - 21.4507. TDI posted an informal draft of the rule text on its website April 17, 2015, and invited further public comment. Originally set to expire May 15, 2015, TDI extended the informal comment period until September 1, 2015, to coincide with the due date for the reimbursement rate data call. TDI issued the annual reimbursement rate data call bulletin on June 5, 2015, and invited issuers to submit a limited set of test data using the methodology proposed in the informal draft of the rule, instead of the full reporting of the 2015 reimbursement rate information under Form LHL616 and the current rule. Issuers were encouraged to communicate problems or concerns with the methodology as well as costs associated with compliance.

In selecting procedures for purposes of data collection, TDI considered several factors. First, TDI considered services that are widely used and that consumers usually plan for in advance of receiving the service. TDI surveyed existing price transparency websites for the services to include. TDI prioritized services, such as imaging, for which the price may vary significantly based on the place of service. TDI

also considered consumers' need for data on fair market prices for services for which they may be balance billed, such as pathology or emergency care.

As referenced in adopted §21.4505(b), the medical billing codes and instructions for the data filing for the calendar year 2015 reporting period are currently available on TDI's website. The medical billing codes on the website have not changed since being posted on December 29, 2015.

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

Section 21.4501. Purpose. The adopted amendment to §21.4501(3) deletes reference to the Department of State Health Services' publication.

Section 21.4502. Applicability. The adopted amendments to §21.4502 delete the word "group" and insert "applicable" before "health benefit plan" to conform to adopted amendments at §21.4503(3). Adopted amendments add new subsection (e), which exempts an applicable health benefit plan issuer with fewer than 20,000 covered lives in comprehensive health coverage, as reported on Part 1 of the National Association of Insurance Commissioners Supplemental Health Care Exhibit at the end of the applicable reporting period, from reporting requirements under §21.4506, as provided in Insurance Code §38.353(e). Adopted amendments add new subsections (f)(1) and (2), which provide that, under Insurance Code §38.353(e), the subchapter does not apply to a Medicare supplemental policy as defined in §1882(g)(1), Social Security Act (42 U.S.C. §1395ss) or a Medicare Advantage plan offered under a contract with the federal Centers for Medicare and Medicaid Services.

Section 21.4503. Definitions. The adopted amendments to §21.4503 add new definitions, update current definitions, and delete definitions no longer relevant to the adopted rule.

Adopted §21.4503(1) defines "allowed amount" as an amount that the applicable health benefit plan issuer allows as payment for a health care service or group of services, including amounts for which a patient is responsible due to deductibles, copayments, or coinsurance.

Adopted §21.4503(2) defines "ambulatory surgical center" as a facility licensed under Health and Safety Code Chapter 243.

Adopted §21.4503(3) changes "group health benefit plan," previously defined at §21.4503(1), to "applicable health benefit plan" and updates current text to include an exclusive provider benefit plan consistent with Insurance Code §1301.0042 and state employee health benefit plans under Insurance Code Chapters 1551, 1575, 1579, and 1601.

Adopted §21.4503(4) defines "billed amount" as the amount charged for health care services on a claim submitted by a provider.

Adopted §21.4503(5) defines "facility claims" as any claim for health care services provided by a facility as defined in 28 TAC §3.3702.

Adopted §21.4503(6) adds "freestanding emergency medical care facility" and defines it as a freestanding emergency medical care facility required to be licensed under Health and Safety Code Chapter 254.

Adopted §21.4503(7) adds "geographic regions" and defines it as a three-digit ZIP code, representing the collection of ZIP codes that share the same first three digits. For purposes of data submitted under this subchapter, a geographic region must be located in Texas, in full or in part.

Adopted §21.4503(8) adds "imaging claims" and defines it as claims for radiological services furnished in a provider's office, outpatient hospital, or other outpatient environment.

Adopted §21.4503(9) adds "inpatient procedure claims" and defines it as claims for health care services furnished in a hospital, as defined by Insurance Code §1301.001, to a patient who is formally admitted.

Adopted §21.4503(10) adds "in-network claims" and defines it as claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider that is contracted as an in-network or preferred provider under the plan.

Adopted §21.4503(11) adds "medical billing codes" and defines it as standard code sets used to bill for specific medical services including the Healthcare Common Procedure Coding System (HCPCS) and Diagnosis-Related Group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the Current Procedural Terminology (CPT) code set maintained by the American Medical Association, and the International Classification of Diseases (ICD) code sets developed by the World Health Organization.

Adopted §21.4503(12) adds "out-of-network claims" and defines it as claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider who is not contracted as an in-network provider or preferred provider under the plan.

Adopted §21.4503(13) adds "outpatient facility procedure claims" and defines it as claims for health care services provided in an ambulatory surgical center or a hospital, as defined by Insurance Code §1301.001, to a patient who is not formally admitted.

Adopted §21.4503(14) adds "place-of-service code" and defines it as a health care claim code in which "place of service" refers to the type of entity where services were rendered, as specified by a two-digit place-of-service code on a professional health care claim, consistent with the ASC X12N standard for electronic transactions. CMS maintains place-of-service codes.

Adopted §21.4503(15) adds "primary plan" and defines it as it is defined in 28 TAC §3.3503(17).

Adopted §21.4503(16) adds "professional claims" and defines it as any claim for health care services provided by a physician or provider that is not an institutional provider, as defined in Insurance Code §1301.001.

Adopted §21.4503(17) redesignates the current definition of "provider" previously found at §21.4503(4) and adds the word "physician" to the definition.

Adopted §21.4503(18) redesignates the current definition of "reporting period" previously found at §21.4503(5) and replaces "six" with "12," inserts the words "each year," and replaces "June 30" with "December 31." The definition is, "The 12-month interval of time for which a plan or health benefit plan issuer must submit data each year, beginning each January 1 and ending the following December 31."

Adopted §21.4503(19) adds "TDI" and defines it as the Texas Department of Insurance.

Adopted amendments to §21.4503 also delete the definition for "institutional provider" at current §21.4503(2) and "physician" at current §21.4503(3). "Physician" is included in the definition of "provider" in adopted amendment §21.4503(16).

Section 21.4504. Geographic Regions. The adopted amendment requires issuers to report data collected under this subchapter according to the three-digit ZIP code in which the health care service was provided. TDI also notes that publication of health care reimbursement rate information derived from the data may be aggregated across broader geographic regions, if necessary to ensure, consistent

with Insurance Code §38.357, that the published information does not reveal the name of any health care provider or health benefit plan issuer.

Section 21.4505. Requirement to Collect Data. The adopted amendments to §21.4505(a) remove the word "group" preceding "health benefit plan" and insert the word "applicable" to conform to adopted amendments at §21.4503(3), add the requirement to collect the data annually, and delete text referring to Form LHL616 to conform to the adopted amendments to §21.4507.

Adopted §21.4505(b) requires that data elements and medical services specified under adopted amendments to §21.4507(b) and (c) must be collected with respect to medical billing codes specified by TDI. The current set of medical billing codes will be available to issuers in a Microsoft Excel template on TDI's website and will be updated no more than annually to account for any changes in standard medical practice and medical billing codes related to the services specified in the adopted amendment to §21.4507(c).

Adopted §21.4505 deletes subsection (c), related to an exemption that is based on the number of covered lives to conform to adopted amendment §21.4502(e).

Section 21.4506. Submission of Report. The adopted amendments to §21.4506(a) add that, in addition to each plan and health benefit plan issuer identified in §21.4502(a) and (b), the plan or issuer's authorized agent may submit the required data. Adopted amendments to §21.4506(a) also change the deadline for the submission of the required data in annual reporting subsequent to the initial filing to no later than May 1, rather than September 1. Adopted amendments to §21.4506(a) also delete language referencing Form LHL616 to conform with adopted §21.4507.

Adopted §21.4506(b) requires the data be filed electronically as a Microsoft Excel form and emailed to TDI, or uploaded by secure File Transfer Protocol.

Adopted §21.4506(c) alerts issuers that they may use a Microsoft Excel template available on TDI's website to meet the requirements of adopted §§21.4501 - 21.4507.

Adopted §21.4506 deletes subsections (d) and (f), both relating to procedures for accessing the report form and acceptance of the End User Agreement to conform to adopted amendments to §21.4507.

Adopted §21.4506 deletes subsection (e) related to an exemption based on the number of covered lives to conform to adopted amendments to §21.4502(e).

Section 21.4507. Data Required. The adopted amendments change the title of the section from "Report Form" to "Data Required," to more accurately describe the section. The adopted amendment to §21.4507 deletes §21.4507(1) - (3) to conform with adopted §21.4507(a) - (d).

Adopted §21.4507(a) requires applicable health benefit plans to include a cover page with each report, and adopted §21.4507(a)(1) - (8) describe the elements to include on the cover page.

Adopted §21.4507(b) requires applicable health benefit plans to submit in-network and out-of-network claims data for each geographic region, as defined by adopted §21.4503, for each service identified in adopted subsection (c) in data columns in the order of the adopted amendments to §21.4507(b)(1) - (17).

Adopted §21.4507(b)(1) adds a data column to report network status of the claims data, using "IN" to indicate in-network claims and "OON" to indicate out-of-network claims. Adopted §21.4507(b)(2) adds a data column to report the geographic region of the claims data, using the three-digit ZIP code to indicate the applicable region. Adopted §21.4507(b)(3) adds a data column to report total number of unique claim identifiers for all claim types. Adopted §21.4507(b)(4) adds a data column to report inpatient procedure facility claims, including total number of discharges. Adopted §21.4507(b)(5) - (18) add 14 additional data columns to the report: total amount billed; total amount allowed; mean amount billed; mean amount allowed; median amount billed; median amount allowed; maximum amount billed; maximum amount allowed; minimum amount billed; minimum amount allowed; lower quartile amount billed, representing the 25th percentile of all amounts billed; lower quartile amount allowed, representing the 25th percentile of all amounts allowed; upper quartile amount billed, representing the 75th percentile of all amounts billed; and upper quartile amount allowed, representing the 75th percentile of all amounts allowed.

Adopted §21.4507(c) requires issuers to report the data elements identified in adopted §21.4507(b) in the specified manner for each category of services listed in adopted §21.4507(c).

Adopted §21.4507(c)(1) relates to inpatient procedures and requires issuers to report the data separately for facility claims and professional claims. Adopted §21.4507(c)(1)(A) - (C) describe the data to report and adopted §21.4507(c)(1)(C)(i) - (xi) list the services to include.

Adopted §21.4507(c)(2) relates to outpatient procedures and requires issuers to report facility claims and professional claims separately. Adopted §21.4507(c)(2)(A) - (C) describe the data to report for outpatient procedures and adopted §21.4507(c)(2)(C)(i) - (xix) list the services to include.

Adopted §21.4507(c)(3) relates to emergency services and requires issuers to report data on emergency room visits for professional claims for which the place of service is an emergency room or outpatient hospital. Adopted §21.4507(c)(3)(A) - (E) describe the different kinds of emergency room visits to report.

Adopted §21.4507(c)(4) relates to imaging services and requires issuers to report the data separately for facility claims and professional claims. Adopted §21.4507(c)(4)(A) - (C) describe the data to report for imaging services, and adopted §21.4507(c)(4)(C)(i) - (xxvi) list the services to include.

Adopted §21.4507(c)(5) relates to pathology services and requires issuers to report the data only for professional claims for which the place of service is an independent lab. Adopted §21.4507(c)(5)(A) - (B) describe the data to report, and adopted §21.4507(c)(5)(B)(i) - (x) list the services to include.

Adopted §21.4507(c)(6) relates to office visits and requires issuers to report data only for professional claims for which the place of service is an office or rural health clinic. Adopted §21.4507(c)(6)(A) - (C) describe the data to report for office visits, and adopted §21.4507(c)(6)(B)(i) - (x) list the types of office visits to include.

Adopted §21.4507(d) specifies that issuers must submit data required in accordance with adopted §21.4507(d)(1) - (4). Adopted §21.4507(d)(1) requires issuers to report data elements according to medical billing codes specified by TDI. Adopted §21.4507(d)(2) requires issuers to separately report data for insurance and HMO, and to exclude any HMO claims paid through a capitation agreement. Adopted §21.4507(d)(3) requires issuers to separately report data for in-network and out-of-network claims. Adopted §21.4507(d)(4) requires that issuers filter claims, and adopted §21.4507(d)(4)(A) - (D) describes the filters to apply.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comment.

Comment: A commenter expressed concern regarding the lack of consistency in referring to health care services and recommended separately specifying "medical care," in order to separately reference

physician-only services where the rules generally reference "health care services." This change was recommended for §§21.4501(1), 21.4501(3), 21.4503(1), 21.4503(9), 21.4503(13), 21.4503(16), 21.4503(17), 21.4504, and 21.4505(b).

Agency Response: TDI agrees with the recommendation for consistency, but instead of the requested changes has made nonsubstantive changes to §§21.4503(4), 21.4503(10), 21.4503(12), and 21.4505(b) to consistently use the term "health care services." "Health care services" broadly includes services provided by physicians, facilities, and other health care practitioners so TDI declines to make a change to distinguish physician-only services.

Comment on §21.4502(e).

Comment: One commenter expressed concern that the flexibility provided to allow issuers to report data for self-insured plans could lead to an interpretation that the state has authority over self-insured plans and recommends removing this subsection from the rule text.

Agency Response: TDI agrees that the statutory authority for this rule limits the applicability to plans included under Insurance Code §38.353, and deletes both §21.4502(e) and §21.4507(d)(4)(C) to remove reference to self-insured plans. While the rule does not require issuers to report data for self-insured plans, in the interest of developing a strong data set that reflects the Texas health care market, TDI will accept data for self-insured plans from any entity that wishes to submit that information. TDI will explain this flexibility in the data collection instructions, instead of including it in the rule text.

Comment on §21.4503.

Comment: A commenter requested that TDI retain the definition of "physician," which is deleted under the rule proposal.

Agency Response: TDI disagrees that this definition is necessary and declines to make the change.

Comment on §21.4503(1).

Comment: One commenter challenged the term "reimbursement" within the definition for "allowed amount," noting that "reimbursement" implies the plan is making the patient whole, and recommended instead using the term "payment," which more accurately describes the potential for an allowed amount to encompass cost-sharing for which the plan does not reimburse the patient.

Agency Response: TDI agrees and revises the rule text to make this change.

Comment on §21.4503(6).

Comment: A commenter questioned the proposed definition of "freestanding emergency medical care facility," which tracks the statutory definition in the Health and Safety Code, but which is very broad. The commenter recommended that the term instead be defined as a "freestanding emergency medical care facility required to be licensed under Health and Safety Code Chapter 254."

Agency Response: TDI agrees that the definition as proposed may be overly broad, and revises the definition as suggested. The term "freestanding emergency medical care facility" is used in §21.4507(c)(3) to make clear that data should not be limited to claims for services provided in an emergency room that is physically attached to a hospital. Generally, issuers should provide data based on the place of service indicated on the claim, and existing place-of-service codes do not distinguish between freestanding and hospital-based emergency rooms.

Comment on §21.4503(10).

Comment: A commenter recommended a change to the definition of "in-network claims," to clarify that the provider must be in-network "under the plan." The commenter also recommends striking "contracted as an," from the definition, noting that some providers may be contracted with the issuer, but out-of-network for certain plans offered by the issuer.

Agency Response: TDI accepts the comment in part, and adds the term, "under the plan," to the definition, while retaining "contracted as an." This makes clear that in-network claims are those with which the provider is contracted as an in-network or preferred provider under the plan.

Comment on §21.4504.

Comment: One commenter recommended that the qualifier "health care," be removed from the term "health care provider," since the defined term is simply "provider."

Agency Response: TDI accepts this comment, and for consistency, also strikes the term "health care" from §21.4503(16).

Comment on §21.4507(c)(2).

Comment: A commenter requested clarification on the types of facilities considered to be a "freestanding clinic," under §21.4507(c)(2).

Agency Response: Generally, the environment in which services were provided is indicated by the standard codes used on claim forms. For a facility claim, the bill code would indicate the facility type (clinic), and the bill classification (freestanding). A freestanding clinic is only an applicable service environment for facility claims for certain outpatient procedures. TDI deletes the term "free standing clinic" from §21.4507(c)(2)(B), which references place-of-service codes for professional claims, because there is not a place-of-service code for freestanding clinics.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with Changes: The Texas Association of Health Plans and the Texas Medical Association.

Against: None.

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§38.351, 38.352, 1301.001, 1301.0042, 843.002, 38.353, 38.354, 38.355, 38.357, 38.358, and 36.001.

Section 38.351 provides that the purpose of Subchapter H is to authorize TDI to collect data concerning health benefit plan reimbursement rates in a uniform format; and disseminate, on an aggregate basis for geographical regions in the state, information concerning health care reimbursement rates derived from the data.

Section 38.352 provides that in Subchapter H, "group health benefit plan" means a preferred provider benefit plan as defined by §1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by §843.002.

Section 1301.001 provides at paragraph (9) that preferred provider benefit plan means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider. Section 1301.001 provides at paragraph (2) that health insurance policy means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

Section 1301.0042 provides that a provision of the Insurance Code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

Section 843.002(9) provides that evidence of coverage means any certificate, agreement, or contract, including a blended contract, that is issued to an enrollee and that states the coverage to which the enrollee is entitled.

Section 38.353(e) permits the commissioner to exclude a type of health benefit plan from the requirements of Subchapter H if the commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of the subchapter.

Section 38.354 grants the commissioner authority to adopt rules as provided by Insurance Code Chapter 36, Subchapter A to implement Subchapter H.

Section 38.355(a) requires each health benefit plan issuer to submit aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by TDI, in the form and manner and at the time required by TDI. Section 38.355(b) requires that TDI establish a standardized format by rule for the submission of the data submitted under the section to permit comparison of health care reimbursement rates. The section also requires TDI, to the extent feasible, to develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates. Section 38.355(c) requires TDI to specify the period for which reimbursement rates must be filed.

Section 38.357 provides that the published information may not reveal the name of any health care provider or health benefit plan issuer and authorizes TDI to make the aggregate health care reimbursement rate information available through TDI's website.

Section 38.358 provides that health plan issuers that fail to submit data as required are subject to an administrative penalty under Chapter 84.

Section 36.001 authorizes the commissioner to adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§21.4501. Purpose.

The purpose of this subchapter is to:

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

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

(3) facilitate TDI's publication of aggregate health care reimbursement rate information derived from the data collected under this subchapter.

§21.4502. Applicability.

(a) This subchapter applies to the issuer of an applicable health benefit plan as defined in §21.4503 of this title and as provided by Insurance Code §38.353(a):

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; and

(6) a health maintenance organization (HMO).

(b) As provided in Insurance Code §38.353(b), and notwithstanding any provision in Insurance Code Chapters 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

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

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

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

(4) basic coverage under Insurance Code Chapter 1601.

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

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

(2) childrens' health benefit plans provided under Insurance Code Chapter 1502;

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

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

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

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

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

(e) An applicable health benefit plan issuer with fewer than 20,000 covered lives in comprehensive health coverage as reported on Part 1 of the National Association of Insurance Commissioners Supplemental Health Care Exhibit as of the end of the applicable reporting period is not required to submit a report under §21.4506.

(f) Under §38.353(e), this subchapter does not apply to:

(1) a Medicare supplemental policy as defined by §1882(g)(1), Social Security Act (42 U.S.C. §1395ss); or

(2) a Medicare Advantage plan offered under a contract with the federal Centers for Medicare and Medicaid Services.

§21.4503. Definitions.

The following words and terms when used in this subchapter have the following meanings unless the context clearly indicates otherwise:

(1) Allowed amount--The amount that the applicable health benefit plan issuer allows as payment for a health care service or group of services, including amounts for which a patient is responsible due to deductibles, copayments, or coinsurance.

(2) Ambulatory surgical center--A facility licensed under Health and Safety Code Chapter 243.

(3) Applicable health benefit plan--A group health benefit plan as specified in Insurance Code §38.352 and §38.353, which is a preferred provider benefit plan as defined by Insurance Code §1301.001, including an exclusive provider benefit plan consistent with Insurance Code §1301.0042, or an evidence of coverage for a health care plan that provides basic health care services as defined by Insurance Code §843.002, or a state employee health plan under Insurance Code Chapters 1551, 1575, 1579, and 1601. The term does not include an HMO plan providing routine dental or vision services as a

single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan.

(4) Billed amount--The amount charged for health care services on a claim submitted by a provider.

(5) Facility claims--Any claim for health care services provided by a facility as defined in §3.3702 of this title.

(6) Freestanding emergency medical care facility--A freestanding emergency medical care facility required to be licensed under Health and Safety Code Chapter 254.

(7) Geographic region--A three-digit ZIP code representing the collection of ZIP codes that share the same first three digits. For purposes of data submitted under this subchapter, a geographic region must be located in Texas, in full or in part.

(8) Imaging claims--Claims for radiological services furnished in a provider office, outpatient hospital, or other outpatient environment.

(9) Inpatient procedure claims--Claims for health care services furnished in a hospital, as defined by Insurance Code §1301.001, to a patient who is formally admitted.

(10) In-network claims--Claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider contracted as an in-network or preferred provider under the plan.

(11) Medical billing codes--Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and Diagnosis-Related Group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the Current Procedural Terminology (CPT) code set maintained by the American Medical Association, and the International Classification of Diseases (ICD) code sets developed by the World Health Organization.

(12) Out-of-network claims--Claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider that is not an in-network provider or preferred provider under the plan. Claims paid on an out-of-network basis are considered out-of-network regardless of whether the provider is reimbursed based on an agreed on rate.

(13) Outpatient facility procedure claims--Claims for health care services furnished in an ambulatory surgical center or a hospital, as defined by Insurance Code §1301.001, to a patient who is not formally admitted.

(14) Place-of-service code--A health care claim code where "place of service" refers to the type of entity where services were rendered, as specified by a two-digit place-of-service code on a professional health care claim consistent with the ASC X12N standard for electronic transactions. Place-of-service codes are maintained by CMS.

(15) Primary plan--As defined in §3.3507(17) of this title.

(16) Professional claims--Any claim for health care services provided by a physician or provider that is not an institutional provider, as defined in Insurance Code §1301.001.

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

(18) Reporting period--The 12-month interval of time for which a plan or applicable health benefit plan issuer must submit data each year, beginning each January 1 and ending the following December 31.

(19) TDI--Texas Department of Insurance.

§21.4504. Geographic Regions.

Issuers must report data collected under this subchapter according to the three-digit ZIP code in which the health care service was provided. Publication of health care reimbursement rate information derived from the data collected under this subchapter may be aggregated by TDI across broader geographic regions if necessary to ensure, consistent with Insurance Code §38.357, that the published information does not reveal the name of any provider or health benefit plan issuer.

§21.4505. Requirement to Collect Data.

(a) Each applicable health benefit plan issuer and plan specified in §21.4502(a) and (b) of this title must annually collect the data specified under §21.4507 of this title and prepare and file data as provided.

(b) Data elements and health care services specified under §21.4507(b) and (c) of this title must be collected with respect to medical billing codes specified by TDI. The current set of medical billing codes will be available to issuers in a Microsoft Excel template on TDI's website at www.tdi.texas.gov/health/reimbursement.html. If there are changes in standard medical practice or

medical billing codes that necessitate changing the identified billing codes for the services specified in §21.4507(c) of this title, the billing codes on TDI's website will be updated and affected carriers notified, but in no event will these updates occur more often than annually or less than six months before the May 1 reporting deadline.

§21.4506. Submission of Report.

(a) Not later than May 1 of each year, each plan and applicable health benefit plan issuer identified in §21.4502(a) and (b) of this title, or the plan or issuer's authorized agent must submit to TDI the data required under §21.4507 of this title.

(b) The data filed under this section is required to be filed electronically as a Microsoft Excel form and emailed to TDI at ReimbursementRates@tdi.texas.gov, or uploaded by secure File Transfer Protocol (FTP).

(c) Issuers may meet the requirements of this subchapter by submitting data using the Microsoft Excel template available on TDI's website at www.tdi.texas.gov/health/reimbursement.html.

§21.4507. Data Required.

(a) Applicable health benefit plans must include the following information as a cover page to each report:

(1) reporting period;

(2) company or plan name;

(3) NAIC number, issued to the company by the National Association of Insurance Commissioners;

(4) TDI company number;

(5) contact information for the person designated to discuss the report with TDI staff, including name, telephone number, and email address;

(6) an indication of whether the report is for insurance business or HMO business, consistent with subsection (d) of this section, or "NA" for reports limited to self-insured business;

(7) an indication of whether the report includes data on self-insured business, including data for certain governmental plans required to report under Insurance Code Chapter 38, Subchapter H; and

(8) a certification that the information provided is a full and true statement of the data required under this subchapter.

(b) Applicable health benefit plans must submit the following data, for in-network and out-of-network claims, for each geographic region, as defined by §21.4503 of this title, for each service identified in subsection (c) of this section, with data columns reported in the following order:

(1) network status of the claims data, using "IN" to indicate in-network claims and "OON" to indicate out-of-network claims;

(2) geographic region of the claims data, using the three-digit ZIP code to indicate the applicable region;

(3) total number of unique claim identifiers for all claim types;

(4) for inpatient procedure facility claims, the total number of discharges;

(5) total amount billed;

(6) total amount allowed;

(7) mean amount billed;

(8) mean amount allowed;

(9) median amount billed;

(10) median amount allowed;

(11) maximum amount billed;

(12) maximum amount allowed;

(13) minimum amount billed;

(14) minimum amount allowed;

(15) lower quartile amount billed, representing the 25th percentile of all amounts billed;

(16) lower quartile amount allowed, representing the 25th percentile of all amounts allowed;

(17) upper quartile amount billed, representing the 75th percentile of all amounts billed; and

(18) upper quartile amount allowed, representing the 75 percentile of all amounts allowed.

(c) Data elements identified in subsection (b) of this section must be reported in the specified manner for each category of services in this subsection.

(1) Inpatient procedures. Data on inpatient procedure claims must be reported separately for facility claims and professional claims.

(A) Facility claims data must be grouped by discharge and only include claims that occurred in an inpatient hospital.

(B) Professional claims data must be reported separately for surgical claims, radiology claims, pathology claims, and anesthesia claims, as applicable, and only include claims for which the place-of-service code indicates inpatient hospital.

(C) Inpatient procedure claims data must be reported for the full cost of any claim, or the full cost of any discharge for facility claims, for the following services, using the medical billing codes specified by TDI consistent with §21.4505(b) of this title:

(i) cesarean section delivery;

(ii) vaginal delivery;

(iii) hysterectomy;

(iv) hip replacement;

(v) knee replacement;

(vi) coronary artery bypass grafting;

(vii) back surgery - laminectomy;

(viii) inguinal hernia repair, unilateral;

(ix) inguinal hernia repair, bilateral;

(x) laparoscopic cholecystectomy; and

(xi) appendectomy.

(2) Outpatient procedures. Data on outpatient facility procedure claims must be reported separately for facility claims and professional claims.

(A) Facility claims data must be reported separately for outpatient procedures that occurred in an outpatient hospital and those that occurred in an ambulatory surgical center or freestanding clinic.

(B) Professional claims data must only include claims for which the place-of-service code indicates outpatient hospital or ambulatory surgical center, and be reported separately for surgical claims, radiology claims, pathology claims, and anesthesia claims, as applicable.

(C) Data on outpatient procedure facility claims must be reported for the full cost of any claim for the following services, using the medical billing codes specified by TDI, consistent with §21.4505(b) of this title:

(i) back surgery - laminectomy

(ii) inguinal hernia repair, unilateral;

(iii) inguinal hernia repair, bilateral;

(iv) laparoscopic cholecystectomy;

(v) appendectomy;

(vi) tonsillectomy;

(vii) adenoidectomy;

(viii) tonsillectomy and adenoidectomy;

(ix) tympanostomy;

(x) colonoscopy;

(xi) upper GI endoscopy;

(xii) upper and lower GI endoscopy;

(xiii) bunion repair;

(xiv) ACL repair;

(xv) rotator cuff repair;

(xvi) cardiac catheterization, left;

(xvii) cardiac catheterization, right;

(xviii) cardiac catheterization, left and right; and

(xix) percutaneous transluminal coronary angioplasty.

(3) Emergency services. Data on emergency room visits must be reported only for professional claims for which the place of service is an emergency room or outpatient hospital. An emergency room includes both a hospital emergency room and a freestanding emergency medical care facility. Data must be reported at the claim-line level for the following types of emergency room visits, using the medical billing codes specified by TDI, consistent with §21.4505(b) of this title:

(A) emergency department visit, self-limited or minor problem;

(B) emergency department visit, low to moderately severe problem;

(C) emergency department visit, moderately severe problem;

(D) emergency department visit, problem of high severity; and

(E) emergency department visit, problem with significant threat to life or function.

(4) Imaging services. Data on imaging services must be reported separately for facility claims and professional claims.

(A) Facility claims must include only claims that occurred in an outpatient hospital, and for which units of service equal one.

(B) Professional claims must be reported only for claims for which units of service equal one. Data must be reported separately for claims billed with CPT code modifiers for the professional component (26), technical component (TC), and a missing or null modifier. Data must be reported separately by place-of-service code:

(i) outpatient hospital;

(ii) office; and

(iii) all other place-of-service codes, excluding office, inpatient hospital, outpatient hospital, and emergency room.

(C) Data must be reported at the claim-line level for the following imaging services, using the medical billing codes specified by TDI, consistent with §21.4505(b) of this title:

(i) CT abdomen and pelvis;

(ii) CT scan abdomen;

(iii) CT scan pelvis;

(iv) CT scan head/brain;

(v) CT scan mouth, jaw, and neck;

(vi) CT scan soft tissue neck;

(vii) CT scan chest;

(viii) CT scan lumbar lower spine;

(ix) CT scan lower extremity;

(x) MRI brain;

(xi) MRI head, orbit/face/neck;

(xii) MRI angiography head;

(xiii) MRI neck spine;

(xiv) MRI spine;

(xv) MRI lumbar spine;

(xvi) MRI lower limb;

(xvii) MRI upper limb, other than joint;

(xviii) MRI lower limb with joint;

(xix) MRI upper limb with joint;

(xx) MRI abdomen;

(xxi) MRI one breast;

(xxii) MRI both breasts;

(xxiii) MRI pelvis;

(xxiv) mammogram, analog;

(xxv) mammogram with CAD; and

(xxvi) mammogram, digital.

(5) Pathology services. Data on pathology services must be reported only for professional claims for which the place of service is an independent lab.

(A) Data must be reported at the claim-line level and averaged to reflect the cost per unit of service.

(B) Data must be reported for the following pathology services, using the medical billing codes consistent with §21.4505(b) of this title:

(i) organ or disease panels;

(ii) evocative suppression testing;

(iii) urinalysis;

(iv) chemistry;

(v) hematology-coagulation;

(vi) immunology;

(vii) microbiology;

(viii) anatomic pathology;

(ix) screening cytopathology; and

(x) complete blood count.

(6) Office visits. Data on office visits must be reported only for professional claims for which the place of service is an office or rural health clinic.

(A) For data elements listed in subparagraph (B) of this paragraph, data must be reported at the claim-line level and averaged to reflect the cost per unit of service.

(B) Data must be reported for the following types of office visits, using the medical billing codes consistent with §21.4505(b) of this title:

(i) office or other outpatient visit with a new patient, by time or complexity;

(ii) office or other outpatient visit with an established patient, by time or complexity;

(iii) office consultation, by time or complexity;

(iv) preventive medicine evaluation and management, new patient, by age group;

(v) preventive medicine evaluation and management, established patient, by age group;

(vi) annual gynecological exam, new patient;

(vii) annual gynecological exam, established patient;

(viii) screening pelvic and breast exam;

(ix) screening pap smear; and

(x) cytopathology for pap smear.

(C) Data must be reported for well-woman exams so that all costs associated with a claim are reported with respect to the medical billing consistent with §21.4505(b) of this title.

(d) In reporting data required under this section, issuers must:

(1) report data elements according to medical billing codes specified by §21.4505(b) of this title;

(2) separately report data for insurance and HMO and exclude any HMO claims paid through a capitation agreement;

(3) separately report data for in-network and out-of-network claims; and

(4) filter claims data to include only:

(A) claims incurred during the 12-month reporting period. For the 2015 reporting period, limit data for inpatient procedure claims and outpatient procedure claims to claims incurred before October 1, 2015, or the date on which the issuer transitioned billing systems to use ICD-10 procedure codes;

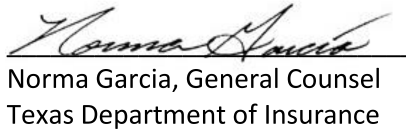
(B) claims for which adjudication is final; exclude pending or denied claims;

(C) claims for which the issuer is the primary plan responsible for payment; exclude claims for which issuer is the secondary plan; and

(D) claims with an allowed amount greater than zero.

CERTIFICATION. This agency certifies that legal counsel has reviewed the amended sections and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 13, 2016.



Norma Garcia, General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC §§21.4501 - 21.4507.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **4462**