

**Subchapter QQ. Health Information Technology**  
**28 TAC §§21.5101 - 21.5103**

**1. INTRODUCTION.** The Texas Department of Insurance (Department) proposes new Subchapter QQ, §§21.5101 – 21.5103, concerning waiver of a health benefit plan issuer’s requirement to use information technology to provide physicians and patients with real-time health insurance information electronically. The Department proposes §§21.5101 – 21.5103 to: (i) implement the Insurance Code §1661.008 as added by House Bill (HB) 1342, enacted by the 81st Legislature, Regular Session, effective May 30, 2009; (ii) identify circumstances that justify a waiver of the requirement for a health benefit plan issuer under Chapter 1661 to use information technology; and (iii) specify and facilitate a waiver application process.

House Bill 1342 adds new Insurance Code Chapter 1661 to require a health benefit plan issuer to use information technology that provides a participating health care provider and a plan enrollee with real-time information relating to the enrollee’s cost and coverage by September 1, 2013. Under §1661.008(a), a health benefit plan issuer may apply to the Commissioner for a waiver of the requirements under Chapter 1661 to use information technology. Under §1661.008(b), the Commissioner is required by rule to identify circumstances that justify a waiver, including: (1) undue hardship, including a financial or operational hardship; (2) the geographical area in which the health benefit plan issuer operates; (3) the number of enrollees covered by a health benefit plan issuer; and (4) other special circumstances.

The HB 1342 bill analysis (Texas House Insurance Committee, Bill Analysis (Committee Substitute), HB 1342, 81st Legislature, Regular Session) states that the purpose of Chapter 1661 is to provide physicians and patients with information, at the point of care, about copayment, coinsurance, and deductibles; what benefits and services the health plan covers; and an estimate of what the health plan's and patient's financial responsibilities are. Further, the bill analysis states that the chapter will provide transparency to health insurance and better inform patients about their health insurance coverage, allowing them to be better consumers of health care, and streamline and simplify the overly complex and administratively burdensome systems that exist today, which should provide cost savings throughout the entire system.

A waiver application is optional on the part of a health benefit plan issuer. However, an approved waiver under these rules expires no later than September 1, 2013, pursuant to the Insurance Code §1661.008(e). Therefore, all health benefit plan issuers, even those who have a waiver application approved under these proposed rules, will have to comply with the real-time information technology requirements of the Insurance Code Chapter 1661 by September 1, 2013.

The Department posted an informal draft of this proposal on its website August 18, 2010, and invited further public comment by September 1, 2010.

The Department notes that it has previously received requests for waivers from a number of carriers and is holding those requests as pending until this rule becomes final. At that time, the carriers will be expected to renew their requests and submit any additional information required by this rule.

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

Proposed §21.5101 states the purpose of the proposed new subchapter.

Proposed §21.5102 identifies the health benefit plans issuers to which the new subchapter applies in accordance with the Insurance Code §1661.001 and §1661.003.

Proposed §21.5103 provides the specifications for the format for the waiver applications, where the requests should be sent, and the circumstances identified by the Commissioner that justify a waiver. In addition to the circumstances that a waiver application may include as provided by statute, the Department has further included four additional specific special circumstances: (i) the actions by the health benefit plan issuer to progress toward compliance; (ii) the estimated date compliance will be achieved if prior to September 1, 2013; (iii) the estimated cost of compliance with Insurance Code section 1661.002 by the date proposed in the request for waiver and a description of any increase in cost if earlier compliance is required; and (iv) whether the issuer is a small business or micro business as defined by the Government Code §2006.001. The proposed section also provides additional guidance about the 60-day time frame for approval or denial of the waiver application. A waiver is deemed received when the Commissioner has received sufficient information to approve or deny the waiver application, including any additional relevant information requested from the health benefit plan issuer. Additionally, the proposed section describes how a waiver application will be reviewed upon submission. The Commissioner will weigh the facts demonstrated by the applicant against the purposes of Chapter 1661, including the

objective to provide better information to physicians and enrollees regarding what is covered by insurance policies and what portion of the cost is to be borne by the patient, as well as streamlining and simplifying complex and administrative processes of the health insurance systems, thus providing cost savings throughout the health care system. Finally, the effective date of the proposed rules is 40 days from the date of publication of the adoption in the Texas Register, so that health benefit plan issuers have adequate time to decide whether to request and draft a waiver application.

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

**3. PUBLIC BENEFIT/COST NOTE.**

**Anticipated Public Benefit.**

Mr. Danzeiser also has determined that for each year of the first five years the proposed new sections are in effect, there are public benefits anticipated as a result of the enforcement and administration of the rule, and there will also be potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits consistent with the intent of Chapter 1661 of

the Insurance Code while mitigating costs. The anticipated public benefits will be to: (i) implement requirements to provide instant or real-time coverage information; and (ii) allow health benefit plan issuers to request an exemption that expires no later than September 1, 2013, under circumstances established by the Commissioner. Specifically, the Insurance Code §1661.008 requires the Department to identify circumstances that may justify a waiver. This proposal will facilitate the Department's provision of such information to health benefit plan issuers so that they may request a waiver of the information technology requirements in Chapter 1661.

**Potential Costs for Persons Required to Comply with the Proposal.**

Overview of proposed requirements resulting in potential costs. The potential costs to persons required to comply with the proposed new sections results from: (i) any administrative personnel costs associated with preparation and submission requirements in proposed §21.5102 and §21.5103; and (ii) printing and delivery costs associated with submitting a waiver application pursuant to §21.5102 and §21.5103. The opportunity to submit a waiver application pursuant to the Insurance Code §1661.008 is entirely at the option of a health benefit plan issuer. Some issuers may determine that a waiver is not necessary, and are ready to comply with the Insurance Code Chapter 1661. All of the analyses in this cost note are equally applicable to and do not vary for small or micro businesses.

Persons required to comply with the proposal. The persons required to comply with the proposal are health benefit plan issuers, as defined in §1661.001, who choose to apply for a waiver pursuant to the Insurance Code §1661.008. A health benefit plan

issuer includes: (i) an insurance company operating under the Insurance Code; (ii) a group hospital service corporation operating under the Insurance Code Chapter 842; (iii) a fraternal benefit society operating under the Insurance Code Chapter 885; (iv) a stipulated premium insurance company operating under the Insurance Code Chapter 884; (v) a Lloyd's plan operating under the Insurance Code Chapter 941; (vi) an exchange operating under the Insurance Code Chapter 942; (vii) a health maintenance organization operating under the Insurance Code Chapter 843; (viii) a multiple employer welfare arrangement that holds a certificate of authority under the Insurance Code Chapter 846; (ix) an approved nonprofit health corporation that holds a certificate of authority under the Insurance Code Chapter 844; and (x) an entity not authorized under the Insurance Code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis. The chapter does not apply to: (i) a health benefit plan issuer offering a health benefit plan that provides coverage only: (a) for a specified disease or diseases as defined in §3.3077 of this title (relating to Minimum Standards for Specified Disease and Specified Accident Coverage); or under a limited benefit policy; (b) for accidental death or dismemberment; (c) as a supplement to a liability insurance policy; or (d) for dental or vision care; (ii) disability income protection coverage, as defined in §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage); (iii) credit accident and health insurance, as defined in the Insurance Code §1153.003; (iv) hospital confinement indemnity insurance; as defined in §3.3073 of this title (relating to Minimum Standards for Hospital Confinement Indemnity Coverage); (v) Medicare

supplement benefit plans, as defined in the Insurance Code Chapter 1652; (vi) workers' compensation insurance; (vii) medical payment insurance coverage under a motor vehicle insurance policy; (viii) long-term care insurance, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section; (ix) the child health plan program under the Health and Safety Code Chapter 62, or the health benefits plan for children under the Health and Safety Code Chapter 63; or (x) a Medicaid managed care program operated under the Government Code Chapter 533, or a Medicaid program operated under the Human Resources Code Chapter 32. Medicare Advantage plans are not specifically included in the definition of "health benefit plan" in Insurance Code §1661.001, and generally federally regulated Medicare and Medicaid programs are excepted from the chapter.

Potential costs resulting from certain proposed requirements. The Insurance Code §1661.008 provides that each health benefit plan issuer may submit to the Department an application to receive a waiver to the information technology requirements established by Chapter 1661. The waiver will expire no later than January 1, 2013. To implement this requirement, proposed §21.5103 allows each health benefit plan issuer identified in proposed §21.5101 to submit a waiver request application.

Cost components. The probable cost to health benefit plan issuers required to comply with this proposal will result from the following cost components: (i) the cost of any administrative personnel costs associated with preparation and submission

requirements in proposed §21.5102 and §21.5103; and (ii) printing and delivery costs associated with submitting a waiver application pursuant to §21.5102 and §21.5103.

(i) *Administrative costs associated with completing and submitting a waiver application.* The Department anticipates that most health benefit plan issuers will incur costs associated with completing and submitting a waiver request to the Department. Health benefit plan issuers may have to perform some statistical analysis of their data in order to report some circumstances. The primary costs associated with the proposed sections is expected to be the personnel costs required to draft the waiver application, including the time required to analyze and specifically identify circumstances that justify a waiver for a health benefit plan issuer. The justifications specified by the Commissioner in this proposal include: (i) undue hardship, including a financial or operational hardship; (ii) the geographical area in which the health benefit plan issuer operates; (iii) the number of enrollees covered by a health benefit plan issuer; (iv) the actions by the health benefit plan issuer to progress toward compliance; (v) the estimated date compliance will be achieved if prior to September 1, 2013; (vi) the estimated cost of compliance with the Insurance Code §1661.002 by the date proposed in the request for waiver and a description of any increase in cost if earlier compliance were required; and (vii) whether the issuer is a small-business or micro-business as defined by Government Code §2006.001. According to wage data obtained from the Department of Labor website, the average salary of an operations manager working in Texas is \$53.32 per hour; the average salary of a supervisor in administrative and office support occupations is \$24.06 per hour; and the average salary of a general office clerk

is \$12.94. The actual number, types, and cost of personnel will be determined by the health benefit plan issuer's specific circumstances applicable to the waiver application. Issuers desiring to elaborate at length or in greater detail in their application will incur correspondingly greater personnel costs. The actual number, types, and cost of personnel will be determined by the health benefit plan issuer's existing staffing and the extent to which the specific circumstances apply to the issuer. The Department anticipates that these personnel costs will typically range from approximately \$25 to \$550. This estimate is based upon a member of a health benefit plan issuer's administrative staff preparing the necessary application in two to ten hours.

*(ii) Printing and delivery costs associated with the submissions of a waiver application.* The Department anticipates that most health benefit plan issuers completing and submitting a waiver request will incur printing and delivery costs. The cost of printing the proposed waiver applications depends on the number of pages being printed. The Department estimates that the cost of printing a single 8.5 x 11 inch page should be approximately \$.08 and the cost of printing a double-sided page should be approximately \$.10. The Department estimates that the length of the proposed waiver application may be from two to six pages. The estimated costs for printing the proposed waiver application are approximately \$.12 - \$.42 per document. The cost of submission is based on postage rates for first-class mail. First-class postage costs are \$.44 for three pages and \$.61 for six to 11 pages in a standard envelope. The overall cost of submitting the waiver application will vary for each health benefit plan issuer.

The Department requested cost information by public comment during the posting of the informal draft of this proposal. The Department received feedback from one commenter suggesting that the cost estimate for the waiver offered by the Department is reasonable and that plans would be able to apply for the waiver within the cost parameters specified. The costs to comply with this proposal for some health benefit plan issuers may be zero. A health benefit plan issuer who has already implemented the necessary information technologies to be compliant with Chapter 1661 is not required to submit a waiver application.

All of the cost components in this cost note are equally applicable to small or micro businesses.

**4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.** The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines “small business” as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than \$6 million in annual gross receipts. The Government Code §2006.001(1) defines “micro business” similarly to “small business” but specifies

that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on approximately 62 to 98 small or micro businesses that are required to comply with the proposed new sections. The Department does not have precise information regarding the number of small or micro life, accident and health insurers doing business in Texas. However, for the purpose of this estimate, the Department assumes that between 10 to 15 percent of the 652 accident, and health insurers and health maintenance organizations (600 accident and health insurers and 52 health maintenance organizations) licensed in Texas as of August 31, 2010, are small or micro businesses. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for health benefit plan issuers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro businesses. As discussed, a small or micro business insurer or HMO potentially would incur costs under the Public Benefit/Cost Note part of this proposal for group health benefit plan issuers that are: (i) administrative personnel costs associated with preparation and submission requirements in proposed §21.5101 and §21.5103; and (ii) printing and delivery costs associated with submitting a waiver application pursuant to §21.5101 and §21.5103.

The proposed new sections incorporate proposed regulatory provisions designed to reduce potential economic impact for all group health benefit plan issuers, including small and micro businesses. The waiver application requirements allow a health benefit plan issuer to provide specific facts and circumstances that justify a waiver of Insurance Code Chapter 1661. As required by statute, proposed §21.5103 requires an issuer seeking a waiver to justify that waiver, in part, based on undue hardship, including financial or operational hardship. This provision in the proposed rules gives the Department the ability to grant a waiver for small and micro businesses that demonstrate undue hardship.

In developing the list of specific facts and circumstances required to be included in a waiver application in proposed §21.5103, the Department considered granting an automatic waiver for any small or micro businesses. However, the Department anticipates that the cost for small and micro businesses for completing a waiver application will not be substantial, and the Department does not believe that an automatic waiver should be granted to those small or micro businesses that are already compliant with the requirements of Chapter 1661. While self-identifying as a small or micro business in the waiver application does not automatically trigger a waiver, such a declaration will be considered pursuant to the statutory intent of the Insurance Code §1661.008. Accordingly, proposed §21.5103 includes specific criteria that the Department will consider with respect to the small or micro business status of a waiver applicant. The Department anticipates that the consideration of these special

circumstances may reduce the economic impact of this proposal for small and micro businesses.

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

In accordance with the Government Code §2006.002(c-1), the Department has considered other regulatory methods to accomplish the objectives of proposed new §§21.5101 – 21.5103 waiver requirements that will also minimize any adverse economic impact on the estimated 62 – 98 insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and are required to comply with these proposed new requirements. The Insurance Code §1661.008, which the proposed new sections are implementing, allows for discretion on the part of the Commissioner to create criteria that would allow a health benefit plan issuer, if desired, to apply for a waiver from the real-time information technology requirements of the chapter. As an alternative method, the Department considered granting an automatic waiver for any small or micro business that applied for the waiver. Under such alternative method, any health benefit plan issuer would be deemed to have a waiver

pursuant to §1661.008 so long as that health benefit plan issuer qualified as a small or micro business under the Government Code §2006.001(1) and (2).

As part of its regulatory flexibility analysis, the Department considered several factors. First, the Department determined that the costs for submitting a waiver application would be small enough that small and micro business could bear the expense. The waiver process is designed to allow small and micro businesses the opportunity to seek a delay in implementing the real-time information technologies as required by Chapter 1661. The Department anticipates that small and micro businesses will be able to succinctly justify a waiver. Further, some small and micro businesses may already or prior to September 1, 2013, be able to provide the required real-time information. These small and micro businesses may have valid business reasons, such as marketing of operational practices pertaining to the provision of the real time information or other competitive advantage, for not wanting a waiver pursuant to these proposed new sections. An automatic or blanket waiver would also reduce the intended transparency benefits of the chapter and could create confusion if a carrier with a waiver nevertheless provided real-time information but in a manner that did not comply with the requirements of Chapter 1661. According to the bill analysis for HB 1342 (Texas Senate State Affairs Committee, Bill analysis (Senate Committee Report), 81st Legislature, Regular Session), the lack of instant or real-time coverage information creates confusion and frustration for both patients and physicians. To the extent that an automatic waiver would reduce the information provided to physicians and patients, at the point of care, about (i) copayment, coinsurance, and deductibles; (ii) what benefits

and services the health plan covers; and (iii) an estimate of what the health plan's and patient's financial responsibilities are, patients and physicians are frustrated in their ability to make fully informed decisions.

Additionally, health benefit plan issuers will be required to begin implementing some information technologies pursuant to federal health reform provisions contained in the Patient Protection and Affordable Care Act of 2010 (PPACA), Sec. 1104. In PPACA, no specific provision is made for the exclusion of small and micro businesses. While the PPACA information technology requirements are not the same as contained in the Insurance Code Chapter 1661, the Department of Health and Human Services (DHHS) is charged with establishing business rules and guidelines for the electronic exchange of information related to administration and financial transactions no later than July 1, 2012, to be effective no earlier than July 1, 2014.

For these reasons, the Department has determined, in accordance with the Government Code §2006.002(c-1), that there are no regulatory alternatives to the proposed requirements in §§21.5101 – 21.5103 that will sufficiently protect the health, safety, environmental, and economic welfare of the state in a manner consistent with the objective and intent of Chapter 1661 of the Insurance Code as enacted by HB 1342 and the proposed rule and that the proposed rule minimizes the impact on small and micro businesses to the extent possible in a manner consistent with the intent of the bill.

**5. TAKINGS IMPACT ASSESSMENT.** The Department has determined that no private real property interests are affected by this proposal and that this proposal does

not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

**6. REQUEST FOR PUBLIC COMMENT.** To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 27, 2010, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Doug Danzeiser, Deputy Commissioner, Life/Health Division, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

**7. STATUTORY AUTHORITY.** The new sections are proposed under HB 1342, as enacted by the 81st Legislature, Regular Session, effective May 30, 2009, and the Insurance Code §§1661.008, 1661.009, and 36.001. Section 1661.008, established by HB 1342, requires that the Commissioner establish circumstances that justify a waiver so that a health benefit plan issuer may apply for a waiver of the requirement under the Insurance Code §1661.002 to provide real-time information at the point of care. Section 1661.001 defines *health benefit plan issuer* as an entity authorized to issue a health

benefit plan in this state. *Health benefit plan* is defined in Section 1661.001 as a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage. Section 1661.009 permits the Commissioner to adopt rules as necessary to implement Insurance Code Chapter 1661. Section 36.001 authorizes the Commissioner of Insurance to adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

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

<u>Rule</u>	<u>Statute</u>
§§21.5101 – 21.5103	Insurance Code Chapter 1661

**9. TEXT.**

§21.5101. Purpose. In accordance with the Insurance Code §1661.008, this subchapter specifies the waiver application requirements for health benefit plan issuers regarding the use of certain required real-time information technology pursuant to the Insurance Code Chapter 1661.

**§21.5102. Applicability.**

(a) Pursuant to the Insurance Code §1661.001, this subchapter applies to an entity authorized to issue a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(1) an insurance company operating under the Insurance Code;

(2) a group hospital service corporation operating under the Insurance Code Chapter 842;

(3) a fraternal benefit society operating under the Insurance Code Chapter 885;

(4) a stipulated premium insurance company operating under the Insurance Code Chapter 884;

(5) a Lloyd's plan operating under the Insurance Code Chapter 941;

(6) an exchange operating under the Insurance Code Chapter 942;

(7) a health maintenance organization operating under the Insurance Code Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under the Insurance Code Chapter 846;

(9) an approved nonprofit health corporation that holds a certificate of authority under the Insurance Code Chapter 844; and

(10) an entity not authorized under the Insurance Code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis.

(b) Pursuant to the Insurance Code §1661.003, this subchapter does not apply to:

(1) a health benefit plan issuer offering a health benefit plan that provides coverage only:

(A) for a specified disease or diseases as defined in §3.3077 of this title (relating to Minimum Standards for Specified Disease and Specified Accident Coverage); or under a limited benefit policy;

(B) for accidental death of dismemberment;

(C) as a supplement to a liability insurance policy; or

(D) for dental or vision care;

(2) disability income protection coverage, as defined in §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage);

(A) credit accident and health insurance, as defined in the Insurance Code §1153.003;

(B) hospital confinement indemnity insurance; as defined in §3.3073 of this title (relating to Minimum Standards for Hospital Confinement Indemnity Coverage);

(C) Medicare supplement benefit plans, as defined in the Insurance Code Chapter 1652;

(D) workers' compensation insurance;

(E) medical payment insurance coverage under a motor vehicle insurance policy;

(F) long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;

(G) the child health plan program under the Health and Safety Code Chapter 62, or the health benefits plan for children under the Health and Safety Code Chapter 63; or

(H) a Medicaid managed care program operated under the Government Code Chapter 533, or a Medicaid program operated under the Human Resources Code Chapter 32.

**§21.5103. Waiver.**

(a) A health benefit plan issuer may apply to the commissioner for a waiver of the information technology requirements of the Insurance Code Chapter 1661.

(b) Waiver applications are required to:

(1) be submitted on 8 1/2 by 11 inch paper;

(2) be legible;

(3) be in typewritten, computer generated, or printer's proof format;

(4) be signed by an officer of the health benefit plan issuer; and

(5) provide specific facts and circumstances in support of the request for a waiver, which must include at a minimum:

(A) evidence of undue hardship, including financial or operational hardship;

(B) the geographical area in which the insurer operates;

(C) the total number of enrollees covered by the insurer and the number of enrollees impacted by the waiver;

(D) the past and planned actions by the health benefit plan issuer to progress toward compliance;

(E) the estimated date compliance will be achieved if prior to September 1, 2013; and

(F) the estimated cost of compliance with Insurance Code §1661.002 and an estimate of the increased cost for compliance at an earlier date.

(c) Waiver applications shall be mailed to Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(d) The waiver application is received when the commissioner has received a waiver application containing all specific facts and circumstances as listed in subsection (b), including any addendums provided by the health benefit plan issuer.

(e) The commissioner may grant a waiver under this subchapter considering the facts demonstrated by the applicant weighed against the purposes of Chapter 1661, including the objective to provide better information to physicians and enrollees

regarding what is covered by insurance policies and what portion of the cost is to be borne by the patient, as well as streamlining and simplifying complex and administrative processes of the health insurance systems, thus providing cost savings throughout the health care system.

(f) This subchapter becomes effective 40 days after the date on which the adoption is published in the Texas Register.