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

Division 2. Mediation Process
28 TAC §§21.5010 – 21.5013

Division 3. Plan Administrator's Required Notice of Claims Dispute Resolution
28 TAC §21.5020

Division 4. Complaint Resolution and Outreach
28 TAC §21.5030 and §21.5031

1. INTRODUCTION. The Texas Department of Insurance proposes 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. The Department proposes this new subchapter to implement SECTION 1 of House Bill (HB) 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009. HB 2256 adds 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) as provided by the Insurance Code §1551.051. The Insurance Code §1467.003 requires 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 proposed 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 proposed 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 as appropriate 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 proposed new subchapter implements these requirements. Rules to implement HB 2256, SECTION 2, concerning network adequacy standards for preferred provider benefit plans, are not included in this proposal.

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

Proposed new §21.5001 sets forth the purpose of the subchapter. Proposed new §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 proposed 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 June 19, 2009; 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 September 1, 2010.

Proposed new §21.5003 contains definitions for words and terms when used in the proposed new subchapter. Included in the defined terms is the term “hospital-based physician” at proposed §21.5003(6), which the Department proposes to define 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) but provides additional clarity by reducing possible ambiguity associated with the use of the term “facility” by substituting the use of the word “hospital.” This clarification is consistent with the statutory requirement at 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.

Proposed new §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), proposed new §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. Proposed 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 proposed clarifying changes, there would be ambiguity concerning whether a particular request for payment of health benefits meets the $1,000 threshold of patient responsibility described in the Insurance Code §1467.051(a)(1) as necessary to eligibility for mandatory mediation. Proposed new §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 proposed 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)(1) of the Insurance Code provides that 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. Proposed §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 proposed clarification, some enrollees, insurers, and physicians might 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 might 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 proposed §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 proposed §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 proposed §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.

Proposed new §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 proposed new §21.5010. Proposed new §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 proposed new §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 proposed §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, they 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 patient 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 protect the economic interests of consumers and the economic welfare of the state.

Section 21.5010(c) provides that a claim shall not be eligible for mandatory mediation under this proposed new subchapter if the hospital-based physician has provided a complete disclosure as described in the Insurance Code §1467.051 and as required under any rules promulgated by the Texas Medical Board under the Insurance Code §1467.003. 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.

Proposed new §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. Proposed new §21.5011(a) also provides a web address from which the form to request mediation may be accessed. Proposed new §21.5011(b)(1) – (3) provides that an enrollee may submit a request for mediation by completing and submitting Form No. LHL619 (Health Insurance Mediation Request Form) by mail, fax, or e-mail. Proposed new §21.5011(b)(4) provides that upon the Department's making available Form No. LHL619 (Health Insurance Mediation Request Form) that may be completed and submitted online, an enrollee may submit the request in this manner. Proposed new §21.5011(c) provides the toll-free telephone number for assistance with submitting a request for mediation.

Proposed new §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 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 proposed §21.5012 and the Insurance Code §1467.054(d) is to provide a forum for settlement of applicable 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, which 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 proposed §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.

Proposed new §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 proposed new section also requires such insurers or administrators to comply with 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.

Proposed new §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 September 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).

Proposed new §21.5030 describes the process for resolution of complaints regarding a qualified claim or a mediation that has been requested under §21.5010. Proposed §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 toll-free number through which Department assistance with filing a complaint is available. Proposed §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; and (vi) the city and county where the service was performed. Proposed new §21.5030(b) is necessary to comply with the §1467.151(a)(1) and (2) requirements that the rules adopted pursuant to §1467.151 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 information elements will facilitate the Department's maintenance of such information as required under the Insurance Code §1467.151(b).

Proposed new §21.5030(c) specifies the steps that the Department will undertake in resolving a complaint under this section. Proposed 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.

Proposed new §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.

2. FISCAL NOTE. Doug Danzeiser, Deputy Commissioner of Regulatory Affairs for the Life, Health & Licensing Division, has determined that for each year of the first five years the proposed new sections will be in effect, there will be a fiscal impact to the state government as a result of the enforcement or administration of the proposal. There will not be a direct fiscal impact upon local governments for each year of the first five years the proposed new sections will be in effect, but there may be an indirect fiscal impact; this is discussed in greater detail following the analysis of the fiscal impact to state government. The Department has determined that, beginning September 1, 2010, the total cost to the state government, (specifically to the Employees Retirement System of Texas (ERS)) for each year of the first five years the proposed new sections will be in

effect is an estimated $81.26 to $1,703.84 per request for mediation of a claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) if an ERS or its administrator staff representative with settlement authority participates in the informal settlement teleconference, mediation, and hearing before a special judge, and an estimated $107.08 to $1,936.18 per request for mediation of such a claim if the ERS or its administrator employs an attorney for the informal settlement teleconference, mediation, and hearing before a special judge. 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, as explained in more detail later in this Fiscal Note. Additionally, there will be the cost of settlement associated with each mediation request resulting from the administering of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). In evaluating the magnitude of the possible aggregate settlement costs to ERS, the Department considered two factors. These factors are the May 28, 2009, Actuarial Analysis of HB 2256 submitted by the ERS to the 81st Legislature and the lack of requests for mediation from preferred provider benefit plan enrollees since June 19, 2009, when HB 2256 became effective for these types of plans. These factors are explained in greater detail in subsequent discussion in this Fiscal Note.

This Fiscal Note is organized into four major areas of discussion of the fiscal impact to the ERS as a result of this proposal: (i) the applicability of the proposal to the administrator for ERS claims; (ii) claims eligible for mediation under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3); (iii) estimated actual settlement costs under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3); and (iv) estimated costs

under proposed §21.5012 for informal settlement teleconferences for claims that qualify for mandatory mediation under the Insurance Code Chapter 1467 independent of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3).

Applicability to administrator for ERS claims. The Insurance Code §1467.051(b) requires an administrator of a health benefit plan under the Insurance Code Chapter 1551 (ERS plans), other than a health maintenance organization plan, to participate in mediation if requested by an enrollee under the Insurance Code Chapter 1467, Subchapter B. 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 ERS as provided by the Insurance Code §1551.051. The Insurance Code §1551.056 authorizes the board of trustees to contract with an entity to act for the board as an independent administrator or manager of the coverages, services, and benefits authorized under Chapter 1551. As such, the Department anticipates that costs to the state as a result of enforcing or administering the proposed rule will be incurred by ERS. Costs to the state government will result from the administrator's participation in the dispute resolution process both as required by the statute and as a result of the enforcement and administration of proposed new §§21.5010(a)(2), 21.5010(b), and 21.5003(3). Proposed §21.5020 requires the administrator to include a notification of the availability of mandatory mediation with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after September 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator. However, ERS has indicated to the Department that the administrator will not pass this cost of the required notification back

to ERS. Thus, this cost is discussed as a cost to the administrator under the Public Benefit/Cost Note section of the proposal.

Pursuant to the provisions in SECTION 6 of HB 2256, there will be an initial period of time during the first year that the rules are in effect that ERS will not incur costs as a result of enforcement and administration of this rule. The Insurance Code §1467.002(2) provides that Chapter 1467 of the Insurance Code applies to an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551. SECTION 6 of HB 2256 provides that the Insurance Code §1467.002(2) "applies to a health benefit claim filed under a group policy or contract executed under Chapter 1551, Insurance Code, on or after September 1, 2010. A claim filed under a group policy or contract executed under Chapter 1551, Insurance Code, before September 1, 2010, is governed by the law as it existed immediately before September 1, 2010, and that law is continued in effect for that purpose." Proposed new §21.5002 incorporates this effective date for the application of the proposed new rules. Under §21.5002, the proposed subchapter applies to a qualified claim filed on or after September 1, 2010, under health benefit plan coverage administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under the Insurance Code Chapter 1551. Thus, while ERS will incur costs as a result of enforcement and administration of this rule for each year of the first five years that the rule is in effect, ERS will not incur such costs for claims filed before September 1, 2010.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3): Claims eligible for mediation. There will be a fiscal impact to ERS resulting from the proposed

clarification at §§21.5010(a)(2), 21.5010(b), and 21.5003(3) concerning claims that are eligible for mandatory mediation and from the proposed requirement at §21.5012 concerning informal settlement teleconferences. There will also be a fiscal impact to ERS resulting from informal settlement teleconferences for claims that qualify for mandatory mediation under the Insurance Code Chapter 1467 independent of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3); these costs are discussed later in this Fiscal Note. Proposed §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 qualify for mandatory mediation. Proposed new §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 proposed new §21.5010. Under proposed new §21.5003(3), the term "claim" is defined 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." Collectively, these three proposed provisions incorporate the eligibility criteria described in the Insurance Code §1467.051(a)(1) and provide additional necessary clarification to reduce possible ambiguity and to facilitate

uniform treatment of out-of-network claims. Also, these proposed provisions together may result in additional costs to the ERS because they clarify 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 for the claim to be eligible for mandatory mediation. Thus, all costs of dispute resolution described in this Fiscal Note for claims that are eligible for mandatory mediation solely because of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are the costs that the Department estimates will result from the enforcement and administration of those proposed provisions.

The estimated costs of $81.26 to $1,703.84 or $107.08 to $1,936.18 (depending on whether the ERS or its administrator uses a staff representative with settlement authority or an attorney) per request for mediation of a health benefit claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), are based on the following cost components: (i) cost of arranging the informal settlement teleconference; (ii) cost of providing a toll-free telephone number for participation in the informal settlement teleconference; (iii) cost of representation at the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (iv) the cost of mediation, if applicable; and (v) the cost of special judge fees and court reporter fees, if applicable. While these costs, as well as the settlement costs, will potentially apply to all requests for mediation, the costs of the entire dispute resolution process addressed in the following discussion of cost components are those costs that

pertain to the subset of requests eligible for mediation solely as a result of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3).

(i) Cost of arranging the informal settlement teleconference. The Insurance Code §1467.054(d) requires that all parties participate in an informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation, thus affording the parties an opportunity to settle the dispute without incurring costs associated with mediation or subsequent litigation. To uniformly implement this requirement, proposed new §21.5012 mandates that the insurer or administrator 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 telephone number for participation in the informal settlement conference.

Arranging a date and time when the parties can participate in the teleconference call will require the ERS to incur salary costs related to the ERS administrator's employee hours required to set up the call. The cost components for the employee hours required to set up the teleconference call will include contacting the enrollee or enrollee's representative and the hospital-based physician or the physician's representative, coordinating a time when all the parties are available, and arranging for the use of a toll-free telephone number. The time required to coordinate the call will vary based on the administrator's success in reaching the other parties. The Department anticipates that the time required to coordinate the teleconference will range from 10 to 30 minutes per mediation request. This is based upon an estimated

five-minute conversation per party per attempt by telephone to coordinate the teleconference and upon an estimated range of one to three attempts to successfully arrange the date. The Department further anticipates that the time required to arrange the teleconference will diminish as the administrator refines the process. Based on the latest United States Department of Labor Bureau of Labor Statistics report, *Occupational Employment and Wages,* May 2008 (DOL Wage Report), the mean hourly wage in Texas for an administrative assistant whose duties include arranging conference calls is $19.25. Thus, at an estimated 10 to 30 minutes per request, the estimated cost for the employee hours to set up the teleconference call is estimated at $3.21 to $9.63 per mediation request.

(ii) Cost of providing a toll-free telephone number. Another anticipated cost will be the actual cost to the ERS administrator of providing a toll-free number. Based on information obtained from a conference call service provider, the Department is estimating that toll-free telephone numbers cost $14 for three lines for one hour. However, if the administrator does not set up a dedicated number for informal settlement teleconference calls and instead uses existing toll-free telephone numbers, the Department anticipates that the cost will be diminished. The need for a dedicated number may increase as use of the mandatory mediation process increases.

(iii) Cost of representation. If the matter is not successfully resolved during the informal settlement teleconference, the parties have an additional opportunity to resolve the dispute at mediation. Under the Insurance Code §1467.055(f), a mediation may not last more than four hours except on the agreement of the participating parties. Absent agreed resolution of the dispute, the Insurance Code §1467.057 provides that the chief

administrative law judge for the State Office of Administrative Hearings shall enter an order of referral to a special judge under the Civil Practice and Remedies Code, Chapter 151. However, under the Insurance Code §1467.058, the facility-based physician and the administrator may elect to continue the mediation after a referral is made to a special judge. The statutory dispute resolution process established under the Insurance Code Chapter 1467, therefore, provides multiple opportunities for settlement of disputed out-of-network claims. The Department anticipates that ERS will incur direct or indirect costs for an ERS or administrator representative with settlement authority to participate in each stage to which a claim progresses. ERS may also incur costs for legal representation by an attorney at each stage.

Based on the Labor Market & Career Information Department (LMCI) of the Texas Workforce Commission, which derives its wage information from the latest DOL Wage Report, general and operations managers in the insurance industry in Texas earn a mean hourly wage of $64.05. The Department estimates that the minimum number of employee participation hours required for each stage of dispute resolution is as follows: (i) informal settlement teleconference – one hour; (ii) mediation - four hours; (iii) litigation before a special judge - four hours. Therefore, the Department estimates a range of one to nine hours of employee participation will be required. Under this methodology, estimated average costs for employee participation will therefore range from $64.05 to $576.45 per request for mediation. Costs for employee participation will be higher if the parties agree to participate in additional hours of mediation as allowed under the statute.

According to the DOL Wage Report, lawyers in Texas earned a mean hourly wage of $59.91. The Department further estimates that the minimum number of representation hours, including legal preparation time, required for each stage of dispute resolution is as follows: informal settlement teleconference – one and a half hours; mediation - six hours; and litigation before a special judge - six hours. This estimated 1.5 to 13.5 hours includes the attorney's preparation time estimated at half of the total time of the actual representation on the phone, in the mediation, or at the hearing. For example, for a one hour phone call, 30 minutes of preparation time is included; for the estimated four-hour mediation representation, an additional two hours of preparation is included. This estimated 1.5 to 13.5 hours for legal representation also assumes that the attorney representing ERS has a working familiarity with reimbursement methodology and that litigation before a special judge will take a comparable amount of time to the four hours specified in the Insurance Code §1467.055(f) as the limit for a mediation unless otherwise agreed to by the participants. Under this methodology, estimated average costs for legal representation will therefore range from $89.87 to $808.79 per request for mediation. Costs for representation will be higher if the parties agree to participate in additional hours of mediation as provided under the Insurance Code §1467.055(f).

(iv) Cost of mediation. The Insurance Code §1467.053(d) provides that mediator fees shall be split evenly and paid by the insurer or administrator and the facility-based physician. The Insurance Code Chapter 1467 does not explicitly address the amount of mediator fees. However, §1467.053 requires the chief administrative law judge at the State Office of Administrative Hearings to appoint a mediator through a

random assignment from a list of qualified mediators maintained by the State Office of Administrative Hearings. Section 1467.053 also provides that a person other than a mediator appointed by the chief administrative law judge may conduct the mediation on agreement of all of the parties and notice to the chief administrative law judge. While the statute does not address the mediator's fees, such fees vary significantly by type of mediation, experience of the mediator, and the geographic location within the state in which the mediation takes place. According to information provided by ERS, the administrator will pass this cost on to ERS. ERS estimates its portion of the mediator charge at $1,000 per mediation, including travel to the county which has jurisdiction. The Insurance Code §1467.054(e) requires that mediation take place in the county in which the medical services were rendered. This estimated cost does not include litigation costs should the dispute not be resolved in mediation. The Department also consulted both commercial and trade association sources in analyzing the scope of costs for mediator fees. These sources included the Texas Medical Association, Texas Society of Anesthesiologists, and Burdin Mediators. According to these sources, costs for mediation may range from $325 to $800 per party for a half-day of mediation. Additionally, according to the latest DOL Wage Report, mediators in Texas earn a mean hourly wage of $25.35. The Insurance Code §1467.055(f) specifies that except on the agreement of the participating parties, a mediation may not last more than four hours. Based upon these factors, the Department estimates that mediator fees will range from $325 to $1,000 per party for a half-day of mediation. Costs for mediation will be higher if the parties agree to participate in additional hours of mediation as provided under §1467.058.

(v) Cost of special judge fees and court reporter fees. Absent a successful mediation, the Insurance Code §1467.057(b) requires the chief administrative law judge to enter an order of referral of the matter to a special judge under the Civil Practice and Remedies Code, Chapter 151, that requires each party to pay the party's proportionate share of the special judge's fee, but the statute is silent concerning the amount of such fee. The Civil Practice and Remedies Code §151.009 requires the parties to pay in equal shares (i) the special judge's fee; and (ii) all administrative costs, including the court reporter's fee, related to the trial. The DOL Wage Report uses the category "Judges, Magistrate Judges, and Magistrates" to indicate mean hourly wages for judges. According to the latest DOL Wage Report for Texas, full-time judges, magistrate judges, and magistrates earn a mean hourly wage of $28.17, while court reporters earn a mean hourly wage of $23.71. 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. Based upon §1467.055(f) of the Insurance Code which provides that a mediation will last no more than four hours except by agreement of the participating parties, the Department has based its estimated litigation costs on a four-hour period of time. The Department therefore estimates that the total cost of special judge fees and court reporter fees will be $207.52 for each request for mediation for which a referral to a special judge is made. This referral will result in an estimated cost to the administrator of half of the cost, $103.76. Costs for special judge fees and court reporter fees will be higher if the process takes longer than the estimated four hours.

Number of requests for mediation. As stated previously in this Fiscal Note, it is not possible for the Department to estimate the total number of requests for mediation

because that number will be determined by a number of factors not suitable to reliable quantification. These factors include: (i) the specialty of the hospital-based physician who provides services to an enrollee and the dollar amount of the claim; (ii) the contract status of hospitals and hospital-based physicians; (iii) enrollee awareness of and participation in the dispute resolution process; (iv) whether and at what stage of a claim the physician provides the enrollee with a disclosure, how frequently that physician exceeds the estimate in the disclosure, and whether the mandatory dispute resolution process increases usage of the disclosure by physicians; (v) whether the mandatory dispute resolution process results in greater utilization by enrollees of in-network hospital-based physicians in non-emergency situations or adversely affects network utilization; (vi) whether HB 2256 results in more extensive networks of hospital-based physicians under contract with the ERS administrator; and (vii) the variation in the number of requests submitted by individual enrollees, whether zero or multiple in number. The ERS has provided information to the Department that there are between 496,000 and 500,000 participants in a health benefit plan under the Insurance Code Chapter 1551, other than an HMO, including state employees, retirees, and dependents. Therefore, that number of enrollees could potentially have a qualified claim for mandatory mediation. However, as a result of the factors previously discussed, not all of these enrollees will submit qualified claims for mandatory mediation, and some may submit more than one qualified claim for mandatory mediation. Under HB 2256, an enrollee of a preferred provider benefit plan offered by an insurer under Chapter 1301 of the Insurance Code could have requested mediation for a qualified claim filed on or after June 19, 2009. As of April 1, 2010, no qualified

request for mediation had been received by the Department. This lack of requests by enrollees of preferred provider benefit plans could indicate that there will be relatively few requests for mediation involving the ERS on or after September 1, 2010, when the mediation process becomes effective for ERS enrollees.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3): Estimated actual settlement costs. While the Department does not anticipate that there will be an actual settlement cost for every request for mandatory mediation made as a result of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), it is possible that some of these mediation requests will result in settlement costs for both insurers and hospital-based physicians. While proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) may result in additional mediation requests and concomitant additional settlement costs, the proposed rules will not impact any particular settlement amounts because the proposed rules do not change what the appropriate charges for services or supplies are. However, the Department considered two factors in evaluating the magnitude of possible aggregate settlement costs. First, the Department reviewed the May 28, 2009, Actuarial Analysis of HB 2256 As Passed Second House, 81st Legislature, Regular Session submitted by the ERS (ERS Cost Estimate). According to the ERS administrator, Blue Cross and Blue Shield of Texas, and as indicated in the ERS Cost Estimate, $21.2 million of charges were potentially subject to balance billing for services provided by out-of-network facility-based physicians during FY08. In the ERS Cost Estimate, approximately $9.7 million in charges were attributable to individual balance bill amounts in excess of $1,000. Therefore, under the ERS analysis, the remaining $11.5 million in charges would be the maximum pool of charges that is attributable to

balance bill amounts not in excess of $1,000 but which could possibly constitute individual units of a claim that could meet the $1,000 statutory threshold amount when aggregated. The ERS Cost Estimate analysis also assumed that the mediation process will result in a compromise on charges that will result in payment of half the amount subject to balance billing. The actual total amount per year for the settlement costs to insurers and to hospital-based physicians will depend on several different factors, including the number of claims subject to mandatory mediation and the costs of the medical services and/or supplies provided.

Second, the Department considered the fact that the mediation process has been available for enrollees of preferred provider benefit plans since June 19, 2009, the effective date of HB 2256 for these types of plans. Under HB 2256 and pursuant to the Insurance Code §1456.004, physicians who bill a patient that is covered by a preferred provider benefit plan that does not have a contract with that physician are required to notify the patient of mandatory mediation if the amount for which the enrollee is responsible, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000. Therefore, an enrollee of a preferred provider benefit plan offered by an insurer under Chapter 1301 of the Insurance Code could have requested mediation for a qualified claim filed on or after June 19, 2009. Based on the Department's Preferred Provider Benefit Plan Survey in May 2009, and the follow-up survey in December 2009, there are approximately 3,109,178 enrollees currently insured by a preferred provider benefit plan in Texas. The ERS provided information that the average number of enrollees in a health benefit plan under the Insurance Code Chapter 1551, other than an HMO, during the first five

months of Fiscal Year 2010 was 496,363, or less than one-sixth of the preferred provider benefit plan enrollee population. As of April 1, 2010, no qualified request for mediation had been received by the Department from enrollees of preferred provider benefit plans. This lack of requests by these enrollees may provide an indicator of the number of requests for mediation that may be made by ERS enrollees on or after September 1, 2010, when the mediation process becomes effective for ERS enrollees.

Proposed §21.5012: Informal settlement teleconferences for claims that qualify for mandatory mediation under the Insurance Code Chapter 1467 independent of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). While this Fiscal Note previously addressed costs to the ERS associated with the informal settlement teleconference required under the Insurance Code §1467.054(d) resulting from proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), the Department also anticipates that informal settlement teleconference costs will create a fiscal impact to the ERS as a result of proposed §21.5012 for those requests for mandatory mediation of claims that qualify independently of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). Specifically, proposed §21.5012 requires that the administrator of the ERS plans coordinate the informal settlement teleconference and provide a toll-free telephone number for participation in the call. While the Insurance Code §1467.054(d) requires the parties to participate in the informal settlement teleconference, the statute is silent with respect to how the teleconference is to be arranged and conducted. As such, the Department has determined that the costs to ERS resulting from proposed §21.5012 for those requests for mandatory mediation for claims that arise under the Insurance Code Chapter 1467

independently of the proposed clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are also the result of the enforcement and administration of this rule. The Department anticipates that the same costs of coordinating the informal settlement teleconference and providing the toll-free telephone number for participation in the teleconference previously discussed in this Fiscal Note with respect to costs attributable to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) will apply to all of the other requests for mediation that result from the enactment of the Insurance Code Chapter 1467. It is not possible for the Department to estimate the total number of such requests for mediation because that number will be determined by the same factors that are outlined in this Fiscal Note under the subheading "Number of requests for mediation."

Impact on local governments, local employment, and local economy. The Department has also determined that there will not be a direct fiscal impact upon local governments as a result of the enforcement or administration of the proposed rules and that there will be no measurable effect on local employment or the local economy as a result of the proposal. The possible indirect impact upon local governments as a result of the administration of the proposed rules could result for the following reasons. The Insurance Code §1467.002(1) provides that the Chapter 1467 requirements relating to mediation apply to a preferred provider benefit plan offered by an insurer under the Insurance Code Chapter 1301. It is possible that there are local governments that provide insurance coverage to their employees through such preferred provider benefit plans. Insurers offering these preferred provider benefit plans will incur costs as a result of the proposed clarification at §§21.5010(a)(2), 21.5010(b), and 21.5003(3) concerning

claims that are eligible for mandatory mediation and from the proposed requirement at §21.5012 concerning informal settlement teleconferences. As previously discussed in this Fiscal Note for state government, these costs to insurers offering preferred provider benefit plans will similarly relate to each request for mediation of a local government employee claim based on the following cost components: (i) cost of arranging the informal settlement teleconference; (ii) cost of providing a toll-free telephone number for participation in the informal settlement teleconference; (iii) cost of employee participation and representation at the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (iv) cost of mediation, if applicable; (v) costs of special judge fees and court reporter fees, if applicable; and (vi) settlement costs, if applicable. The probable increase in the cost of administering the preferred provider benefit plans for local government employees may or may not have a fiscal impact on the local government, depending on whether insurers raise premiums in response to the increased cost of administration, and if so, whether the local government shares in the cost of the employee premiums and whether the local government will opt to increase its share of employee premiums if it does share in such costs. However, even if the local government currently shares in the cost of employee premiums, there is no requirement in Chapter 1467 of the Insurance Code or this rule proposal that requires a local government employer or any other type of employer to increase the cost of its participation in employee premiums and no requirement that prohibits the local government employer from increasing employee participation in premiums to compensate for higher costs the local government employer may incur as a result of the enforcement and administration of this proposal.

Each local government impacted by this rule proposal has knowledge of or access to the information needed to estimate any increase in costs that may result to the local government as a result of administering or enforcing this proposal.

3. PUBLIC BENEFIT/COST NOTE. Mr. Danzeiser also has determined that for each year of the first five years the proposed new sections are in effect, there are several 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 1467 of the Insurance Code while mitigating costs.

Anticipated Public Benefits

The anticipated public benefits include: (i) adoption of a uniform, standardized form for use by enrollees in submitting a request for mediation; (ii) clarification of eligibility criteria for requesting mediation; (iii) clarification of the Department's regulation concerning the investigation and review of complaints regarding a qualified claim or a mediation that has been requested under the proposed new subchapter; (iv) increased consumer awareness of the availability of mandatory mediation that will result from the plan administrator's required notice under proposed new §21.5020 and the consumer outreach under proposed new §21.5031; (v) improved access to participation in the informal settlement teleconference for the enrollee that will result from proposed new §21.5012; (vi) more efficient regulation by the Department of the dispute resolution process established in the Insurance Code Chapter 1467; and (vii) increased uniformity in determining eligibility for the mandatory mediation of similar claims.

Potential Costs for Persons Required to Comply with the Proposal

The costs to persons required to comply with proposed new Subchapter PP result from five provisions of the proposal as follows: (i) the cost to insurers offering preferred provider benefit plans and hospital-based physicians that will result from the proposed clarification at §§21.5010(a)(2), 21.5010(b), and 21.5003(3) concerning claims that are eligible for mandatory mediation; (ii) the cost to insurers offering preferred provider benefit plans that will result from the proposed requirement at §21.5012 that the insurer coordinate the mandatory informal settlement teleconference required under the Insurance Code §1467.054(d); (iii) the cost to the administrator of a plan under the Insurance Code Chapter 1551, other than an HMO plan, that will result from the proposed requirement in §21.5020 for an administrator to include a notification of the availability of mandatory mediation with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after September 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator; (iv) the cost to each enrollee that submits a request for mediation that may result from the requirements concerning the manner of submission of the form as specified in proposed §21.5011(b); and (v) the cost to each individual who submits a complaint regarding a qualified claim or a mediation that has been requested under proposed §21.5010 that may result from the requirements concerning the manner of submission of the complaint as specified in proposed §21.5030. *(Note: The proposed clarification at §§21.5010(a)(2), 21.5010(b), and 21.5003(3) and the proposed requirement at §21.5012 will also result in costs to the administrator of a health benefit plan, other than a health maintenance organization plan, under the Insurance Code Chapter 1551 (ERS*

plans). These estimated costs to the ERS plan administrator are discussed in detail in the Fiscal Note part of this proposal.)

In accordance with the allocation of these costs, this Cost Note is divided into three major areas of discussion. The first section addresses costs to insurers offering preferred provider benefit plans and hospital-based physicians, as applicable, and discusses specific cost bases as follows: (i) claims eligible for mediation under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3); (ii) actual settlement costs under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3); and (iii) costs under proposed §21.5012 for informal settlement teleconferences for claims that qualify for mandatory mediation under the Insurance Code Chapter 1467 independent of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). The second section addresses costs to an administrator of an ERS plan under proposed §21.5020 for inclusion of a notification of the availability of mandatory mediation with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after September 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator. The third section addresses costs to enrollees and individuals, as applicable, and discusses specific cost bases as follows: (i) costs under proposed §21.5011(b) for submission of a request for mediation; and (ii) costs under proposed §21.5030 for submission of a complaint regarding a qualified claim or a mediation that has been requested under proposed §21.5010.

I. Cost to insurers and hospital-based physicians.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3): Claims eligible for mediation. The Department anticipates that insurers and hospital-based physicians will

incur costs as a result of the proposed clarification at §§21.5010(a)(2), 21.5010(b), and 21.5003(3) concerning claims that are eligible for mandatory mediation and as a result of the proposed requirement at §21.5012 concerning informal settlement teleconferences. Pursuant to proposed §21.5002(1) and §21.5003(7), insurers are those insurers that issue a preferred provider benefit plan under the Insurance Code Chapter 1301. Pursuant to proposed §21.5003(6), a "hospital-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist: (i) to whom the hospital has granted clinical privileges; and (ii) who provides services to patients of the hospital under those clinical privileges.

Proposed §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 qualify for mandatory mediation. Proposed new §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 proposed new §21.5010. Under proposed new §21.5003(3), the term “claim” is defined 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.” Collectively,

these three proposed provisions incorporate the eligibility criteria described in the Insurance Code §1467.051(a)(1) and provide additional necessary clarification to reduce possible ambiguity and to facilitate uniform handling of out-of-network claims. Also, these proposed provisions together may result in additional costs to the insurer or hospital-based physician because they clarify 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. Thus, all costs of dispute resolution described in this Cost Note for claims that are eligible for mandatory mediation solely because of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are the costs that the Department estimates will result from the enforcement and administration of those proposed provisions. 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, as explained in more detail in a subsequent portion of this Cost Note entitled “Number of requests for mediation.”

The Department anticipates that the total estimated cost to an insurer will be $81.26 to $1,703.84 per request for mediation of a claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) if an insurer staff representative with settlement authority participates in the informal settlement teleconference, mediation, and hearing before a special judge, and an estimated $107.08 to $1,936.18 per request for mediation of such a claim if the insurer employs an attorney for the informal settlement teleconference, mediation, and hearing before a special judge. Additionally,

there will be the cost of settlement associated with each mediation request resulting from the administering of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). The Department anticipates the total estimated cost to the hospital-based physician will be $89.87 to $1,912.55 per request for mediation of a claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), plus the cost of settlement associated with each request. The estimated costs of $81.26 to $1,703.84 or $107.08 to $1,936.18 (depending on whether the insurer uses a staff representative with settlement authority or an attorney) to insurers per request for mediation pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), are based on the following cost components: (i) cost of arranging the informal settlement teleconference; (ii) cost of providing a toll-free telephone number for participation in the informal settlement teleconference; (iii) cost of representation for the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (iv) cost of mediation, if applicable; and (v) cost of special judge fees and court reporter fees, if applicable. The estimated costs of $89.87 to $1,912.55 to hospital-based physicians per request for mediation pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are based on the following cost components: (i) cost of representation for the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (ii) cost of mediation, if applicable; and (iii) cost of special judge fees and court reporter fees, if applicable. While these costs, as well as the settlement costs, will potentially apply to all requests for mediation, the costs of the entire dispute resolution process addressed in the following discussion of cost components are those costs that pertain to the subset of requests eligible for mediation

solely as a result of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3).

(i) Cost of arranging the informal settlement teleconference. The Insurance Code §1467.054(d) requires that all parties participate in an informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation. This provides the parties an opportunity to settle the dispute without incurring costs associated with mediation or subsequent litigation. To uniformly implement this requirement, proposed new §21.5012 mandates that the insurer or administrator 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 telephone number for participation in the informal settlement conference.

Arranging a date and time when the parties can participate in the teleconference call will require the insurer to incur salary costs related to the insurer's employee hours required to set up the call. The cost components for the employee hours required to set up the teleconference call will include contacting the enrollee or enrollee's representative and the hospital-based physician or the physician's representative, coordinating a time when all the parties are available, and arranging for the use of a toll-free telephone number. The time required to coordinate the call will vary based on the insurer's success in reaching the other parties. The Department anticipates that the time required to coordinate the teleconference will range from 10 to 30 minutes per mediation request. This is based upon an estimated five minute conversation per party

per attempt by telephone to coordinate the teleconference and upon an estimated range of one to three attempts to successfully arrange the date. The Department further anticipates that the time required to arrange the teleconference will diminish as the insurer refines the process. Based on the latest United States Department of Labor Bureau of Labor Statistics report, *Occupational Employment and Wages*, May 2008 (DOL Wage Report), the mean hourly wage in Texas for an administrative assistant whose duties include arranging conference calls is $19.25. Thus, at an estimated 10 to 30 minutes per request, the estimated cost to the insurer for the employee hours required to set up the teleconference call is estimated at $3.21 to $9.63 per mediation request.

(ii) Cost of providing a toll-free telephone number. Another anticipated cost to the insurer will be the actual cost to the insurer of providing a toll-free telephone number. Based on information obtained from a conference call service provider, the Department has determined that toll-free telephone numbers cost $14 for three lines for one hour. However, if the insurer does not set up a dedicated number for informal settlement teleconference calls and instead uses existing toll-free telephone numbers, the Department anticipates that the cost will be diminished. The need for a dedicated number may increase as use of the mandatory mediation process increases.

(iii) Cost of representation. Under the Insurance Code §1467.054(d), the insurer and the facility-based physician or the facility-based physician's representative, in an effort to settle the claim before mediation, must participate in an informal settlement teleconference prior to mandatory mediation. If the matter is not successfully resolved during the informal settlement teleconference, the parties have an additional opportunity

to resolve the dispute at mediation. Under the Insurance Code §1467.055(f), a mediation may not last more than four hours except on the agreement of the participating parties. Absent agreed resolution of the dispute, the Insurance Code §1467.057 provides that the chief administrative law judge for the State Office of Administrative Hearings shall enter an order of referral to a special judge under the Civil Practice and Remedies Code, Chapter 151. However, under the Insurance Code §1467.058, the facility-based physician and the insurer may elect to continue the mediation after a referral is made to a special judge. The statutory dispute resolution process established under the Insurance Code Chapter 1467, therefore, provides multiple opportunities for settlement of disputed out-of-network claims. The Department anticipates that the insurer will incur costs for a representative with settlement authority to participate in each stage to which a claim progresses. The insurer may also incur costs for legal representation by an attorney at each stage.

Based on the Labor Market & Career Information Department (LMCI) of the Texas Workforce Commission, which derives its wage information from the latest DOL Wage Report, general and operations managers in the insurance industry in Texas earn a mean hourly wage of $64.05. The Department estimates that the minimum number of employee participation hours required for each stage of dispute resolution is as follows: (i) informal settlement teleconference – one hour; (ii) mediation - four hours; (iii) litigation before a special judge - four hours. Therefore, the Department estimates a range of one to nine hours of employee participation will be required. Under this methodology, estimated average costs for employee participation will therefore range from $64.05 to $576.45 per request for mediation. Costs for employee participation will

be higher if the parties agree to participate in additional hours of mediation as allowed under the statute.

Because the Insurance Code §1467.051 does not require the physician to attend if a physician's representative participates in the mediation, the Department does not anticipate that the hospital-based physician will incur costs for employee participation as a result of this proposal. However, the hospital-based physician may incur costs for legal representation at the mediation, which are addressed in the following discussion.

According to the latest DOL Wage Report, lawyers in Texas earn a mean hourly wage of $59.91. The Department further estimates that the minimum number of representation hours, including legal preparation time, required for each stage of dispute resolution is as follows: (i) informal settlement teleconference – one and a half hours; (ii) mediation - six hours; (iii) litigation before a special judge - six hours. This estimated 1.5 to 13.5 hours includes the attorney's preparation time estimated at half of the total time of the actual representation on the phone, in the mediation, or at the hearing. For example, for a one hour phone call, 30 minutes of preparation time is included; for the estimated four-hour mediation representation, an additional two hours of preparation is included. This estimated 1.5 to 13.5 hours for legal representation also assumes that the attorney representing the insurer or the hospital-based physician has a working familiarity with reimbursement methodology and that litigation before a special judge will take a comparable amount of time to the four hours specified in the Insurance Code §1467.055(f) as the limit for a mediation unless otherwise agreed to by the participants. Under this methodology, estimated average costs for legal representation will therefore range from $89.87 to $808.79 per request for mediation. Costs for

representation will be higher if the parties agree to participate in additional hours of mediation as allowed under the statute.

(iv) Cost of mediation. The Insurance Code §1467.053(d) provides that mediator fees shall be split evenly and paid by the insurer or administrator and the facility-based physician. The Insurance Code Chapter 1467 does not explicitly address the amount of mediator fees. However, §1467.053 requires the chief administrative law judge at the State Office of Administrative Hearings to appoint a mediator through a random assignment from a list of qualified mediators maintained by the State Office of Administrative Hearings. Section 1467.053 also provides that a person other than a mediator appointed by the chief administrative law judge may conduct the mediation on agreement of all of the parties and notice to the chief administrative law judge. While the statute does not address the mediator's fees, such fees vary significantly by type of mediation, experience of the mediator, and the geographic location within the state in which the mediation takes place. As previously discussed in the Fiscal Note section, ERS provided estimates for its administrator's participation in this mediation process, anticipating that the administrator would pass this cost on to ERS and estimating its portion of the mediator charge at $1,000 per mediation, including travel to the county which has jurisdiction. The Insurance Code §1467.054(e) requires that mediation take place in the county in which the medical services were rendered. This estimated cost does not include litigation costs should the dispute not be resolved in mediation. The Department also consulted both commercial and trade association sources in analyzing the scope of costs for mediator fees. These sources included the Texas Medical Association, Texas Society of Anesthesiologists, and Burdin Mediators. According to

these sources, fees for mediation may range from $325 to $800 per party for a half-day of mediation. Additionally, according to the latest DOL Wage Report, mediators in Texas earn a mean hourly wage of $25.35. The Insurance Code §1467.055(f) specifies that except on the agreement of the participating parties, a mediation may not last more than four hours. Based upon these factors, the Department estimates that mediator fees will range from $325 to $1,000 per party for a half-day of mediation. Costs for mediation will be higher if the parties agree to participate in additional hours of mediation as provided under §1467.058.

(v) Cost of special judge fees and court reporter fees. Absent a successful mediation, the Insurance Code §1467.057(b) requires the chief administrative law judge to enter an order of referral of the matter to a special judge under the Civil Practice and Remedies Code, Chapter 151, that requires each party to pay the party's proportionate share of the special judge's fee, but the statute is silent concerning the amount of such fee. The Civil Practice and Remedies Code §151.009 requires the parties to pay in equal shares: (i) the special judge's fee; and (ii) all administrative costs, including the court reporter's fee, related to the trial. The DOL Wage Report uses the category "Judges, Magistrate Judges, and Magistrates" to indicate mean hourly wages for judges. According to the latest DOL Wage Report for Texas, full-time judges, magistrate judges, and magistrates earn a mean hourly wage of $28.17, while court reporters earn a mean hourly wage of $23.71. 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. Based upon §1467.055(f) of the Insurance Code which provides that a mediation will last no more than four hours except by agreement of the

participating parties, the Department has based its estimated litigation costs for the same period of time. The Department therefore estimates that the total cost of special judge fees and court reporter fees will be $207.52 for each request for mediation for which a referral to a special judge is made. This referral will result in an estimated cost to the insurer and hospital-based physician of $103.76 each. Costs for special judge fees and court reporter fees will be higher if the process takes longer than the estimated four hours.

Number of requests for mediation. As stated previously in this Cost Note, it is not possible for the Department to estimate the total number of requests for mediation because that number will be determined by a number of factors not suitable to reliable quantification. These factors include: (i) the specialty of the hospital-based physician who provides services to an enrollee and the dollar amount of the claim as eligibility factors; (ii) the contract status of hospitals and hospital-based physicians; (iii) enrollee awareness of and participation in the dispute resolution process; (iv) whether and at what stage of a claim the physician provides the enrollee with a disclosure, how frequently that physician exceeds the estimate in the disclosure, and whether the mandatory dispute resolution process increases usage of the disclosure by physicians; (v) whether the mandatory dispute resolution process results in greater utilization by enrollees of in-network hospital-based physicians in non-emergency situations or adversely affects network utilization; (vi) whether HB 2256 results in more extensive networks of hospital-based physicians under contract with the insurer; and (vii) the variation in the number of requests submitted by individual enrollees, whether zero or multiple in number. Based on the Department's Preferred Provider Benefit Plan Survey

in May 2009 and the follow-up survey in December 2009, there are approximately 3,109,178 enrollees currently insured by a preferred provider benefit plan in Texas. However, as a result of the factors previously discussed, not all of these enrollees will submit qualified claims for mandatory mediation. Under HB 2256, an enrollee of a preferred provider benefit plan offered by an insurer under Chapter 1301 of the Insurance Code could have requested mediation for a qualified claim filed on or after June 19, 2009. As of April 1, 2010, no qualified request for mediation had been received by the Department.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3): Estimated actual settlement cost. While the Department does not anticipate that there will be an actual settlement cost for every request for mandatory mediation under Chapter 1467, it is possible that some mediation requests will result in settlement costs for both insurers and hospital-based physicians. The Department expects that the cost of settlement will vary from case to case due to multiple factors, including variations in the services provided. While proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) may result in additional mediation requests and concomitant additional settlement costs, the proposed rules will not impact any particular settlement amounts because the proposed rules do not change what the appropriate charges for services or supplies are. In analyzing potential settlement costs, the Department considered two reports. First, according to the Department's "Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results" to the 81st Legislature in April, 2009 (SB 1731 Report), the total difference between amounts billed by out-of-network facility-based physicians and allowed amounts established by

insurers offering preferred provider benefit plans in calendar year 2007 was $44,415,781. Neither the SB 1731 Report nor the underlying data collected as a basis for that report included information identifying charges attributable to balance bill amounts in excess of $1,000. However, according to the second report considered, the May 28, 2009 ERS Cost Estimate for HB 2256 (ERS Cost Estimate) (Actuarial Analysis of HB 2256, As Passed Second House, 81st Legislature, Regular Session), under ERS plans during FY08 approximately 46 percent of charges potentially subject to balance billing for services furnished by out-of-network facility-based physicians were attributable to individual balance bill amounts in excess of $1,000 (or approximately $9.7 million in charges out of $21.2 million). By comparison, 46 percent of charges potentially subject to balance billing for services furnished by out-of-network facility-based physicians for preferred provider benefit plans in calendar year 2007 is estimated at $20.4 million. Approximately $24 million is therefore the estimated amount of charges that is attributable to balance bill amounts not in excess of $1,000 but which could possibly constitute individual units of a claim that could meet the $1,000 statutory threshold amount when aggregated. Using the same methodology employed in the ERS Cost Estimate, the Department further estimates that the mediation process will result in a compromise on charges that will result in payment of half of whatever the amount subject to balance billing is for each year of the first five years that the proposal is in effect. The actual total amount per year for the settlement costs to insurers and to hospital-based physicians will depend on several different factors, including the number of claims subject to mandatory mediation and the costs of the medical services and/or

supplies provided. As of April 1, 2010, the Department had not received any requests for mediation.

Proposed §21.5012: Informal settlement teleconferences for claims that qualify for mandatory mediation under the Insurance Code Chapter 1467 independent of the Department's clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). While this Cost Note previously addressed costs to the insurer associated with the informal settlement teleconference required under the Insurance Code §1467.054(d) resulting from proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), the Department also anticipates that informal settlement teleconference costs will create a fiscal impact to the insurer as a result of proposed §21.5012 for those requests for mandatory mediation of claims that qualify independently of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). Specifically, proposed §21.5012 requires that the insurer coordinate the informal settlement teleconference and provide a toll-free telephone number for participation in the call. While the Insurance Code §1467.054(d) requires the parties to participate in the informal settlement teleconference, the statute is silent with respect to how the teleconference is to be arranged and conducted. As such, the Department has determined that the costs to the insurer resulting from proposed §21.5012 for those requests for mandatory mediation for claims that arise under the Insurance Code Chapter 1467 independently of the proposed clarification at proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are also the result of the enforcement and administration of this rule. The Department anticipates that the same costs of coordinating the informal settlement teleconference and providing the toll-free telephone number for participation in the teleconference previously discussed in this

Cost Note with respect to costs attributable to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) will apply to all of the other requests for mediation that result from the enactment of the Insurance Code Chapter 1467. It is not possible for the Department to estimate the total number of such requests for mediation because that number will be determined by the same factors that are outlined in this Cost Note under the subheading “Number of requests for mediation.”

II. Cost to the administrator.

The Department anticipates that the administrator of a plan under the Insurance Code Chapter 1551, other than an HMO plan, will incur costs as a result of proposed §21.5020, which requires an administrator to include a notification of the availability of mandatory mediation with each explanation of benefits sent to an enrollee for an out-of-network claim filed on or after September 1, 2010, for services and/or supplies furnished in a hospital that has a contract with the administrator.

The estimated cost for this notification is $0.08 or less per explanation of benefits sent to an enrollee. This estimated cost is based upon the cost of ink and the cost of an additional printed page, if applicable.

If the administrator is able to print the notification on the same piece of paper as the explanation of benefits, the Department estimates that the cost of adding the notification will be $0.01 or less for the additional ink required to print the notification on the same piece of paper. If the administrator prints the notification on a separate piece of paper, the Department estimates that the cost of one additional printed page will be $0.08. If the administrator issues explanations of benefits electronically, there may be no additional cost for ink or paper.

Additionally, proposed §21.5020 may initially require personnel costs for programming the administrator's information systems for compliance with the proposed rule. Programming costs may vary depending on the number of hours required, the skill level of the programmer or programmers, the complexity of the administrator's information systems, and whether outside contract programmers will be involved. The administrator will have the information needed to estimate its individual costs for such programming. The ERS provided information to the Department that the administrator's programming costs will be "minimal." Based on data from the Labor Market & Career Information Department (LMCI) of the Texas Workforce Commission, which derives its wage information from the latest DOL Wage Report, the mean hourly wage for a computer programmer working for an insurance carrier in Texas is $37.54. The actual number, types, and cost of personnel will be determined by the administrator's existing information systems and staffing.

For those explanations of benefits that the administrator mails, the Department does not anticipate that additional costs will be incurred by the administrator for mailing the §21.5020 notification because the cost of the envelope and postage would already have been incurred as a result of the administrator's mailing of the underlying explanation of benefits. The administrator will also not incur mailing costs if the enrollee has agreed not to receive paper explanations of benefits and the notification is provided electronically.

The actual total cost to the administrator required to comply with proposed §21.5020 will depend upon the number of explanations of benefits sent to enrollees for out-of-network claims filed on or after September 1, 2010, for services and/or supplies

furnished in a hospital that has a contract with the administrator. Therefore, it is not possible for the Department to estimate the total number of notifications that the administrator will be required to send. The ERS provided information to the Department that 7,110,390 claims that would have required an explanation of benefits were processed from August 2008 to September 2009. The ERS has stated to the Department that the administrator will include the notification on every explanation of benefits for all claims processed on or after September 1, 2010, and not just on each explanation of benefits for out-of-network claims for medical services and/or supplies provided in a hospital that has a contract with the administrator, as required in proposed §21.5020. Therefore, any additional cost incurred by the administrator to send the notice with every explanation of benefits for all claims, rather than as required in proposed §21.5020, will be incurred at the option of the administrator.

III. Cost to enrollees and individuals.

Some enrollees who request mandatory mediation will incur costs to comply with proposed §21.5011, which prescribes the form and manner by which an enrollee may request mediation. Proposed §21.5030 prescribes the recommended form and manner by which an enrollee may file a complaint. Some enrollees or enrollee representatives who submit a complaint regarding a qualified claim or a mediation that has been requested under proposed §21.5010 will incur costs to comply with proposed §21.5030.

Proposed §21.5011: Submitting a request for mandatory mediation.

The Department anticipates that some enrollees who request mandatory mediation will incur costs as a result of proposed §21.5011, which prescribes the form

and manner by which the enrollee may request mediation. Proposed §21.5011(b) provides that the enrollee may submit a request for mediation by completing and submitting Form No. LHL619 (Health Insurance Mediation Request Form), proposed for adoption by reference in proposed §21.5011(a), by mail, fax, or e-mail. Also, if the Department makes Form No. LHL619 (Health Insurance Mediation Request Form) available for online submission, an enrollee will be able to use that means of submitting a request. The Department estimates that each form submitted via U.S. mail under proposed §21.5011 will cost approximately $0.73 to the enrollee. The estimated $0.73 is based on the following estimated cost factors: (i) estimated $0.24 for printing the three-page mediation request form or approximately $0.08 for paper and ink for one printed page; (ii) estimated $0.05 for a single envelope; and (iii) estimated $0.44 for first class postage using the United States Post Office. An enrollee who opts to submit the mediation request form by fax, e-mail, or online submission will likely not incur any costs or will incur very nominal costs. The choice among the prescribed methods for submitting the form is at the discretion of the enrollee.

Proposed §21.5030: Submitting a complaint regarding a qualified claim or a mediation that has been requested under proposed §21.5010. The Department anticipates that some individuals, including enrollees, who submit a complaint regarding a qualified claim or a mediation that has been requested under proposed §21.5010 will incur costs as a result of proposed §21.5030. Proposed §21.5030 prescribes the recommended form and manner by which the enrollee may file a complaint. Proposed §21.5030(a) provides that the complaint may be submitted by mail, fax, e-mail or online submission. The Department estimates that each complaint submitted via U.S. mail

under proposed §21.5030 will cost approximately $2.10 for the filing of the complaint. The estimated $2.10 is based on the following estimated cost factors: (i) estimated $0.72 for printing the nine-page complaint form or approximately $0.08 for paper and ink for one printed page; (ii) estimated $0.16 for a single 10 x 13 envelope; and (iii) estimated $1.22 for first class postage using the United States Post Office. An individual who opts to submit the complaint form by fax, e-mail, or online submission will likely not incur any costs or will incur very nominal costs. The choice among the prescribed methods for submitting the complaint form is at the discretion of the individual.

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 adverse 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.

Analysis of Economic Impact.

The Department has determined that this proposal contains two requirements that may have an adverse economic effect on approximately 10 small or micro business insurers and must be analyzed in order to determine costs to small and micro business insurers required to comply with this proposal, and one of these requirements may also have an adverse economic effect on approximately 8,831 physicians whose practice may qualify, singly or in combination with the practice of other physicians, as small or micro businesses.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) Requirements. First, proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) together clarify how to calculate whether an out-of-network claim is qualified for mandatory mediation. The Insurance Code §1467.051(a) provides that an enrollee may request mediation of a settlement of an out-of-network health benefit "claim" if: (i) 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 (ii) the health benefit "claim" 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 §1467.051(b) requires an insurer offering a preferred provider benefit plan under the Insurance Code Chapter 1301 and a facility-based physician or the physician's representative to participate in mediation if requested by an enrollee under the Insurance Code Chapter 1467, Subchapter B, subject to

certain exceptions related to advance disclosure of a facility-based physician's out-of-network status with a health benefit plan to an enrollee. The Department has determined that the additional clarification in proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), which is explained in detail in the Introduction of this proposal, is necessary to reduce ambiguity and to achieve more uniform handling of out-of-network claims of similarly situated enrollees. The primary purpose of Chapter 1467 of the Insurance Code is to create a remedy for patients 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”). Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) are consistent with the legislative intent of Chapter 1467 because together they provide necessary clarification in how to calculate whether an out-of-network claim is qualified for mandatory mediation and thereby, ensure uniform handling of out-of-network claims of similarly situated enrollees in the Chapter 1467 dispute resolution process.

Proposed §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 qualify for mandatory mediation. Proposed new §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 proposed new §21.5010. Under proposed new §21.5003(3), the term “claim” is defined 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." Collectively, these three proposed new provisions incorporate the eligibility criteria described in the Insurance Code §1467.051(a)(1) and provide additional necessary clarification. These proposed provisions may also result in additional costs to the insurer and hospital-based physician because they clarify that individual units of an out-of-network 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 an out-of-network claim having to reach the $1,000 threshold in order to be eligible for mandatory mediation. Due to these clarifications, it is likely that more claims will be eligible for mandatory mediation; thus, more requests for mandatory mediation will likely result, including requests for mandatory mediation of claims of small or micro business insurers.

Impact of Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) on Insurers. In accordance with the Government Code §2006.002(c), the Department has determined that proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) may have an adverse economic impact on approximately 10 insurers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules. This estimate is based on the Department's Preferred Provider

Benefit Plan Survey conducted in May 2009 and the follow-up survey in December 2009, in which the Department asked all insurers having one or more approved preferred provider benefit plans on file with the Department whether they met the definition of "small business" in the Government Code §2006.001(2). Based on the insurers' responses, 10 insurers out of the 135 insurers responding to the survey identified their companies as meeting the definition of a "small business." Only 5 of those 10 insurers currently cover enrollees under a preferred provider benefit plan. However, because the five insurers that do not currently offer coverage under a preferred provider benefit plan have one or more approved preferred provider benefit plans on file with the Department, these insurers could potentially offer such coverage in the future. If so, they would be required to comply with these proposed rules and therefore have been included in the number of small businesses. While the Department's survey did not ask the insurers about meeting the definition of "micro business" in the Government Code §2006.001(1), the number of micro businesses would at most be 10 insurers. The Department anticipates that it is more likely that a subset of those 10 small business insurers qualify as micro businesses.

The Department's cost analysis and resulting estimated costs, as detailed in the Public Benefit/Cost Note part of this proposal, for insurers that will be required to participate in mandatory mediation as required under the Insurance Code §1467.051(b) and in accordance with proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), are equally applicable to small or micro business insurers. Therefore, the following is a summary of this cost analysis and resulting estimated costs. The Department anticipates that the total estimated cost to an insurer, including small and micro

business insurers, will be $171.13 to $2,512.63 per request for mediation of a claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), plus the cost of settlement associated with each request. These estimated costs are based on the following cost components: (i) cost of arranging the informal settlement teleconference; (ii) cost of providing a toll-free telephone number for participation in the informal settlement teleconference; (iii) cost of employee participation and representation for the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (iv) cost of mediation, if applicable; and (v) cost of special judge fees and court reporter fees, if applicable. Small and micro business insurers are likely to have less settlement costs individually than larger insurers because the small and micro business insurers will likely handle fewer claims that will be subject to mandatory mediation. The actual total amount per year for the settlement costs to insurers, regardless of size, will depend on several different factors, including the number of claims subject to mandatory mediation and the costs of the medical services and/or supplies provided. As previously explained in detail in the Public Benefit/Cost Note part of this proposal, 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. These factors, which include the specialty of the hospital-based physician who provides services to an enrollee, the dollar amount of the claim, and enrollee participation in the dispute resolution process, also pertain to small and micro business insurers. As of April 1, 2010, the Department had not received any requests for mediation.

Impact of Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) on Hospital-Based Physicians. The Insurance Code §1467.001(4) defines a “facility-based physician” as “a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist: (A) to whom the facility has granted clinical privileges; and (B) who provides services to patients of the facility under those clinical privileges.” The term "hospital-based physician" as defined in proposed §21.5003(6) is used in lieu of the term “facility-based physician” for reasons previously explained in detail in the Introduction of this proposal. Pursuant to proposed §21.5003(6), a "hospital-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist: (i) to whom the hospital has granted clinical privileges; and (ii) who provides services to patients of the hospital under those clinical privileges. The proposed §21.5003(6) definition is necessary to provide clarity regarding which physicians, including small and micro business physician practices, are subject to Chapter 1467 of the Insurance Code and these proposed rules.

The Department has determined that proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) may have an adverse economic impact on approximately 8,831 physicians whose practice may qualify, singly or in combination with the practice of other physicians, as small or micro businesses under the Government Code §2006.001(1) and (2). Data provided by the Texas Medical Board identifies an estimated 10,309 physicians whose primary practice consists of one of the applicable specialties. This data, however, is not limited to physicians who practice in a hospital setting. An estimated 8,831 of the 10,309 physicians are members of physician groups comprised of 20 or less physicians. An estimated 7,476 of the 10,309 physicians are members of

physician groups comprised of four or less physicians. According to estimates from the Texas Medical Association, for each physician in a group, there are four to five non-medical employees. Therefore, the Department estimates that any physician groups with over 20 physicians would have 100 employees or more when factoring in the average number of non-medical employees. The Department estimates that any physician group with more than four physicians would have 20 employees or more when factoring in the average number of non-medical employees. These physicians, however, do not all necessarily meet the definition of "hospital-based physician." Thus, not all of these physicians will be affected by the enforcement and administration of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). Further, only a subset of those physicians who are hospital-based physicians will actually have out-of-network claims that meet the additional criteria for mandatory mediation. Of those hospital-based physicians' practices that do have out-of-network claims that meet the additional criteria for mandatory mediation, the Department estimates that 8,831 may qualify, singly or in combination with the practice of other physicians, as small or micro businesses under the Government Code §2006.001(1) and (2). The Department further estimates that 7,476 of these hospital-based physicians may operate practices that qualify, singly or in combination with the practice of other physicians, as micro businesses under the Government Code §2006.001(1).

The Department's cost analysis and resulting estimated costs, as detailed in the Public Benefit/Cost Note part of this proposal, for physicians who will be required to participate in mandatory mediation required under the Insurance Code §1467.051(b) and under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), are equally

applicable to small or micro business physicians. Therefore, the following is a summary of this cost analysis and resulting estimated costs. The Department anticipates the total estimated cost to the small or micro business hospital-based physician will range from $89.87 to $1,912.55 per request for mediation of a claim pursuant to proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), plus the cost of settlement associated with each request. These estimated costs are based on the following cost components: (i) cost of representation for the informal settlement teleconference and, as necessary, for mediation and subsequent litigation before a special judge; (ii) cost of mediation, if applicable; and (iii) cost of special judge fees and court reporter fees, if applicable. The actual total amount per year for the settlement costs to hospital-based physicians, regardless of size, will depend on several different factors, including the number of claims subject to mandatory mediation and the costs of the medical services and/or supplies provided. As previously explained in detail in the Public Benefit/Cost Note part of this proposal, 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. These factors, which include the specialty of the hospital-based physician who provides services to an enrollee, the dollar amount of the claim, and enrollee participation in the dispute resolution process, also pertain to small and micro business hospital-based physicians. As of April 1, 2010, the Department had not received any requests for mediation.

Proposed §21.5012 Requirement and Impact on Insurers. A second cost applicable only to insurers, including small and micro business insurers, results from the requirement at proposed §21.5012 that the insurer coordinate the informal settlement

teleconference required by the Insurance Code §1467.054(d). The Department has determined that proposed §21.5012 may have an adverse economic impact on approximately 10 insurers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules. As previously explained in detail in the section of this Economic Impact Statement entitled, *Impact of Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) on Insurers*, this estimate is based on the Department's May 2009 Preferred Provider Benefit Plan Survey and the follow-up survey in December 2009.

Proposed §21.5012 requires the insurer to: (i) arrange a date and time when the insurer, the enrollee or the enrollee's representative, and the hospital-based physician or the hospital-based physician's representative can participate in the informal teleconference, which shall occur not later than the 30th day after the date on which the enrollee submitted a request for mediation; and (ii) provide a toll-free number for participation in the informal settlement teleconference. Cost estimates for insurer compliance with these requirements are already factored into the overall estimates under the section of this Economic Impact Statement entitled *Impact of Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) on Insurers.* In addition, the Department anticipates that insurers will incur the same costs as a result of proposed §21.5012 for those requests for mandatory mediation of claims that qualify independently of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). For example, a single line item claim could qualify for mediation under the Insurance Code §1467.051(a) without applying the interpretative clarification under proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3). In such a situation, under proposed §21.5012, the insurer would still

bear the cost of arranging the informal settlement teleconference for the claim. Whether the small or micro business insurers will be required to arrange the informal settlement teleconference for those requests for mandatory mediation of claims that qualify independently of proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) or for those requests for mandatory mediation of claims that qualify as a result of the clarification in proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3), the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal are equally applicable to small or micro business insurers.

The Department has determined that the requirement for the insurer to coordinate the statutorily mandated teleconference is necessary to provide for a more uniform implementation of the teleconference requirement. This determination is based on the fact that of the preferred provider benefit plan claims that will be eligible for mandatory mediation under the Insurance Code and this proposed subchapter, the most frequent participant in the mediation process will be the insurer, including small or micro business insurers. The Department anticipates that the individual enrollees requesting mandatory mediation and the representatives of those enrollees will vary greatly. Similarly, while individual hospital-based physicians and physician representatives may participate in the mediation process more frequently than individual enrollees, the Department does not anticipate that they will participate as frequently as insurers. As previously discussed, coordination of the teleconference by the insurer will provide a foundation for more consistent and uniform implementation of the Insurance Code §1467.054(d) informal settlement teleconference requirement and will reduce

potential confusion for all participants in the informal settlement teleconference relating to which party will be responsible for coordinating the teleconference.

The following is a summary of the cost analysis and resulting estimated costs that are detailed in the Public Benefit/Cost Note. The cost components to insurers, including small or micro business insurers, to comply with proposed §21.5012 are: (i) costs for the insurer's employee hours required to set up the teleconference call; and (ii) costs to provide a toll-free telephone number for participation in the informal settlement conference. The Department estimates the cost to an insurer for the employee hours required to set up the teleconference call will range from $3.21 to $9.63 per mediation request. This estimate is based on an estimated 10 to 30 minutes per request and on the mean hourly wage of $19.25 for an administrative assistant whose duties include arranging conference calls. The Department estimates the costs for insurers to provide a toll-free telephone number to be $14 for three lines for one hour. These costs will be less if the insurer does not set up a dedicated number for informal settlement teleconference calls and instead uses existing toll-free telephone numbers. However, the need for a dedicated number may increase as use of the mandatory mediation process increases. As previously explained in the Public Benefit/Cost Note, 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. These factors, which include the specialty of the hospital-based physician who provides services to an enrollee, the dollar amount of the claim, and enrollee participation in the dispute resolution process, also pertain to small and micro

business insurers. As of April 1, 2010, the Department had not received any qualified requests for mediation.

Regulatory Flexibility Analysis.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3): Determination that No Regulatory Flexibility Alternatives Are Required. In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the Department's proposed clarification of the Insurance Code §1467.051(a) as proposed in §§21.5010(a)(2), 21.5010(b), and 21.5003(3) may have an adverse economic effect on small or micro businesses that are required to comply with these proposed requirements, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code. Section 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. Section 2006.002(c-1) of the Government Code 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." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The primary purpose of Chapter 1467 of the Insurance Code is to create a remedy for patients 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.

Proposed §§21.5010(a)(2), 21.5010(b), and 21.5003(3) clarify how to calculate whether a claim is qualified for mandatory mediation. The purpose of this clarification is to consistently and uniformly protect the economic welfare of <u>all</u> consumers who have been balance billed and who are eligible for mandatory mediation, regardless of the size of the insurer or physicians' business. The purpose is not just to protect the economic interests of those enrollees covered by insurers or treated by physicians that do not meet the definitions of small or micro businesses in the Government Code §2006.001(1) and (2). To waive or modify the requirements of the proposed clarification for small and micro businesses would result in a disparate effect on enrollees affected by the

proposed rule and would not be equally protective of the economic welfare of enrollees covered by insurers or treated by physicians that qualify as small or micro businesses. Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that because the purpose of proposed §§21.5010(a)(2), 21.5010(b), 21.5003(3), and the authorizing statutes of the Insurance Code is to protect the economic welfare of all enrollees who have been charged large and unanticipated medical bills resulting from balance billing, there are no regulatory alternatives to the proposed clarification that will sufficiently protect the economic interests of consumers and the economic welfare of the state.

Proposed §21.5012. Discussion of Regulatory Flexibility Alternatives. Proposed §21.5012 specifies the requirements for insurers and administrators that are subject to mandatory mediation requested under proposed §21.5011 and that are required by the Insurance Code §1467.054(d) to participate in an informal settlement teleconference. Proposed §21.5012(1) requires the insurer to arrange the date and time when the insurer or administrator, the enrollee or the enrollee's representative if either 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. The Department has considered waiving or modifying the requirements of proposed §21.5012(1) for small and micro businesses and has determined that such waiver or modification would result in a disparate effect on enrollees subject to the proposed rule and who are covered by insurers or treated by physicians that meet the definitions of small or micro businesses in the Government

Code §2006.001(1) and (2). The Insurance Code §1467.054(d) requires all "parties" to participate in the informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation in an effort to settle the claim before mediation but is silent with respect to how this requirement is to be implemented. However, under the Insurance Code §1467.001(7), the definition of "party" does not include an enrollee or the enrollee's representative for purposes of the informal settlement teleconference. Therefore, an enrollee or the enrollee's representative are not required to participate in the informal settlement conference but may participate at their option. The requirement under §21.5012(1) that the insurer coordinate the informal settlement teleconference is necessary to provide for more uniform implementation of the statutory teleconference requirement and to provide for more efficient regulation by the Department of the teleconference requirement by removing ambiguity with respect to where responsibility for coordination of the teleconference resides. The purpose of proposed §21.5012 and the authorizing statute is to provide a forum for settlement of applicable enrollee claims before mediation commences. Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that 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, including those covered by insurers or treated by physicians that meet the definitions of small or micro businesses in the Government Code §2006.001(1) and (2). The Department has further determined that there are no regulatory alternatives, including the waiving or modifying of the requirements of

proposed §21.5012(1), that will sufficiently protect the economic interests of consumers and the economic welfare of the state.

Proposed new §21.5012(2) requires the insurer to provide a toll-free number for participation in the informal settlement teleconference. Pursuant to the Government Code §2006.002(c-1), the Department has considered using regulatory methods that will accomplish the objective of this rule while minimizing adverse impacts on small business insurers. The Insurance Code §1467.054(d) requires all parties to participate in the informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation in an effort to settle the claim before mediation. As previously discussed, an enrollee or the enrollee's representative are not required to participate in the informal settlement conference but may participate at their option. However, the statute does not require that the informal settlement teleconference take place on a toll-free number or otherwise assign responsibility for payment of the telephone call. The regulatory alternative methods considered by the Department included: (i) requiring small and micro business insurers to provide a telephone number for participation in the informal settlement teleconference, but the number would not have to be toll-free; (ii) requiring the enrollee to provide the telephone number for use in the teleconference; (iii) requiring the hospital-based physician to provide the telephone number for use in the teleconference call, either on a toll-free basis or otherwise; and (iv) adopting a rule that would be silent regarding who must provide the telephone number and instead allowing the insurer, hospital-based physician, enrollee, and respective representatives, as applicable, to make the arrangements on an *ad hoc* basis. For the following reasons, the Department rejected

each of these alternatives: (i) as not being sufficiently consistent with the objective and intent of Chapter 1467 of the Insurance Code, i.e., to afford possible financial relief to all enrollees who have incurred significant and unexpected financial responsibility resulting from balance billing practices; (ii) as not being sufficiently protective of the economic welfare of consumers in this state; and (iii) in some instances, as being contrary to the purpose of regulatory flexibility under the Government Code §2006.002(b) and (c)(2).

Under the first regulatory alternative considered by the Department, small and micro business insurers would be required to provide a telephone number for participation in the informal settlement teleconference, but the number would not have to be toll-free. This alternative could result in requiring enrollees or their representatives who wished to participate in the informal settlement teleconference to incur costs if the telephone number provided by the insurer required a long-distance call. As discussed previously, the overall intent of Chapter 1467 of the Insurance Code is to afford possible financial relief to enrollees who have incurred large amounts of unexpected financial responsibility due to discrepancies between what insurers and hospital-based physicians find to be appropriate or reasonable reimbursement for covered services. For example, consistent with and in support of this purpose, under the Insurance Code §1467.054(e), the mediation is to be held in the county where the medical services were rendered, not where the insurer is located. Similarly, under §1467.053(d), the mediator's fees are to be split evenly and paid by the insurer and the facility-based physician. The enrollee is not required by statute to pay for the mediation. Because the overall intent of the statute is to afford possible financial relief to the enrollee, the Department has determined that a requirement that may impose a long-distance calling

fee for participation in the informal settlement teleconference is contrary to the overall purpose of the statute and not sufficiently protective of the economic welfare of consumers in this state.

Under the second regulatory alternative considered by the Department, the enrollee would be required to provide a telephone number that could be used for a teleconference. The Department has determined that this alternative is not viable because requiring the enrollee to bear the cost of providing a teleconference telephone number is contrary to the overall purpose of Chapter 1467 of the Insurance Code, which is to afford possible financial relief to the enrollees who have claims subject to Chapter 1467. The Department's analysis of this regulatory alternative concluded that such a requirement would likely create a barrier to enrollee participation in the informal settlement teleconference because not all enrollees will have access to a telephone with teleconferencing features. The Department's position that the enrollee was not intended to bear the cost of the teleconference is supported by the Insurance Code §1467.054, which provides that an enrollee's participation in the teleconference is elective. It is not necessary for the enrollee to participate in the teleconference and, therefore, it would not make sense that the enrollee would have to provide a phone number for the teleconference. Another reason why the Department determined that this alternative is not viable is that it could result in some small or micro business physician practices or insurers being required to make many long-distance calls to enrollees' phone numbers, and the cost of such long-distance calls could have an adverse economic impact on small or micro business physicians or insurers. As such, this alternative would not be consistent with the purpose of regulatory flexibility pursuant

to the Government Code §2006.002(b) and (c)(2). Additionally, such a requirement could not be enforced by the Department because the Department does not have regulatory authority over enrollees.

For these reasons, the Department has determined that this regulatory alternative is contrary to the overall purpose of Chapter 1467 of the Insurance Code because it is not sufficiently protective of the economic welfare of consumers in this state and is contrary to the purpose of §2006.002(b) and (c)(2) of the Government Code.

Under the third regulatory alternative considered by the Department, the hospital-based physician would be required to provide the telephone number for use in the teleconference call, either on a toll-free basis or otherwise. The Department determined that this regulatory alternative is not viable for the following reasons: (i) such a requirement would be contrary to the purpose of regulatory flexibility under the Government Code §2006.002(b) and (c)(2) because it would sometimes result in small or micro business physician practices being required to bear the cost of providing a toll-free number for the informal settlement teleconference or providing or having access to a telephone with a teleconferencing feature; and (ii) such a requirement could not be enforced by the Department because the Department does not have regulatory authority over physicians.

Under the fourth regulatory alternative considered by the Department, the rule would be silent regarding who must provide the telephone number and would, instead allow the insurer, hospital-based physician, enrollee, and respective representatives, as applicable, to make the arrangements on an *ad hoc* basis. This could be done either for

informal settlement conferences involving insurers of any size or only for informal settlement conferences involving small and micro business insurers. The Department rejected this alternative for the following reasons: (i) it could result in confusion and lack of certainty concerning how to implement the requirement, especially for individuals who did not participate in such informal settlement teleconferences on a routine basis; (ii) it could actually result in shifting costs to small or micro business physician practices, which would be contrary to the purpose of regulatory flexibility under the Government Code §2006.002(b) and (c)(2); (iii) the insurer, not the hospital-based physician or the enrollee, is more likely to participate in several mediations and therefore is in the best position experience-wise as well as knowledge-wise to provide the telephone number and arrange the teleconference; the process will be more likely to become routine for the insurer than for the hospital-based physician or enrollee; and (iv) the failure to not require anyone to provide a telephone number could result in less likelihood that the statutory requirement to participate in the informal settlement teleconference not later than the 30th day after the date on which the enrollee submits a request for mediation will be met.

For these reasons, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that there are no regulatory alternatives to proposed §21.5012(2) that will sufficiently protect the health and economic interests of Texas consumers and the welfare of the state.

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 June 14, 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 and Licensing 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 sections are proposed pursuant to 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 (HB 2256), SECTION 7. Section 1467.003 provides that the Commissioner shall adopt rules as necessary to implement the Commissioner's respective powers and duties under Chapter 1467 of the Insurance Code. 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) provides that the Commissioner, as appropriate,

shall 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 of Insurance may 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. 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.

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

Rule	Statute
§21.5001	Insurance Code Chapter 1467
§21.5002	Insurance Code §1467.002 and Chapters 1301 and 1551
§21.5003	Insurance Code §1467.001 and §1467.051 and Chapters 1301 and 1551
§21.5010	Insurance Code §§1467.051, 1467.055, and 1467.056

§21.5011 and §21.5012	Insurance Code §1467.054
§21.5013	Insurance Code §§1467.051, 1467.055, 1467.056, 1467.101, and 1467.102
§21.5020	Insurance Code §1467.151
§21.5030	Insurance Code Chapter 1467, Subchapter B, and §1467.151
§21.5031	Insurance Code §1467.151

9. 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. 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 June 19, 2009; 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 September 1, 2010.

§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 insureds 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;

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

(D) otherwise comply with any rules promulgated by the Texas Medical Board under the Insurance Code §1467.003.

§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 available Form No. LHL619 (Health Insurance Mediation Request Form) that may 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 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 shall comply with 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 September 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; and

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

(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.

10. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on April 30, 2010.

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