SUBCHAPTER QQ. HEALTH INFORMATION TECHNOLOGY
28 TAC §§21.5101 - 21.5103

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts new Subchapter QQ, §§21.5101 – 21.5103, concerning waiver of a health benefit plan issuer's requirement to use information technology to provide physicians and patients with real-time health insurance information electronically. Sections 21.5102 and 21.5103 are adopted with changes to the proposed text published in the November 26, 2010 issue of the *Texas Register* (35 TexReg 10416). Section 21.5101 is adopted without changes.

2. REASONED JUSTIFICATION. The new sections are necessary to: (i) implement the Insurance Code §1661.008 as added by House Bill (HB) 1342, enacted by the 81st Legislature, Regular Session, effective May 30, 2009; (ii) identify circumstances that justify a waiver of the requirement for a health benefit plan issuer under Chapter 1661 to use information technology; and (iii) specify the waiver application process.

House Bill 1342 added new Insurance Code Chapter 1661 to require a health benefit plan issuer to use information technology that provides a participating health care provider and a plan enrollee with real-time information relating to the enrollee's cost and coverage by September 1, 2013. Under §1661.008(a), a health benefit plan issuer may apply to the Commissioner for a waiver of the requirements under Chapter 1661 to use information technology. Under §1661.008(b), the Commissioner is required by rule to identify circumstances that justify a waiver, including: (1) undue hardship,

including a financial or operational hardship; (2) the geographical area in which the health benefit plan issuer operates; (3) the number of enrollees covered by a health benefit plan issuer; and (4) other special circumstances.

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

A waiver application is optional on the part of a health benefit plan issuer. The authority of a health benefit plan issuer to apply for a waiver under this subchapter expires January 1, 2012, pursuant to the Insurance Code §1661.008(d). An approved waiver under this subchapter expires September 1, 2013, pursuant to the Insurance Code §1661.008(e). Therefore, all health benefit plan issuers, even those that have a waiver application granted under these rules, will have to comply with the real-time information technology requirements of the Insurance Code Chapter 1661 by September 1, 2013.

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

The Department posted an informal draft of the proposal on its website August 18, 2010, and invited further public comment by September 1, 2010. The Department published the proposed rule in the November 26, 2010 issue of the *Texas Register (35 TexReg 10416)*. No public hearing on the proposal was held. The Department has determined that it is necessary for purposes of clarification and internal consistency to revise §21.5102, and §21.5103 as proposed. None of these changes to the proposed text, however, materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Proposed §21.5102 is revised to add a new subsection (c) to provide that the authority of a health benefit plan issuer to apply for a waiver under this subchapter expires January 1, 2012, pursuant to the Insurance Code §1661.008(d). This addition is necessary to clarify that health benefit plan issuers are limited in the time in which they can apply for a waiver from the information technology requirement in §16601.008 of the Insurance Code.

Proposed §21.5103(b) is revised to include an additional special circumstance to support the request for a waiver from the information technology requirements of the Insurance Code Chapter 1661. The Department has added new §21.5103(b)(5)(G) to provide an additional minimum special circumstance to support the request for a waiver

from the information technology requirements of the Insurance Code Chapter 1661. Under §21.5103(b)(5) as adopted, a health benefit plan issuer may apply to the Commissioner for a waiver of the Chapter 1661 information technology requirements on the basis of the special circumstances listed in proposed subsection (b)(5)(A) – (F) and the added subsection (b)(5)(G) special circumstance regarding "whether the issuer is a small business or micro business as defined by the Government Code §2006.001." The change is necessary to implement the Department's intent that was expressed in the rule proposal Introduction. The rule proposal Introduction stated: "Proposed §21.5103 provides the specifications for the format for the waiver applications, where the requests should be sent, and the circumstances identified by the Commissioner that justify a waiver. In addition to the circumstances that a waiver application may include as provided by statute, the Department has further included four additional specific special circumstances: (i) the actions by the health benefit plan issuer to progress toward compliance; (ii) the estimated date compliance will be achieved if prior to September 1, 2013; (iii) the estimated cost of compliance with Insurance Code §1661.002 by the date proposed in the request for waiver and a description of any increase in cost if earlier compliance is required; and *(iv) whether the issuer is a small business or micro business as defined by the Government Code §2006.001 [*emphasis added*].*" Section 21.5103(b)(5)(G) states the special circumstance listed as number (iv) in the rule proposal Introduction. The Government Code §2006.001(1) defines "micro-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 not more than 20 employees. 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.

Additionally, the Department has determined that editorial changes to the proposed text in §21.5102(b) and §21.5103(c) and (d) are necessary. These changes are: (i) in §21.5102(b) as adopted, §21.5102(b)(2)(A) – (H) are redesignated as (b)(3) – (10); this redesignation is necessary to clarify the non-applicability of the rules to separate products, lines, or programs of insurance rather than to subsets of proposed "(b)(2) disability income protection coverage, as defined in §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage)"; (ii) in §21.5103(c) as adopted, the term "shall" is changed to "must" to comply with the rule of statutory construction that the term "shall" be used only to denote a duty and therefore, must be used only with persons; and (iii) in proposed §21.5103(d) as adopted, the reference to "subsection (b)" is changed to "subsection (b) of this section" for purposes of clarity and to conform to *Texas Register* style.

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

§21.5101 Purpose. The rules are necessary to specify the waiver application requirements for health benefit plan issuers regarding the use of certain required real-time information technology pursuant to the Insurance Code Chapter 1661. Section 21.5101 sets forth this purpose.

§21.5102 Applicability. Section 21.5102 identifies the health benefit plan issuers to which the new subchapter applies and does not apply in accordance with the Insurance Code §1661.001 and §1661.003. Section 21.5102(a) specifies that the subchapter applies to an entity authorized to issue a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage, except as provided in §21.5102(b). The entities subject to these rules are (i) an insurance company operating under the Insurance Code; (ii) a group hospital service corporation operating under the Insurance Code Chapter 842; (iii) a fraternal benefit society operating under the Insurance Code Chapter 885; (iv) a stipulated premium insurance company operating under the Insurance Code Chapter 884; (v) a Lloyd's plan operating under the Insurance Code Chapter 941; (vi) an exchange operating under the Insurance Code Chapter 942; (vii) a health maintenance organization operating under the Insurance Code Chapter 843; (viii) a multiple employer welfare arrangement that holds a certificate of authority under the Insurance Code Chapter 846; (ix) an approved nonprofit health corporation that holds a certificate of authority under the Insurance Code Chapter 844; and (x) an entity not authorized under the Insurance Code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis.

Section 21.5102(b) specifies that the subchapter does not apply to certain health benefit plans. A health benefit plan issuer may be subject to the rule because it offers a

health benefit plan subject to §21.5102(a), but may also offer health benefit plans for which providing of certain required real-time information technology is not required pursuant to Insurance Code §1661.003. Health benefit plans that are exempted from the rule are not required to provide real-time information technology required pursuant to Insurance Code §1661.003. However, a health benefit plan not exempt is required to comply with the rule, and a health benefit plan issuer that issues a non-exempt plan may request a waiver pursuant to these rules. The issuers that are not subject to these rules include (i) a health benefit plan issuer offering a health benefit plan that provides coverage only for (a) a specified disease, (b) accidental death or dismemberment, (c) a supplement to a liability insurance policy, or (d) for dental or vision care; (ii) disability income protection coverage, as defined in §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage); (iii) credit accident and health insurance, as defined in the Insurance Code §1153.003; (iv) hospital confinement indemnity insurance, as defined in §3.3073 of this title (relating to Minimum Standards for Hospital Confinement Indemnity Coverage); (v) Medicare supplement benefit plans, as defined in the Insurance Code Chapter 1652; (vi) workers' compensation insurance; (vii) medical payment insurance coverage under a motor vehicle insurance policy; (viii) long-term care insurance policy, including a nursing home fixed indemnity policy, unless the Commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section; (ix) the child health plan program under the Health and Safety Code Chapter 62, or the health benefits plan for children under the Health and Safety Code

Chapter 63; or (x) a Medicaid managed care program operated under the Government Code Chapter 533, or a Medicaid program operated under the Human Resources Code Chapter 32.

Section 21.5102(c) provides that the authority of a health benefit plan issuer to apply for a waiver under this subchapter expires January 1, 2012. This expiration is in accordance with Insurance Code §1661.008(d).

§21.5103 Waiver. Section 21.5103 is necessary to provide the specifications for the format for the waiver application, where the waiver requests should be sent, and the special circumstances identified by the Commissioner that justify a waiver. In addition to the statutorily specified circumstances that a waiver application may include, §21.5103(b)(5) includes four additional specific special circumstances: (i) the actions by the health benefit plan issuer to progress toward compliance; (ii) the estimated date compliance will be achieved if prior to September 1, 2013; (iii) the estimated cost of compliance with Insurance Code §1661.002 and an estimate of the increased cost for compliance at an earlier date; and (iv) whether the issuer is a small business or micro business as defined by the Government Code §2006.001.

In addition, the statutorily specified special circumstance in §21.5103(b)(5)(C) related to the number of enrollees covered by a health benefit plan issuer also includes the number of enrollees impacted by the waiver. The Department determined that this additional factor is necessary because there may be instances where the total number of enrollees covered differs from the total number of enrollees impacted by the waiver. For example, some health benefit plan issuers may already be able to be compliant with

Insurance Code §1661.002, but, because of obsolete information technology for a portion of those enrollees, may not be able to provide for all of their enrollees the real-time information required under §1161.002. Additionally, there may be other reasons that the issuer may not be able to provide all of the required real-time information. For example, there may be a situation in which the insurer can provide the real-time information for most enrollees, but cannot do so for a small fraction of enrollees. This may be because the remaining fraction is covered by a particular type of plan or that the book of business was recently acquired. In such situations, the provision of only the number of total enrollees may not provide enough detail to determine whether the waiver should be approved or denied. For example, if the cost for providing the real-time information for that small fraction of enrollees would be costly, then the case for the waiver may be stronger from a cost/benefit perspective. Therefore, this additional factor will help provide a more accurate assessment of the facts stated in the waiver application weighed against the purposes of Insurance Code Chapter 1661.

Section 21.5103(b)(5) only describes the minimum facts and circumstances to include in a waiver application. Therefore, health benefit plan issuers with other concerns or relevant factors may also submit specific facts and circumstances to support these concerns in the waiver application.

Section 21.5103(c) specifies where the waiver applications must be filed.

Section 21.5103(d) provides additional guidance about the 60-day time frame for approval or denial of the waiver application. Insurance Code §1661.008(c) specifies that the Commissioner shall approve or deny a waiver application under Section

1661.008 not later than the 60th day after the date of receipt of the application. Under §21.5103(d), a waiver is deemed received when the Commissioner has received sufficient information to approve or deny the waiver application, including any additional relevant information requested from the health benefit plan issuer.

Additionally, §21.5103(e) describes how the Commissioner will determine whether to grant a waiver. The Commissioner will weigh facts demonstrated by the applicant against the purposes of Chapter 1661, including the objective to provide better information to physicians and enrollees regarding what is covered by insurance policies and what portion of the cost is to be borne by the patient, as well as the objective of streamlining and simplifying complex and administrative processes of the health insurance systems, thus providing cost savings throughout the health care system. Section 21.5103(f) provides that the effective date of the rules is June 29, 2011. This effective date provision is necessary to allow health benefit plan issuers adequate time to decide whether to request and draft a waiver application and, consistent with the proposal, is based on an effective date that is 40 days after publication of the adoption order notice in the *Texas Register*.

3. HOW THE SECTIONS WILL FUNCTION.

Section 21.5101 states the purpose of the new subchapter.

Section 21.5102 identifies the health benefit plan issuers to which the new subchapter applies and does not apply.

Section 21.5103 provides the specifications for the format for the waiver applications, where the waiver requests should be sent, and the special circumstances identified by the Commissioner that justify a waiver. Additionally, §21.5103(e) describes how the Commissioner will determine whether to approve or deny a waiver application upon submission. Section 21.5103(f) provides that the effective date of the rules is June 29, 2011.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department received comments from one commenter on the published proposal.

Comment: A commenter urges that the Department amend the rule to specifically recognize the requirements of the Patient Protection and Affordable Care Act of 2010 (PPACA) as a special circumstance that provides for an automatic approval of a waiver request. The commenter's reasons are: (i) Section 1104 of PPACA directs the federal Department of Health and Human Services (HHS) to establish business rules and guidelines for the electronic exchange of information related to administration and financial transactions; and (ii) PPACA amends Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) by adding requirements for financial and administrative transactions that the standards and associated operating rules adopted by the Secretary shall "to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care."

Agency Response: The Department declines to make the requested change for the following three reasons. First, the Department is of the opinion that the waiver application process already includes a means for health benefit plan issuers to justify a waiver based on PPACA. The rules at §21.5103(b) allow for a health benefit plan issuer to provide specific facts and circumstances in support of the request for a waiver, and a health benefit plan issuer's explanation of PPACA's effect on the listed factors is an appropriate fact or circumstance to assert in the waiver application for the Commissioner's consideration. The Department agrees that the broader regulatory environment, including PPACA, may create evidence of undue hardship, including financial or operational hardship. Further, the Department recognizes that PPACA may impact the past and planned actions by the health benefit plan issuer to progress toward compliance and the cost of compliance. Because §21.5103(b)(5) only describes the minimum facts and circumstances to include in a waiver application, health benefit plan issuers expressing concerns regarding PPACA are welcome to detail those specific facts and circumstances in a waiver application. In accordance with §21.5103(e), the Commissioner will consider the facts demonstrated by the applicant weighed against the purposes of Chapter 1661, including the objective to provide better information to physicians and enrollees regarding what is covered by insurance policies and what portion of the cost is to be borne by the patient. The Commissioner will also consider the purpose of Chapter 1661 to streamline and simplify complex and administrative processes of the health insurance systems, thus providing cost savings throughout the health care system.

Second, the Insurance Code Chapter 1661 was effective prior to the passage of PPACA and constitutes potentially different regulatory requirements regarding the provision of real-time health insurance information. Until the HHS adopts federal regulations implementing PPACA Section 1104, the Department cannot be certain that health benefit plan issuers compliant with federal requirements would be providing the same information required by the Insurance Code Chapter 1661. Third, waivers granted through this rule will expire September 1, 2013, but it is not clear when similar provisions in PPACA will be implemented. PPACA requires varying implementation dates from the HHS Secretary for PPACA Section 1104. Depending on the HHS final rules, the "health claims or equivalent encounter information" required by PPACA Section 1104 may be similar to the real-time information required by Chapter 1661. The federal rules may be adopted as late as July 1, 2014, and effective as late as January 1, 2016. Alternatively, the federal operating rules for eligibility for a health plan and health claim status transactions must be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013. It is not clear which set of dates PPACA Section 1104 will require for transactions similar to the real-time information required by Chapter 1661. Providing automatic waivers on the basis of PPACA may mean that the waivers expire prior to the federal rules being adopted. Therefore, it is consistent with the intent of HB 1342 to have all applicable insurers providing the real-time information technology requirements of the Insurance Code Chapter 1661 prior to PPACA's implementation.

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

For, with changes: Texas Association of Health Plans (TAHP).

Against: None.

6. STATUTORY AUTHORITY. The new sections are adopted under HB 1342, as enacted by the 81st Legislature, Regular Session, effective May 30, 2009, and the Insurance Code §§1661.008, 1661.009, and 36.001. Section 1661.008, enacted by HB 1342, requires that the Commissioner establish circumstances that justify a waiver so that a health benefit plan issuer may apply for a waiver of the requirement under the Insurance Code §1661.002 to provide real-time information relating to the enrollee's cost and coverage at the point of care. Section 1661.001 defines *health benefit plan issuer* as an entity authorized to issue a health benefit plan in this state. *Health benefit plan* is defined in Section 1661.001 as a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage. Section 1661.009 requires the Commissioner to adopt rules as necessary to implement Insurance Code Chapter 1661. Section 36.001 authorizes the Commissioner of Insurance to adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

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

§21.5102. Applicability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) for accidental death or dismemberment;

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

(D) for dental or vision care;

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

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

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

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

(6) workers' compensation insurance;

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

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

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

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

(c) Pursuant to the Insurance Code §1661.008(d), the authority of a health benefit plan issuer to apply for a waiver under this subchapter expires January 1, 2012.

§21.5103. Waiver.

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

(b) Waiver applications are required to:

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

(2) be legible;

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

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

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

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

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

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

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

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

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

(G) whether the issuer is a small business or micro business as defined by the Government Code §2006.001.

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

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

(e) The commissioner may grant a waiver under this subchapter considering the facts demonstrated by the applicant weighed against the purposes of Chapter 1661, including the objective to provide better information to physicians and enrollees regarding what is covered by insurance policies and what portion of the cost is to be borne by the patient, as well as streamlining and simplifying complex and administrative processes of the health insurance systems, thus providing cost savings throughout the health care system.

(f) This subchapter becomes effective June 29, 2011.

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

Issued at Austin, Texas, on May 2, 2011.

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

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that new Subchapter QQ, §§21.5101 – 21.5103 specified herein, concerning waiver of a health benefit plan issuer's requirement to use information technology to provide physicians and patients with real-time health insurance information electronically, is adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. 11-0384

MAY 02 2011