SUBCHAPTER X. Preferred Provider Plans
28 TAC §§3.3701 - 3.3713

1. INTRODUCTION. The Texas Department of Insurance (Department) proposes amendments to §§3.3701 – 3.3706 and new §§3.3707 – 3.3713, concerning preferred provider benefit plans and network adequacy requirements. These amendments and new sections are necessary to implement SECTION 2 of House Bill (HB) 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009, and HB 1030, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. HB 2256 adds new §1301.0055 to the Insurance Code and requires the Commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. HB 1030 mandates that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. In addition to implementing HB 2256 and HB 1030, these new and amended sections are necessary to: (i) ensure reasonable accessibility and availability of preferred provider services to Texas residents as provided in the Insurance Code §§1301.005, 1301.006, and 1301.007; and (ii) establish standards that support the use of preferred

provider benefit plans that are not unjust under Chapter 1701, unfairly discriminatory under Chapter 544, Subchapters A and B, or in violation of Chapter 1451, Subchapters B and C, concerning designation and selection of providers. The new and amended sections also require the provision of consumer information in a manner consistent with the requirements of SECTION 11 of Senate Bill (SB) 1731, enacted by the 80th Legislature, Regular Session, effective September 1, 2007. The proposed amendments also update statutory references resulting from the nonsubstantive revision of the Insurance Code and Occupations Code and amend existing text for clarification, correct punctuation and grammar, and correct and update internal references. As preparation for this proposal, the Department has solicited extensive feedback from stakeholders. To obtain comments, the Department made an informal posting on its website of a concept paper and proposed revisions to the rules governing preferred provider benefit plans on April 23, 2010. The Department held a meeting to discuss the drafts on May 5, 2010. After consideration of comments received, the Department made a second informal posting on its website of proposed revisions to the rules and an estimate of anticipated costs to comply with the revised rules on September 13, 2010. In making the posting, the Department requested comments on the substance of the draft rules, the accuracy of the Department's estimates of costs to comply with the draft rules, and input on what costs certain draft provisions would entail. A second informal stakeholder meeting was held to discuss the draft rules and potential costs on September 21, 2010.

Implementation related to network adequacy. The Insurance Code §1301.005 requires that an insurer offering a preferred provider benefit plan ensure that

both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. Section 1301.005 further mandates that if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider. Additionally, the Insurance Code §1301.006 requires that insurers contract with sufficient providers to ensure that all covered services will be provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. Title 28 Texas Administrative Code Chapter 3, Subchapter X, contains the existing adopted sections governing preferred provider benefit plans.

The bill analysis for HB 2256 includes the following statement of intent: *"Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. 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."* TEXAS SENATE

STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, "Author's/Sponsor's Statement of Intent") HB 2256, 81st Leg., R.S. (May 22, 2009). One of the remedies provided in HB 2256 for the problem of unexpected balance bills is the addition of §1301.0055 to the Insurance Code in SECTION 2 of the bill, mandating the Commissioner to adopt by rule network adequacy standards The proposed amended and new sections address the issues of network adequacy and unexpected balance billing in several ways: (i) the amendment and addition of network requirements; (ii) the amendment and addition of disclosure requirements; (iii) the amendment and addition of contracting requirements; and (iv) the addition of requirements concerning payment of certain out-of-network (basic benefit) claims.

Network adequacy: network requirements. The Department has addressed network requirements as required by the Insurance Code §1301.0055 and as further authorized under the Insurance Code §1301.007. Proposed new §3.3704(e) imposes specific network requirements that each preferred provider benefit plan must include in the health care service delivery network that supports the plan. The Department has adapted the network requirements to reflect the rural or nonrural nature of the service area, the nature of the services as routine, urgent, or emergency care, and the type of physician or provider that furnishes the services. Because the need for an adequate network is ongoing, proposed new §3.3704(f) requires insurers to monitor compliance with these network requirements on an ongoing basis and to take any needed corrective action as required to ensure that the network is adequate.

The Department proposes new §3.3706(a)(5) to prohibit the selection standards used by an insurer from: (i) avoiding high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or (ii) excluding a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or health services utilization. This prohibition is necessary to ensure that insurers afford all providers a fair, reasonable, and equivalent opportunity to apply to be and be designated as preferred providers, as required by the Insurance Code §1301.051. The prohibition is also consistent with the requirement in the Insurance Code §1301.058 that any economic profiling of physicians and providers by insurers be adjusted to recognize the characteristics of a provider's practice that may account for variations from average costs. Additionally, the prohibition ensures that the health insurance policy providing for the use of preferred providers is not unjust under the Insurance Code §1701.055(a)(2). It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers would not be just if selection criteria for preferred providers discriminated against the types of providers that are most particularly necessary for those insureds that present a risk of higher than average claims or health care services utilization. The prohibition is necessary to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided are accessible and available as specified in the Insurance Code §1301.006. The

Department further proposes new §3.3706(c) to require insurers to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. The credentialing standards must, at a minimum, meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Additionally, there shall be a presumption of compliance with credentialing requirements if the insurer has received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, the URAC, or the Accreditation for Ambulatory Health Care. Proposed new §3.3706(c) will ensure that the service delivery network of preferred providers is appropriately qualified to provide the benefit package required under the health insurance policy, a necessary requirement in a policy that provides for different levels of coverage depending upon the use of preferred providers. The Insurance Code §1301.006 requires insurers to contract with sufficient physicians and providers to ensure “availability of and accessibility to adequate personnel, specialty care, and facilities.” It is the Department’s position that the use of a process for the selection and retention of physicians and providers that are appropriately credentialed is necessary to meet the adequacy requirement of §1301.006. It is also the Department’s position that the requirement is necessary to ensure that the policy is just as contemplated in the Insurance Code §1701.055(a)(2).

Proposed §3.3707 specifies the manner by which an insurer may request a waiver from one or more network adequacy requirements due to local market

conditions. An insurer may seek such waiver upon a showing that providers or physicians necessary for an adequate network are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable. Proposed §3.3707(b) further requires an insurer submitting a waiver request to submit a copy of the request to any provider or physician named in the request by any reasonable means and maintain evidence that such submission has been made. Proposed §3.3707(c) permits such provider or physician to electively submit a response to the waiver request. These provisions are necessary to permit the Department to fully consider the circumstances that the insurer asserts to support a waiver request. To limit the negative impact on insureds of plans operating without a supporting network that complies with network adequacy requirements, proposed §3.3707(a) also provides that the Department may impose reasonable conditions on the grant of such waiver. As required by the Insurance Code §1301.0055(3), proposed §3.3707(d) requires that upon such waiver being granted, the Department shall post on the Department's Internet website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area. To ensure that such a waiver does not continue indefinitely despite potential changes in the circumstances that originally supported the waiver, proposed §3.3707(e) requires that the insurer apply for renewal of the waiver annually. Physicians and providers will have an opportunity to furnish information in opposition to the request each year that the insurer applies for renewal of the waiver.

Proposed new §3.3709 requires insurers to file a network adequacy report with the Department on or before April 1 of each year and prior to marketing any plan in a new service area. Each report must specify the trade name of each plan in which insureds currently participate, the applicable service area of each plan, and whether the preferred provider service delivery network supporting each plan is adequate under the standards specified in §3.3704. Annual reports must include additional demographic information on the basis of specified geographic regions. This information includes the number of: (i) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level; (ii) claims for basic benefits paid at the preferred benefit coinsurance level; (iii) complaints by nonpreferred providers; (iv) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing; (v) complaints by insureds relating to the availability of preferred providers; and (vi) complaints by insureds relating to the accuracy of preferred provider listings. Data collected by the Department indicates that insurers do not closely monitor some important network adequacy indicators. For example, a majority of health benefit plan issuers reported that they do not separately monitor balance billing complaints and inquiries. *See Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results*, April 2009 (*April 2009 Network Report*) at 4, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork409b.doc. Further, less than half of the surveyed health benefit plan issuers reported that they have a process for monitoring the extent to which insureds receive treatment from out-of-network

(nonpreferred) facility-based physicians at in-network (preferred provider) facilities. *April 2009 Network Report* at 4. The information required to be reported under §3.3709 will encourage insurers to more closely monitor these important network adequacy indicators. In conjunction with TDI complaint data, the information will also facilitate the Department's oversight of compliance with network adequacy requirements on an ongoing basis in order to determine if additional examination of particular insurers is necessary. If the insurer does not use a service delivery network that complies with §3.3704, the insurer is required to submit an access plan as part of the annual report. The access plan must include for each service area that does not meet the network adequacy requirements: (i) the geographic area in which a sufficient number of preferred providers are not available, including a specification of the type of provider that is not sufficiently available; (ii) a map identifying the geographic area in which such health care services and/or physicians and providers are not available; (iii) the reason(s) that the preferred provider network does not meet the adequacy requirements; (iv) the procedures that the insurer will use to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and (v) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708. In addition to the access plan, insurers are required under proposed §3.3709(f) to establish and implement documented procedures for use in all service areas for which an access plan is submitted. Such procedures are required to identify requests for preauthorization of services for insureds that are likely to require the

rendition of services by physicians or providers that do not have a contract with the insurer, furnish to such insureds a pre-service estimate of the amount the insurer will pay the physician or provider, and notify the insured that the insured may be liable for balance bill amounts. The insurer must also have a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured and make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. Access plans may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible. Proposed new §3.3709(h) specifies that the annual network adequacy report must be filed electronically in a format acceptable to the Department at a specified e-mail address. Additionally, proposed new §3.3709(i) requires insurers to establish an access plan within 30 days of the date on which a network no longer meets the adequacy requirements established in §3.3704. Such access plan is required to be made available to the Department upon request. Collectively, the requirements specified in proposed §3.3709 are necessary to permit ongoing monitoring of insurer compliance with network adequacy standards specified in the subchapter by the Department and to ensure that insurers are taking reasonable steps to reduce the potential scope of unanticipated balance bills. Further, it is the Department's position that the Insurance Code §1301.005 and §1301.069 contemplate that there will be instances in which insureds are seen by nonpreferred physicians or providers due to the inadequacy of an insurer's network. Section 1301.005(b) requires that insurers pay such claims at the preferred benefit level of reimbursement, and §1301.069 requires

that such claims be paid promptly. Proposed new §3.3704(f) ensures compliance with the Insurance Code §1301.005 by requiring insurers to proactively identify those areas in which networks are inadequate, and §3.3704(f) requires that insurers take steps to ensure that claims from nonpreferred providers under those circumstances are paid correctly. The additional provision of information from insurers concerning the reasons for the network's inadequacy and specifying the steps taken by the insurer to protect insureds faced with an inadequate network will facilitate the Department's determinations of what regulatory response is most appropriate to address an insurer's use of an inadequate network in support of its preferred provider benefit plan.

The Department proposes new §3.3710 to address an insurer's failure to provide an adequate network. Proposed §3.3710 provides that if the Commissioner determines, after notice and opportunity for hearing, that the insurer's preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the Commissioner may order one or more specified sanctions. Under the Commissioner's authority to issue cease and desist orders as specified in the Insurance Code Chapter 83, proposed §3.3710(a) specifies that such sanctions may include an order to: (i) reduce the service area; (ii) cease marketing in parts of the state; and/or (iii) cease marketing entirely and withdraw from the preferred provider benefit plan market. Proposed §3.3710 is necessary to

apprise insurers of potential sanctions that may result from the insurer's failure to provide an adequate network.

Proposed new §3.3711 defines 11 geographic regions by ZIP Code designations. The designation of regions will facilitate the required disclosure of specified demographic information as required under §3.3705(b)(14) for those plans that are offered on a less than statewide basis to permit the comparison of information among plans for prospective and current policyholders. The designation of regions also facilitates the provision of demographic information submitted by insurers as part of the annual network adequacy report as required in proposed §3.3709(c) and aids the Department's efforts to monitor network adequacy throughout the state. The designated regions correspond to public health regions established by the Department of Health and Human Services and are familiar to insurers. The regions also correspond to regions adopted separately by the Department in Texas Administrative Code §21.4504 for use by insurers in providing health care rate reimbursement data to the Department pursuant to the Insurance Code §38.355.

Proposed new §3.3712 specifies professional services for which insurers must require public disclosure of billed charges under §3.3703(a)(26)(B)(i). The use of a defined minimum data set for the disclosure will facilitate comparison by insureds. Additionally, the data set corresponds to those professional services for which health care reimbursement data collection is performed under the Insurance Code §38.355. *See* Form No. LHL616 (Health Care Claims Reimbursement Rate Report), adopted by reference in 28 Tex. Admin. Code §21.4507. The Department anticipates that the use

of a comparable data set for the billed charges of physicians may additionally facilitate the mediation of some claims as permitted under the Insurance Code §1467.051(a).

Network adequacy: disclosure requirements. The Department proposes to amend and increase the disclosure requirements with which an insurer must comply to ensure that prospective and current insureds considering the purchase or renewal of coverage that relies upon the network have access to information that conveys the scope and limitations of the plan's ability to ensure the availability and accessibility of preferred benefit services. Proposed new §3.3704(g) specifies the manner in which an insurer may define a preferred provider benefit plan's service area to provide for a clear delineation of a plan's boundaries for review by insureds. This delineation will facilitate an insured's ability to identify the service area in which preferred benefits are available and additionally permit comparison to the service areas of other plans. Collectively, this information will help prospective and current insureds to assess the network characteristics of a preferred provider benefit plan to determine if the plan is appropriate for the needs of the insured. Existing §3.3705(b)(12) requires an insurer to provide to a prospective or current group contract holder or insured on request: (i) a current list of preferred providers and complete network descriptions; and (ii) a disclosure of which preferred providers are not accepting new patients. The Department proposes to amend this paragraph to specify that this information may be provided electronically with the agreement of the insured provided that the insurer also furnishes the insured with information about how to obtain a nonelectronic provider listing free of charge. This amendment will provide insurers with a less costly alternative for complying with the

requirement based upon the insured's ability to access the information electronically. Further, the paragraph is consistent with the Insurance Code §1301.158(b) and §1301.159. Section 1301.158(b) requires insurers to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must include a current list of preferred providers. Section 1301.159 requires insurers to provide a current list of preferred providers at least annually. The Department also proposes an additional disclosure requirement in new §3.3705(b)(14). Proposed §3.3705(b)(14) will require insurers to provide current and prospective group contract holders or insureds with information regarding network demographics for each service area, if the plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of the subchapter if the plan is offered on a statewide service area basis. The network demographic information must be updated at least annually and includes: (i) the number of insureds in the service area or region; (ii) the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an active access plan pursuant to §3.3709 of the subchapter applies to the services furnished by particular types of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; (iii) the percentage of preferred providers that are accepting new patients; (iv) the percentage of preferred providers with board certifications in the area of practice, as applicable; (v) the number of preferred provider hospitals in the service area or region and the ratio of insureds to

hospital beds, as well as an indication of whether an active access plan pursuant to §3.3709 applies to hospital services in the service area or region and how the access plan may be obtained or viewed; (vi) the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and (vii) the average surgical site infection rate at each specific preferred provider hospital in the service area or region. Disclosure of this network demographic information will assist current and prospective insureds and group contract holders to compare plans and to make informed decisions concerning the selection or retention of a plan. Further, such information will assist the insureds and group contract holders to more accurately assess the risk of unanticipated balance bills associated with reliance upon a particular plan and the network that supports such plan. The Department proposes additional required disclosures at §3.3705(e) for insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds. Such insurers are required to provide: (i) an Internet-based provider listing for use by current insureds, consistent with the requirements of the Insurance Code §1301.0591; (ii) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county, or ZIP Code area the insurer's determination that its network does or does not meet the network adequacy requirements of 28 Texas Administrative Code, Chapter 3, Subchapter X; and (iii) an Internet-based listing of the information specified for disclosure in §3.3705(b). Section 3.3705(b) addresses the insurer's required disclosure

of terms and conditions of the policy to current and prospective insureds and group contract holders on request to permit comparison and informed decision-making concerning the selection or retention of a health care plan. The additional inclusion of that information on the insurer's website, in conjunction with the other specified disclosures, will facilitate such comparison and informed decision-making. The Department proposes new §3.3705(f) to require insurers to include a notice concerning rights of insured participants in preferred provider benefit plans in all policies, certificates, and outlines of coverage. The content of the required notice is prescribed in Figure 28 TAC §3.3705(f) and addresses: (i) rights to an adequate network of preferred providers, consistent with the Insurance Code §1301.005(a); (ii) rights to file a complaint with the Department concerning an inadequate network, consistent with the Insurance Code §1301.161; (iii) rights to reimbursement of claims at preferred benefit levels if services were received from a nonpreferred provider due to a lack of reasonably available preferred providers, consistent with the Insurance Code §1301.005(b); (iv) rights to obtain a current listing of preferred providers and to obtain assistance in locating available preferred providers, consistent with the Insurance Code §1301.006 and §1301.159; (v) rights to reimbursement of claims at preferred benefit levels if the listing of preferred providers relied upon by the individual in seeking preferred providers is inaccurate, consistent with §3.3705(k); (vi) notice about the potential for balance billing by nonpreferred providers, as required by the Insurance Code §1456.003(b)(1); (vii) rights to advance estimates of bills from physicians and providers and of payment for services from insurers, consistent with the Health and

Safety Code §324.101(d), the Occupations Code §101.352(c), and the Insurance Code §1301.158(d) and §1456.007; and (viii) rights concerning mediation, consistent with the Insurance Code §1467.051(a) and §1467.053(d). Inclusion of the notice concerning these rights and facts is necessary to assist insureds and group contract holders to understand the several rights available to an insured both before and after the provision of services that affect, disclose, and potentially mitigate the scope of the insured's potential liability for balance bill amounts. Although not submitted by public counsel or specifically labeled as a "consumer bill of rights," this proposed notice of rights is similar to the bill of rights contemplated in the Insurance Code §501.156 for each personal line of insurance regulated by the Department. The Department proposes new §3.3705(h) - (j) to address in greater detail an insurer's obligations to provide information concerning preferred provider listings. Subsection (h) requires the insurer to notify all insureds at least annually of the manner in which the insured may access a current listing of all preferred providers on a cost-free basis. Minimum requirements for the notice include information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers. Insurers are required to maintain a toll-free telephone number to receive complaints and provide information as specified in the Insurance Code §521.102. Proposed new subsection (i) requires the insurer to ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months, consistent with the requirements in the Insurance Code §1301.159 and §1301.1591 concerning the annual provision of

current preferred provider listings and the quarterly updating of preferred provider listings on the insurer's Internet website, respectively. Proposed new subsection (j) requires that if no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer is required to distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if such alternative method is agreed to by the insured, group policyholder on behalf of the group, or the certificate holder. To clarify the Department's position that an insured should be able to rely upon information recently obtained from an insurer or the insurer's designee concerning the status of preferred providers in accessing covered services at the preferred level of benefit, the Department proposes new §3.3705(k). Subsection (k) requires insurers to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider of the services is a preferred provider within the insurer's network. This requirement is necessary to ensure the reasonable accessibility and availability of preferred provider services as specified in

the Insurance Code §1301.007. The Department has previously entered a consent order against one large insurer based on allegations that the insurer's listings of its contracted providers were not accurate. *See Commissioner's Order No. 08-0514*, June 13, 2008 at 3. It is the Department's position that if an insured reasonably relies an insurer's representation that a physician or provider is available to insureds as a preferred provider, but the physician or provider is, in fact, not contracted with the insurer, then the insurer has failed to make preferred provider benefits reasonably available to the insured. In such an instance, it is the Department's position that the insured is entitled to the protections of the Insurance Code §1301.005(b), which requires that the insurer reimburse a claim from a nonpreferred provider at the preferred benefit percentage level if services are not available through a preferred provider. Subsection (k) is also necessary to ensure that the underlying policy is not unjust in application, consistent with the requirements of the Insurance Code §1701.055(a)(2). The Department proposes additional listing-specific disclosure requirements at new §3.3705(l) for all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, as specified in paragraphs (1) – (11) of the subsection. Section 3.3705(l)(1) requires the insurer to include a method by which insureds may identify those hospitals that have contractually agreed with the insurer to: (i) exercise good faith efforts to accommodate requests from insureds to use preferred providers; and (ii) provide insureds with information sufficient to enable the insured to identify a facility-based physician or physician group that is assigned to provide services to the insured

with enough specificity that the insured may determine the status of the physician or physician group as preferred or nonpreferred. The latter disclosure requirement would only reflect contractual agreements that apply to instances in which the physician or physician group is assigned at least 48 hours prior to services being rendered and would require that the responsive information be furnished to the insured at least 24 hours prior to services being rendered. Section 3.3705(l)(2) requires the insurer to include in its listings a method by which the insured may identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer by or on behalf of facility-based physicians, other than neonatologists and pathologists, are filed by or on behalf of a physician that is not under a contract with the insurer. Section 3.3705(l)(3) provides specificity concerning the requirement at subsection (l)(2) by clarifying that in determining whether a hospital meets the specifications in that paragraph, the insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information is furnished to the insured. Section 3.3705(l)(4) requires the insurer to indicate in each listing whether each preferred provider is accepting new patients. Section 3.3705(l)(5) requires the insurer to designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program. Section 3.3705(l)(6) requires the insurer to provide a method by which insureds may notify the insurer of inaccurate information in the provider listing, with specific reference to information about the provider's contract status and whether the provider is accepting new patients. Section 3.3705(l)(7) requires insurers to provide a method by which

insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities. Section 3.3705(l)(8) requires the provider information to be furnished in fonts of not less than 10-point type. Section 3.3705(l)(9) requires the insurer to furnish provider information that specifically identifies those facilities at which the insurer has no contracts with a type of facility-based provider, specifying the applicable type of provider. Section 3.3705(l)(10) requires the insurer to specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type. The particular requirements in §3.3705(l)(9) and (10) address the requirement of the Insurance Code §1456.003(c) for clear identification of those network (preferred provider) facilities in which facility-based physicians do not participate in the health benefit plan's provider network by providing for clear delineation of those facilities at which there is a greater or, alternatively, no risk of unanticipated balance bills from facility-based physicians. Section 3.3705(l)(11) requires the insurer to specify the date on which the information was provided to the insured in each provider listing. Collectively, these listing-specific disclosure requirements will facilitate the insured's ability to proactively seek out preferred provider services in nonemergency situations and to assess for future purposes the risk that some services may not be accessible through the insurer's preferred provider network. Data collected by the Department has indicated that approximately 10 percent of facility-based provider claims are from nonpreferred providers. *See April 2009 Network Report* at 3. Because of the economic significance of the potential balance bills that an insured may receive for health care

services of this nature, the information required to be provided in subsection (l) is necessary for insureds to make appropriate decisions about their care. Proposed new §3.3705(m) requires an insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 to notify all policyholders of this fact at issuance and at least 30 days prior to renewal of a policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes illustrating the affected service area. This information is necessary to facilitate comparison and informed decision-making with respect to the purchase or renewal of a policy by current and prospective policyholders. Proposed new subsection (n) requires an insurer to provide notice on the insurer's website of a substantial decrease in the availability of preferred facility-based physicians at preferred provider facilities. As specified in §3.3705(n)(1), a decrease is substantial if: (i) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at that facility terminates; or (ii) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination. Notice of the substantial decrease is not required if alternative preferred providers of the same specialty as the physician group that terminates a contract are made available to insureds at the facility, provided the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease. The notice of the termination and substantial decrease in availability of providers must

be maintained on the insurer's website for six months from the initial posting or until adequate preferred providers of the same specialty become available to insureds at the facility. Further, an insurer is required to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after the effective date of a contract termination between the insurer and physician group or the date on which the insurer receives notice of a contract termination between a physician group and a preferred provider facility. The notice requirements in proposed §3.3705(n) are necessary to place current and prospective policyholders on notice of the increased potential that services received at the preferred provider facility in question may include services from nonpreferred facility-based physicians and therefore include a greater risk of unanticipated balance bills. Armed with this information, insureds will have increased options to elect to receive services in preferred provider facilities at which there is a reduced likelihood that facility-based provider services will be furnished by nonpreferred providers as feasible. Proposed §3.3705(o) requires insurers to make certain disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services. Insurers must disclose how reimbursement of nonpreferred providers will be determined. If reimbursement is based upon data concerning usual, customary, or reasonable provider charges, the insurer must disclose: (i) the source of the data; (ii) how the data is used to determine reimbursements; and (iii) the existence of any applicable reductions. If reimbursement is based upon any amount other than full billed charges, the insurer must: (i) disclose that the insurer's reimbursement may be less than the billed charge; (ii) disclose that

the insured may be liable to the nonpreferred provider for balance bill amounts; (iii) provide a description of the methodology used to determine the reimbursement amount; and (iv) provide a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service. In addition to educating insureds both generally and specifically concerning the potential for unanticipated balance bills, the Department anticipates that the provision of reimbursement methodology information may facilitate the insured's ability to mediate balance bill amounts owed to nonpreferred providers as contemplated in the Insurance Code §1467.054. Data collected by the Department indicates that insurers' allowable payment rates for nonpreferred providers varies significantly among insurers and by type of provider. *See Report of the Health Network Adequacy Advisory Committee, January 2009* at 19, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc. Additionally, the Department has entered a disciplinary order against one large preferred provider benefit plan insurer based on allegations that: (i) the insurer's policy documents did not adequately define how it would determine out of network (nonpreferred provider) facility reimbursements; and (ii) those reimbursements were unreasonably low in context with representations made in advertising and policy documents. *See Commissioner's Order No. 08-0514*, June 13, 2008, at 2. Based upon such information, the Department's position is that disclosure of the information required by proposed §3.3705(o) is important to insureds' understanding of their coverage. Proposed new §3.3705(p) authorizes insurers to designate preferred provider benefit plans using a network that

complies with the network adequacy requirements for hospitals under §3.3704 without reliance upon an access plan as having an “Approved Hospital Care Network” (AHCN). A plan using a service delivery network that does not meet the requirements for hospitals under §3.3704 is required to disclose that the plan has a “Limited Hospital Care Network.” The disclosure is required: (i) on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network; and (ii) on the cover page of any nonelectronic provider directory describing the network. Further, proposed new §3.3705(q) requires that a preferred provider benefit plan that is designated as an AHCN but loses its compliance status with the network adequacy requirements for hospitals notify the Department of such change if the noncompliant status is not corrected within 30 days of the insurer becoming noncompliant. Such insurer is additionally required to cease marketing the plan as an AHCN and to inform all insureds of such change of status at the time of renewal. The designation, notice, and marketing requirements in proposed new §3.3705(p) and (q) will assist current and prospective policyholders to assess the risk that a plan will not have available and accessible facility-based physicians at preferred provider hospitals as the insured compares plans in determining whether to select or renew a policy. The requirements will additionally assist the Department to monitor network adequacy status and help to prevent inappropriate, misleading, or deceptive marketing. Proposed §3.3707(f) specifies that an insurer’s receipt of a waiver for a plan under the section requires the insurer to designate such plan as having a “Limited Hospital Care Network.” This requirement is necessary to ensure that prospective and current insureds understand

the limitations of the plan's ability to ensure the availability and accessibility of preferred benefit services when considering the purchase or renewal of coverage that relies upon the network.

Proposed §3.3708(e) imposes a disclosure requirement on insurers that applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as identified in proposed §3.3708(a). In such case, the insurer is required to disclose with each explanation of benefits that the insured has the right to request three categories of reimbursement data in relation to the claim for comparison purposes: (i) the median per-service amount that the insurer has negotiated with preferred providers for the services furnished, or notification that the claim was paid at this amount; (ii) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers, or notification that the claim was paid at this amount; and (iii) the amount that would be paid under Medicare for the service. The disclosure amounts are calculated exclusive of cost sharing responsibilities of the insured. Section 3.3708(e) is proposed to apply effective January 1, 2012, and the Department proposes to provide for a six-month waiver process with respect to the disclosure in §3.3708(f). The disclosure is necessary to provide to insureds faced with the financial consequences of unanticipated balance bills that arise due to the need for emergency care or due to the failure of the insurer to provide an adequate network with information on request to evaluate the reimbursement made by the insurer and to determine whether to request mediation as permitted under the Insurance Code

§1467.054 for eligible claims. Even if mediation is not available, the information provided by the insurer could greatly assist an insured who wishes to contest an alleged unreasonable balance bill by a nonpreferred provider by allowing the insured to compare the physician or provider's charge to the average rate other providers have agreed to with the insurer. The six-month waiver process is necessary to provide flexibility to insurers for which circumstances justify an extended period of time in which to comply with the new disclosure requirement.

The Department proposes a final disclosure requirement concerning the effects of uncompensated care upon health care costs in proposed §3.3713. Proposed §3.3713(a) is not effective until the expiration of seven years from the effective date of the section. At that time, insurers are required to initiate an annual reporting requirement that provides to the Department the following information: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. Effective at the expiration of eight years from the effective date of §3.3713, proposed §3.3713 requires insurers to make the information concerning the effects of uncompensated care as reported to the Department publicly available and to provide notice of the availability of such information in each policy, certificate, and outline of coverage. Proposed §3.3713(d) further requires that an insurer's contract with a facility contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required under §3.3713. Proposed §3.3713(a) – (d) is necessary to

provide information to both the Department and the interested public concerning the relationship of uncompensated care to health care costs incurred by insurers and insureds. Information concerning the impact of uncompensated care upon health care fees and insurance premium rates will help insureds to educate themselves concerning possible barriers to improved networks of preferred providers and factors influencing health insurance premium rates. Proposed §3.3713(e) – (g) establish a six-month waiver process for the requirements of §3.3713 to provide flexibility to insurer's whose particular circumstances justify such delay.

Network adequacy: contracting requirements. The Department has addressed contracting requirements that will support increased availability and accessibility of preferred benefit services. The Department proposes to amend §3.3703(a)(4). Existing §3.3703(a)(4) provides that a contract between an insurer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. The Department proposes to limit this prohibition such that it applies more narrowly by phasing out the prohibition with respect to certain groups of physicians or practitioners over a five-year period. The proposed prohibition will not apply to physicians or practitioners that are members of a practice group that includes 15 or more physicians or practitioners after June 1, 2014. The prohibition will not apply to physicians or practitioners that are members of a practice group that includes at least seven and not more than 14 physicians and practitioners after June 1, 2016. However, the contracting prohibitions will remain effective with respect to practice groups of physicians or practitioners that have not

previously held staff membership or privileges with a hospital or institutional provider and acquire such membership or privileges for the first three years of such membership or privileges. This latter limitation is intended to prevent the requirement from deterring the extension of new staff memberships and privileges. The Department's position is that the proposed amendment to §3.3703(a)(4) removes the contracting prohibition with respect to larger practice groups that are better positioned to bargain with insurers in connection with preferred provider contracts while retaining the prohibition with respect to those physicians and practitioners not as well-positioned to so bargain. In this way, those insurers not otherwise precluded from making use of such a contract provision will now be permitted to voluntarily seek through market negotiations to increase the number of contracted physicians and practitioners at the preferred provider hospitals and institutional providers that participate in the insurer's plan. Such a change will provide a basis from which insurers may improve accessibility and availability of preferred provider services to insureds under the plan while still affording a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners, institutional providers, and practitioners as required under the Insurance Code §1301.051(a). The Department proposes new §3.3703(a)(23) to specify that a contract between an insurer and a preferred provider may contain a provision requiring a referring physician or provider, or a designee, to disclose specified information to the insured concerning the referral as applicable. Under proposed §3.3703(a)(23)(A), the referring physician or provider must disclose that the physician, provider, or facility to whom the insured is being referred is not a

preferred provider. Under proposed §3.3703(a)(23)(B), the referring physician or provider must disclose that the referring physician or provider has an ownership interest in the facility to which the insured is being referred. Proposed §3.3703(a)(23) is permissive in nature and does not apply to contracts between insurers and institutional providers. The provision clarifies the Department's position that such contract provisions are permitted and benefits insureds by increasing the information furnished by referring physicians or providers. This additional information will afford the insured an opportunity to consider whether to seek referral to a preferred provider and thereby reduce the potential for unanticipated balance bills from nonpreferred providers. Proposed §3.3703(a)(24) further clarifies that, if used, a contract provision requiring disclosure of the nonpreferred status of the physician, provider, or facility to whom an insured is being referred is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care. The contract requirement also may not limit access to nonpreferred providers. Proposed §3.3703(a)(24) is necessary to ensure that the benefits of the disclosures made pursuant to such a contractual provision do not result in delay of medically necessary care or interfere with the insured's freedom to elect to receive basic benefit care from nonpreferred providers should the insured desire to do so. Proposed §3.3703(a)(25) requires that contracts between insurers and preferred providers include a requirement that the preferred provider comply with all applicable requirements of the Insurance Code §1661.005. Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the

overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. Proposed §3.3703(a)(25) will reinforce this statutory requirement and help to ensure that overpayments are promptly refunded to insureds, reducing unnecessary negative financial consequences associated from receipt of care from within the insurer's network of preferred providers, and providing an effective remedy for insureds alleging violations of §1661.005. Finally, the Department proposes new §3.3703(a)(26) to impose new requirements for contracts between insurers and facilities. Under proposed §3.3703(a)(26)(A), such contracts must require the facility to give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer. This requirement is necessary to facilitate the insurer's ongoing responsibility to monitor the network(s) that support the insurer's preferred provider benefit plans for compliance with network adequacy requirements and take corrective action as needed. Under proposed §3.3703(a)(26)(B), contracts between insurers and facilities must require facilities to impose requirements upon facility-based physicians providing services at the facility. Specifically, such facility-based physicians must be required to: (i) make disclosure to the general public of the typical range of the physician's billed charges for professional services as specified in proposed §3.3712; and (ii) provide responsive information no more than annually to surveys of physician fees conducted by the Department or by an academic institution conducting the survey on behalf of the Department. This requirement will increase the

information available to insureds to facilitate informed decision-making in the selection of facilities and facility-based physicians to the extent that such selection is possible. The Department anticipates that such informed decision-making will help to reduce the potential for unexpected balance bill amounts incurred by insureds who receive care at preferred provider facilities from physicians that are not preferred providers. Additionally, such information will permit insureds to more accurately assess potential personal liability for balance bill amounts in some instances if compared to an estimate of payments that will be made for a health care service or supply. An insurer is required to provide such an estimate on request pursuant to the Insurance Code §1456.007.

Network adequacy: payment of certain basic benefit claims. The Department proposes new §3.3708 to establish minimum standards for certain basic benefit claims. Proposed §3.3708 applies to services provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured, including circumstances: (i) requiring emergency care; (ii) when no preferred provider is reasonably available within the designated service area for which the policy is issued; and (iii) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider. In each of these circumstances, the insurer is required to pay the claim at the preferred benefit coinsurance level as required pursuant to the Insurance Code §1301.005(b) and §1301.155(b). Proposed new §3.3708(b)(2) also requires the insurer to credit out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. This requirement is intended to protect insureds who

do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive such credit if they had received services from a contracted preferred provider. This is consistent with the intent of the Insurance Code §1301.005 and §1301.069, which provide that, if an insured obtains out of network services from a nonpreferred provider due to an inadequate network or an emergency, the insured is entitled to the preferred level of benefits. Proposed new §3.3708(c) requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria. The methodology is required to: (i) be based on generally accepted industry standards and practices for determining customary billed charges for a service and to fairly and accurately reflect market rates, including geographic differences in costs, for those methods based upon usual, reasonable, or customary charges; (ii) be based on sufficient data to constitute a representative and statistically valid sample, if based on claims data; (iii) be updated at least annually; (iv) not to use data that is more than three years old; and (v) be consistent with nationally recognized and generally accepted bundling edits and logic. The reimbursement standards in proposed §3.3708 are necessary to ensure that preferred provider benefit plan policies are offering meaningful reasonable availability of basic benefits covered under the benefit package as specified in the Insurance Code §1301.005(a). It is the Department's position that establishment of unreasonably low reimbursement rates for basic services creates a barrier to the reasonable availability of basic services in a manner that is inconsistent with §1301.005(a) and that renders the underlying policy

unjust under the Insurance Code §1701.055(a). The standards established in proposed §3.3708(c) will help to ensure that reimbursement rates are based upon relevant, current, and statistically valid data in order to mitigate the potential unexpected balance billing to which insureds are subjected as a result of health care emergencies and inadequate networks. The standards will give physicians, providers, and insureds greater confidence that the methodologies underlying reimbursement determinations are appropriate, and that terms used in preferred provider benefit plan documents will have consistent meanings as applied by different insurers, as well as provide the Department clear standards to apply when reviewing the appropriateness of reimbursement methodologies used for nonpreferred providers. Proposed new §3.3708(d) requires insurers to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan. This provision is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005 by limiting coverage to those services provided within the designated service area. It is the Department's position that imposition of such a restriction by an insurer would reduce the insured's access to basic level services in a manner that would render the policy unjust as contemplated in the Insurance Code §1701.055(a)(2).

Implementation related to HB 1030. In connection with HB 1030, the Department proposes an amendment to §3.3704(a)(6). Existing §3.3704(a)(6) specifies

that: (i) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30 percent less than the higher level of coverage; and (ii) a reasonable difference in deductibles is determined considering the benefits of each individual policy. HB 1030 amends the Insurance Code by adding §1301.0046 to mandate that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Proposed §3.3704(a)(6) updates the specifications of the paragraph for greater consistency with this statutory requirement.

Changes to update and clarify. The Department proposes additional amendments to reflect and clarify the reorganized and updated content of the subchapter, including applicability. Existing §3.3701(a) is subdivided into two subsections to address the prospective application of the proposed subchapter to policies delivered, issued for delivery, or renewed on or after June 1, 2011, and the remaining subsections are redesignated accordingly. The proposed amendment to §3.3701(d), redesignated as §3.3701(e), updates the language concerning the severability of the subchapter's provisions and applications to clarify the scope of such severability. The Department proposes amendments to §3.3702 to add definitions for words and terms used in proposed amendments to the subchapter to clarify the scope of such usage. These proposed words and terms include: (i) *billed charges* at paragraph (1); (ii) *facility* at paragraph (4); (iii) *facility-based physician* at paragraph (5); (iv) *general practitioner* at paragraph (6); (v) *NCQA* at paragraph (13); (vi) *nonpreferred provider* at paragraph (14); (vii) *pediatric practitioner* at paragraph (15);

(viii) *rural area* at paragraph (22); (ix) *specialist* at paragraph (24); and (x) *urgent care* at paragraph (25). Existing paragraphs of §3.3702 are proposed to be redesignated accordingly. The proposal includes new catchlines in each subsection of §3.3704 to better reflect the organization and content of the section with respect to fairness requirements, payment of nonpreferred providers, prohibited retaliatory action, access to certain institutional providers, network requirements, network monitoring and corrective action, and service areas. The Department proposes to delete existing §3.3704(a)(10), which provides that if covered services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. The existing paragraph also specifies that the section does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience. Because the paragraph is largely duplicative of statutory language in the Insurance Code §1301.005(b) and (c), the Department has determined that retention of the paragraph in this subsection is unnecessary. The remaining paragraphs in §3.3704(a) are redesignated accordingly. The Department proposes to amend the title of §3.3705 to better reflect the content of the section. The proposed amendment revises the title to "Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations." Further, the Department proposes to add catchlines to existing subsections (a) – (d) of §3.3705 to better reflect the content of those subsections concerning readability, disclosure of terms and

conditions of the policy, filing requirements, and promotional disclosure requirements. The Department proposes to amend §3.3705(b)(12) by deleting the term “and” at the end of paragraph due to the proposed addition of a paragraph to the subsection. A proposed amendment to §3.3705(b)(13) recognizes that an insurer may have more than one service area and accommodates an additional paragraph proposed in the subsection by substituting a semi-colon and the word “and” for the period at the end of the paragraph. As part of the reorganization of the content of §3.3705, existing subsection (e) is redesignated as subsection (g), and a catchline is added to the subsection to reflect that the subsection addresses the prohibition on the distribution of untrue or misleading information. The Department proposes to delete existing §3.3705(f), concerning the distribution and filing of current lists of preferred providers. The distribution of such lists is addressed in proposed new §3.3705(h) - (j). Filing requirements concerning preferred provider listings are addressed and updated in the proposed amendment to §3.3705(c). This proposed amendment permits the filing of such provider listings to be made electronically at a specified email address in a format acceptable to the Department or by submission of an Internet website address at which the Department may view the listing. For carriers choosing to file the listings nonelectronically, the proposed amendment additionally specifies the address to which nonelectronic filings are required to be submitted. The Department also proposes to delete existing §3.3705(g), which specifies that insurers must provide to each insured a toll-free number to be maintained 50 hours per week during business hours that the insured may call to obtain current listings of preferred providers, unless exempted by

statute or rule. The provision of this information is addressed in proposed new §3.3705(h). To better reflect the organization and content of §3.3706, the Department proposes to amend existing subsections (a) and (b) to add catchlines to emphasize that the subsections address access to designation as a preferred provider and withholding preferred provider designation, respectively. The Department proposes to redesignate existing subsections (c) and (d) as subsections (d) and (e), respectively, to accommodate the addition of new proposed subsection (c). The Department further proposed to add catchlines to the subsections to emphasize that the subsections address notice of termination of a preferred provider contract and review of a decision to terminate. The Department proposes to redesignate existing §3.3705(d)(3) as subsection (f) and to add a catchline to the subsection to emphasize that the subsection addresses completion of the review process. The Department proposes to redesignate existing subsection (e) as subsection (g), accordingly, and to add a catchline to the subsection to emphasize that the subsection addresses the expedited review process. The Department proposes to redesignate existing subsection (e)(3) as subsection (h) and to add a catchline to the subsection to emphasize that the subsection addresses completion of the expedited review process. The Department further proposes to redesignate existing subsections (f) and (g) as subsections (i) and (j), respectively, to accommodate the addition of subsections to the section. The Department also proposes to amend §3.3706(a) by adding the phrase “subject to subsection (b) of this section” to clarify the manner in which the two subsections are intended to work together. Proposed amendments throughout the rule update statutory references that

have changed as a result of the legislature's nonsubstantive reorganization of the Insurance Code and Occupations Code. These updates are made in proposed §§3.3701(c); 3.3702(3), (7) – (12), (16) – (21), (23) and (26); 3.3703(a)(11) - (15), (17), and (18), (b), and (c)(1) and (2); and 3.3704(a), (a)(1), (4), (5), and (9), and (d). Amendments to update or provide greater specificity concerning internal references in the subchapter are proposed at §§3.3703(a)(8) and (19); 3.3704(a)(10); 3.3705(a); 3.3706(d)(2); and 3.3706(j)(2). Additional amendments for clarity**,** ease of reading, and correction of punctuation, capitalization, and grammar are proposed throughout the rule, as well. These proposed amendments appear in §§3.3701(c) and (d); 3.3702(3), (7) – (12), (16 – 21), (23), and (26); 3.3703(a), (a)(1) - (3), (5) – (20), (20)(A), (20)(A)(i) and (iii), (20)(B) - (D), (F), (G)(i)(I) – (IV), and (H), and (22), (b), and (c)(1) and (2); 3.3704(a), (a)(1) – (6), (8) and (9), (b) - (d); 3.3705(a), (b), (b)(9), (c) and (d); and 3.3706(a), (a)(1) – (4), (b), (b)(1) and (2), (2)(A) – (E), (d), (d)(2), (e), (e)(1), (f), (g), (i), (i)(1) and (2), (j), and (j)(1) – (3).

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

3. PUBLIC BENEFIT/COST NOTE. Mr. Danzeiser also has determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the enforcement and administration of this proposal, as well as potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits consistent with the authorizing statutes while mitigating costs.

ANTICIPATED PUBLIC BENEFITS.

The public benefits anticipated as a result of the proposal relate primarily to network adequacy and improvements in information available to consumers. With respect to network adequacy, the following public benefits are anticipated: (i) the establishment of standards for the Department's evaluation of the preferred provider networks supporting preferred provider benefit plans; (ii) improved access to and availability of preferred providers for insureds; (iii) the establishment of a standardized reporting process for insurers concerning the network adequacy of preferred provider benefit plans in Texas; (iv) the establishment of a waiver process for network adequacy requirements in accordance with the requirements of the Insurance Code §1301.0055(3); and (v) standards for the payment of out of network (basic benefit) claims. With respect to improved transparency of information available to consumers, the following public benefits are anticipated: (i) greater availability of more standardized network demographic information and other health plan information to permit prospective and current insureds to be able to better compare plans in determining whether to select or retain coverage using a particular network; (ii) greater availability of

consumer information for assessing the risk of receiving services from nonpreferred providers at preferred provider facilities, and therefore the risk of experiencing unanticipated balance bills; (iii) greater availability of information concerning typical billed charges for possible use in the selection of physicians and facilities or in contesting billed charges from nonpreferred providers; (iv) greater transparency concerning the rights of an insured before and after the provision of services that may affect, disclose, and potentially mitigate the scope of the insured's potential liability for balance bill amounts; and (v) improved information for consumers to use in the selection of preferred providers. Additional benefits of the proposal include clarification of the Department's position on the permitted inclusion of certain contractual provisions in preferred provider contracts and increased consistency with the requirements of HB 1030, enacted by the 79th Legislature, Regular Session, effective September 1, 2005.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL.

On September 13, 2010, the Department posted a second informal draft of proposed network adequacy rules and an estimate of anticipated costs to comply with §§ 3.3703 - 3.3710. The Department sought comments on the substance of the draft rules, on the accuracy of the Department's estimates of costs of compliance, and input on what costs certain provisions would entail. A second informal stakeholder meeting was held to discuss the draft rule and potential costs on September 21, 2010. Except as otherwise noted in this cost analysis, the Department did not receive information from any stakeholders concerning the cost information included in the Department's

informal posting. The Department did receive general input that the cost of compliance would be significant.

Mr. Danzeiser estimates that there could be potential costs to insurers required to comply with several of the proposed amendments and new sections during each year of the first five years that the rules will be in effect. The Department has identified eight sections of the proposal that may result in compliance costs only for insurers that offer preferred provider benefit plans. These sections are: (i) proposed §3.3703 concerning contract requirements; (ii) proposed §3.3704 concerning network adequacy requirements; (iii) proposed §3.3705 concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations; (iv) proposed §3.3706 concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process; (v) proposed §3.3707 concerning waiver requirements due to failure to contract in local markets; (vi) proposed §3.3708 concerning payment of certain basic benefit claims and related disclosures and waivers; (vii) proposed §3.3709 concerning the annual network adequacy and access plan reports; and (viii) submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements. This cost note analysis addresses the cost of compliance with these eight sections for an insurer that undertakes steps necessary for compliance on its own behalf.

Use of a PPO network to achieve compliance. The Department anticipates that insurers could alternatively contract with one or more independent preferred provider organization networks (PPO networks) such that the PPO network(s) assume primary

responsibility for undertaking one or more of the steps necessary to comply with this proposal. Under this alternative, while it remains the responsibility of the insurer to either meet the requirements or ensure that the requirements are met in accordance with §3.3703(c), the factors and components affecting the cost of compliance with the requirements would necessarily vary for each requirement. The Department estimates that this variation will be based upon the size of the network(s) used by each insurer, the scope of the underlying contract between the insurer and the PPO network, and the fees charged by the PPO network for performance of the contract. Each individual insurer that uses or considers the use of this method of achieving compliance with some or all of the provisions of this proposal has or may obtain the information necessary to assess these factors and to determine its resulting anticipated costs of compliance.

Pass-through costs from physicians and providers. The Department further anticipates that the contracting process used by insurers with some physicians and providers could reflect increased preferred provider fees based upon the increased requirements of the underlying preferred provider contract. It is not possible for the Department to estimate the amount of such pass-through costs because there are numerous factors involved in setting contract reimbursement rates that are not suitable to reliable quantification.

I. Costs concerning contract requirements.

Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred providers and of ownership interests in

facilities to which the insured is being referred. Proposed new §3.3703(a)(23)(A) and §3.3703(a)(23)(B) specify that a contract between an insurer and a non-institutional preferred provider may contain provisions at the insurer's option requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or provider has an ownership interest in the facility to which the insured is being referred. If insurers elect to include the contract provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) in contracts with non-institutional providers, the Department anticipates that insurers may incur costs associated with drafting new contracts or amendments to existing contracts. The Department estimates that the total cost for an insurer that opts to include the contract provisions may involve cost components including the following: (i) cost of administrative staff wages necessary for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments.

(i) Cost of administrative staff wages for drafting and basic review. The Department anticipates that, because the proposed required provisions will likely require little or no modification from the proposed rule text, an insurer's administrative staff will do most if not all of the drafting and basic review of new contracts or amendments to existing contracts. The Department anticipates that this drafting will likely require on average less than one hour administrative staff time per contract modified. The cost to an insurer may vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, review the new or

amended contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission, Labor Market and Career Information Department, Occupation & Employment Statistics Estimate Delivery System (hereafter referred to as the Texas Workforce Commission *OES Report*), available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=11-1021&compare=2. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=43-6011&compare=2. The Department therefore estimates that an insurer could incur an average annual cost of staff wages for drafting and basic review of contracts of less than $57.96 per contract, with anticipated variation depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, draft and review the new or amended contract language templates. The cost could also vary depending upon whether the contracting practices of an insurer require review of multiple or single contract templates, the extent to which contracts vary, and, if multiple contract templates or unique contracts are used, the number of such templates or unique contracts.

(ii) Cost of legal staff. The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding,

each new contract or amendment of existing contracts that includes the provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). The Department anticipates that, because the proposed required provisions will likely require little or no modification from the proposed rule text, the legal review service from a lawyer will consist mainly of reviewing new or amended contracts drafted by the insurer's administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce Commission *OES Report* available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=23-1011&compare=2. Therefore, the Department estimates that an insurer could incur an average annual cost of less than $51.11 in legal fees on average for each new or amended contract reviewed. The cost, however, for a particular insurer could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, and the number of such templates or unique contracts. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost for contracting with an attorney in private practice for the legal review will likely vary from and could exceed the stated salaried hourly wage.

(iii) Cost to print new contracts or amendments. The Department anticipates that an insurer could incur a cost for printing new contracts or amendments to existing contracts in order to include contract requirements as specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). The Department estimates that this cost could range from approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that an insurer will need approximately one page per contract. The number of total pages will depend on the number of contracts the insurer chooses to amend. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(iv) Cost to transmit new contracts or amendments. The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail to include the contract provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each contract or amendment of existing

contracts that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract or per set of amendments of existing contracts. However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts or amendments, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or amendments to existing contracts would be incurred by an insurer that opts to transmit new contracts or amendments electronically. These costs would be part of the ongoing information technology equipment and service costs of the insurer.

Though the Department has identified factors attributable to the cost of compliance with proposed new §3.3703(a)(23)(A) and §3.3703(a)(23)(B), it is not possible for the Department to estimate the absolute total amount of compliance costs that an insurer could incur because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts.

Proposed §3.3703(a)(25): Contract provision between an insurer and a preferred provider that mandates that a preferred provider comply with all applicable requirements of the Insurance Code §1661.005. Proposed §3.3703(a)(25) specifies that a contract between an insurer and preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005, relating to refunds of overpayments from enrollees. (Note:

Some statutory provisions referenced in this proposal use the term “enrollees” and some use the term “insureds”; but the Department interprets these two terms to have the same meaning for purposes of this proposal.) The Insurance Code §1661.005, effective May 30, 2009, mandates that a physician, hospital, or other health care provider that receives an overpayment from an enrollee refund such overpayment within 30 days of the date the determination an overpayment was made. Proposed new §3.3703(a)(25) mandates that this statutory requirement be included in any contract between an insurer and a preferred provider. The Department anticipates that proposed §3.3703(a)(25) could result in compliance costs for insurers. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) are applicable to estimating the cost for compliance with proposed §3.3703(a)(25). Because the cost is based on the same methodology and cost components as those determined for compliance with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B), the following is a summary of the Department’s analysis (which is detailed in this Cost Note under the subheading for “*Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)”)*: (i) cost of administrative staff wages for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments. Because this is a required contract provision, these costs will be incurred by those insurers required to comply with these rules that do not currently have such a provision

in their contracts with preferred providers. However, the total cost for each insurer will depend largely on the size of an insurer's network(s) and its internal business practices, such as the extent to which an insurer negotiates individual contract terms on a case by case basis.

Though the Department has identified factors attributable to the cost of implementing §3.3703(a)(25), it is not possible for the Department to estimate the absolute total amount of compliance costs that an insurer could incur because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts.

Proposed §§3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii): Requirement that insurer include contract requirement that facilities give notice of termination of contracts with facility-based physician groups, require facility-based physicians to publicly disclose physician fees, and require facilities to respond to annual surveys of physician fees. Proposed new §3.3703(a)(26)(A) specifies that a contract between an insurer and a facility must require the facility to give notice to the insurer as soon as reasonably practicable, but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer. Proposed new §3.3703(a)(26)(B)(i) specifies that a contract between an insurer and a facility must require the facility to mandate its facility-based physicians providing services at the facility to make disclosure to the general public of the typical range of the physician's

billed charges for certain specified professional services. Proposed new §3.3703(a)(26)(B)(ii) specifies that a contract between an insurer and a facility must require the facility to mandate facility-based physicians providing services at the facility to provide responsive information no more than annually to surveys of physician fees conducted by the Department or by an academic institution conducting the survey on the Department's behalf. The Department anticipates that proposed §§3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii) could result in costs to comply for insurers. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) are applicable to estimating the cost for compliance with proposed §3.3703(a)(25). Because the cost is based on the same methodology and cost components as those determined for compliance with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B), the following is a summary of the Department's analysis (which is detailed in this Cost Note under the subheading for "*Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)"*: (i) cost of administrative staff wages for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments. These costs may additionally vary as explained in the introduction to this cost analysis based upon the use of PPO networks to achieve compliance with proposed §3.3703(a)(25) or as a result of pass-through costs from physicians and/or providers. The Department notes that proposed §§3.3703(a)(26)(A),

3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii) specify required contract provisions, and thus these costs will be incurred by most insurers; however, the total cost for each insurer will depend largely on the size of the network(s) used by an insurer and its internal business practices, such as the extent that an insurer negotiates individual contract terms on a case by case basis.

Though the Department has identified factors attributable to the cost of implementing §§3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii), it is not possible for the Department to estimate the total amount of cost attributable to the paragraph because there are numerous factors involved that are not suitable to reliable quantification by the Department, including issues such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts. The Department also notes that in addition to the Department's determination of cost estimates for legal services necessary to administer and comply with proposed §§3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii), the Department received a cost estimate from one insurer of $800, or 40 hours at $20 per hour, for these legal services The Department anticipates that this cost will vary for each insurer. Each insurer, however, has the information necessary to estimate the insurer's cost for such legal services.

II. Cost to insurers concerning network adequacy requirements.

Proposed §3.3704(e) and §3.3704(f): Network adequacy requirements, monitoring, and corrective actions. Proposed new §3.3704(e) requires that each preferred provider benefit plan include a health care delivery network that complies with

the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements mandated in proposed §3.3704. Proposed new §3.3704(f) requires that each insurer monitor compliance with the network adequacy requirements of proposed §3.3703(e) on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. The Department anticipates that proposed §3.3704(e) and §3.3704(f) could result in costs to comply for insurers. The proposed §3.3704(e) network adequacy requirements include: (i) providing a network sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the current utilization of covered health care services within the specified prescribed geographic and projected utilization of covered health care services; (ii) providing an adequate number of preferred providers available and accessible to insureds 24 hours per day and 7 days per week within the insurer's designated service area; (iii) providing sufficient numbers and types of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area; (iv) providing an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area; (v) providing for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable; (vi) providing, if covered, for physical and occupational therapy services and

chiropractic services by preferred providers that are available and accessible within the insurer's designated service area; (vii) providing for emergency care by preferred providers that is available and accessible 24/7; (viii) providing for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than 30 miles in non-rural areas and 60 miles in rural areas for primary care and general hospital care and 75 miles for specialty care and specialty hospitals; (ix) ensuring that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions; (x) ensuring that routine care is available and accessible from preferred providers within three weeks for medical conditions or within two weeks for behavioral health conditions; and (xi) ensuring that preventive health services are available and accessible from preferred providers within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services and within three months for an adult.

The Department has determined that the total estimated cost for an insurer to comply with both proposed §3.3704(e) and §3.3704(f) could vary based upon the following components: (i) cost of geographic analysis software; (ii) cost of administrative staff to use the software; (iii) cost of staff to conduct the network monitoring and take corrective action; (iv) cost of legal review of new contracts or renewals of existing contracts as needed to comply with proposed §3.3704(e) and §3.3704(f); (v) cost of additional administrative staff; (vi) cost to print new contracts or

renewals of existing contracts; and (vii) cost to transmit new contracts or renewals of existing contracts to physicians and providers. The extent to which an insurer will incur such costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and (f) will require additional monitoring and corrective action in excess of the insurer's current practices. The Department anticipates that some insurers' costs will be minimal because compliance with the Insurance Code §1301.005 and §1301.006 already mandates availability of preferred providers and accessibility to health care services. Though the Department has identified factors attributable to the costs of compliance with proposed §3.3704(e) and (f), it is not possible for the Department to estimate the total amount of cost attributable to compliance with proposed §3.3704(e) and (f) because there are numerous factors affecting such total that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's current service area and the scope of physicians, providers, and health care services available in the network currently used by the insurer.

(i) Cost of geographic analysis software. The Department estimates that the cost of geographic analysis software such as GeoAccess or ArcMap for gap analysis of current networks, if necessary for compliance with proposed §3.3704(e) and §3.3704(f) could be mitigated for those insurers who already have an HMO license or a workers' compensation network certification because the requirements are very similar. It is also possible that an insurer already uses such software in evaluating its network and will not incur a cost for a new purchase of the software. According to one insurer that provided

information to the Department, the estimated initial cost of procuring GeoAccess software is $15,000 per user, followed by annual fees of $7,000 per user. Therefore, based on the assumption that each insurer will require two GeoAccess software programs to comply with proposed §3.3704(e) and §3.3704(f), the Department estimates a total initial fee could be $30,000, with annual fees of $14,000 thereafter.

(ii) Cost of administrative staff to use the software. In addition to the cost for software to perform gap analysis of an insurer's network, the Department estimates that insurers could incur labor costs for administrative staff to use the geographical analysis software and manage the data and reporting functions of the software to comply with proposed §3.3704(e) and §3.3704(f). The Department anticipates that the amount of administrative staff time will range between 10 to 100 hours per month on an ongoing basis. The Department anticipates that approximately 10 to 40 hours will be needed for a small service area, and 40 to 100 hours will be needed for a large service area. The Department received input from one insurer that the hourly wage for software-trained staff is $18.00 to $35.00 per hour. Therefore, an insurer with a small service area could incur costs of $180.00 to $1400, and an insurer with a large service area could incur costs ranging from $720 to $3500 per month on an ongoing basis. The extent to which an insurer will incur such monthly costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and §3.3704(f) will require additional staff work in excess of the insurer's current practices.

(iii) Cost of staff to conduct the network monitoring and take corrective action. The Department estimates that insurers could incur costs for monitoring the network adequacy and taking corrective action if needed to comply with proposed §3.3704(e) and §3.3704(f). This cost component identifies the cost of monitoring in addition to that undertaken as part of network gap analysis as identified previously with respect to the cost of compliance with proposed §3.3704(e) and §3.3704(f). For example, this component would include analysis of complaints related to unanticipated balance billing events associated with the reimbursement of health care services furnished at a preferred provider facility by nonpreferred providers. It is anticipated that the monitoring could be conducted by a general operations manager at an estimated salary cost of $1,159.20 to $9,273.60 per month. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* The number of hours spent monitoring the network adequacy will depend on the size and quality of the insurer's current network. It is estimated that monitoring a small service area could require an estimated 20 to 160 hours per month of by a general operations manager. The extent to which an insurer will incur such costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and §3.3704(f) will require additional monitoring and corrective action in excess of the insurer's current practices. The Department further anticipates that individual insurers could need to employ a range of 0.5 to 1 additional administrative staffer position if necessary to bring the insurer's current network into

compliance with the more specific requirements of proposed §3.3704(e) and (f) by assisting to expand the insurer's network of contracted physicians and providers. The costs to the insurer will vary depending on whether the insurer uses an administrative assistant or a general operations manager, or a combination of both, to assist in contracting with network providers. A general operations manager working for an insurer in Texas earns a median salary of $120,556 per year, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median salary of $43,397 per year, according to the same report. The Department therefore estimates that an insurer could incur the cost of additional administrative staff positions ranging from $21,698.50 to $120,556 per year, depending on the salary level of the staffer and whether the insurer needs the staffer part-time or full-time in order to comply with proposed §3.3704(e) and §3.3704(f). Each insurer, however, has the information necessary to determine its network contracting staff needs to comply with proposed §3.3704(e) and §3.3704(f).

(iv) Cost of legal staff. The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding, each new contract or renewal of existing contracts necessary to comply with the network adequacy requirements specified in proposed §3.3704(e). The Department anticipates that most such contracts will likely require little or no modification from the insurer's existing contract templates. Therefore, the legal review service from a lawyer will consist mainly of reviewing new or renewal contracts drafted by the insurer's

administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce Commission *OES Report.* Therefore, the Department estimates that an insurer could incur an average annual cost of less than $51.11 in legal fees on average for each new or renewing contract that requires legal assistance. The cost, however, for a particular insurer could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, and the number of such templates or unique contracts. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost for contracting with an attorney in private practice for the legal review will likely vary from and could exceed the stated salaried hourly wage. Some insurers may require additional direct legal involvement to obtain new contracts or renew existing contracts, including: (i) the negotiation of contract options; and (ii) the provision of legal advice on the merits and consequences of the addition of contract requirements.

(v) Cost of additional administrative staff. The Department anticipates that an insurer will likely require minimal administrative staff time to draft new contracts or amend existing contracts as necessary to ensure compliance with network adequacy requirements as specified in proposed §3.3704(e) and §3.3704(f). This is because the

Insurance Code §1301.005 and §1301.006 already respectively require insurers to: (i) ensure that preferred provider benefits are reasonably available to all insureds within a designated service area; and (ii) contract with physicians and providers to ensure that all medical and health care services and items contained in the package of benefits for which is coverage is provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. The Department anticipates that possible drafting as necessary to prepare new contracts as needed to comply with proposed §3.3704(e) and §3.3704(f) could require approximately 0 to 40 hours per month of administrative staff time in addition to the staff hours currently used by the insurer to perform this function. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, review the additional new contracts or renewals of existing contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department, therefore, estimates that the insurer will incur the cost of administrative staff ranging from $0 to $2,318.40 per month, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, review the additional new contracts or renewals of existing contracts.

(vi) Cost to print new contracts or renewals of existing contracts. The Department anticipates that an insurer could incur a cost for printing new contracts or

renewals of existing contracts to form a health care delivery network that complies with the local market adequacy requirements mandated in proposed §3.3704(e). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper for each new contract or renewal of an existing contract necessary to comply with proposed §3.3704(e). The Department anticipates that the insurer has the information necessary to determine its individual printing costs associated with compliance with proposed §3.3704(e), including the number of pages that will need to be printed per contract, in-house printing costs, or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(vii) Cost to transmit new contracts or renewals of existing contracts. The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail as necessary to comply with the network adequacy requirements specified in proposed §3.3704(e). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each new contract or renewal of an existing contract that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract.

However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or renewals of existing contracts would be incurred by an insurer that opts to transmit new contracts electronically. These costs would be part of the ongoing information technology equipment and service costs of the insurer.

III. Cost to insurers concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations.

Proposed §3.3705(b)(14): Requirement for network demographics to be included in the written description of policy terms and conditions. Proposed new §3.3705(b)(14) requires that an insurer offering a preferred provider benefit plan provide information that is updated at least annually regarding the demographics of the insurer's network as part of the written description of the insurer's policy terms and conditions that the insurer must furnish upon request to current and prospective group contract holders and insureds. Section 3.3705(b) provides that an insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all the requirements set forth in the subsection, including the level of disclosure required. Proposed §3.3705(b)(14) requires that the insurer disclose the network demographics for each service area or region, including: (i) the number of insureds in the service area or region; (ii) the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an access plan is in effect for that service area or region and how such access plan may be obtained or viewed, for

each provider area of practice including, at a minimum, internal medicine, family/general practice, pediatrics, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery; (iii) the percentage of preferred providers that are accepting new patients by area of practice; (iv) the percentage of providers with board certifications in the area of practice; (v) the number of preferred provider hospitals in the area or region; (vi) the ratio of insureds to hospital beds; (vii) how to view an access plan if one is in effect for the service area or region with respect to hospitals; (viii) the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and (ix) the average surgical site infection rate at each preferred provider hospital in the service area or region. The Department anticipates that compliance with proposed §3.3705(b)(14) could result in costs to comply for insurers. The Department anticipates that the total initial estimated annual cost for an insurer to comply with proposed §3.3705(b)(14) could vary. This estimate is based upon the following components: (i) cost of programming; (ii) cost to print additional pages for written descriptions of terms and policies or handbooks; and (iii) cost of market research analyst staff time to research network demographic information.

(i) Cost of programming. The Department anticipates that insurers could incur a one-time cost for programming necessary to summarize network demographics and to automate the inclusion of the network demographic information in the written description of terms and conditions of the insurer's policies or handbook in order to comply with proposed §3.3705(b)(14). The Department estimates that an in-house programmer could require 10 to 25 hours to program a reporting function to monitor the network

demographics of a given service region or area. Based on the Texas Workforce Commission *OES Report*, computer programmers working for insurers in Texas earn a median hourly wage of $38.51, as indicated at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=15-1021&compare=2. Therefore, the estimated average cost for an insurer's in-house programmer time could range from $385.10 to $962.75 per year, depending upon the number of hours that a particular insurer needs the programmer based upon its unique preferences and existing information technology resources. The Department has in the past received estimates from insurers that indicated that contract programmers could cost $200 per hour or more. An insurer's total cost for programming necessary to generate reports as necessary for compliance with proposed §3.3705(b)(14) will vary depending on the insurer's computer systems and whether the insurer will use an in-house or contract programmer. The actual number of hours, types, and cost of personnel will be determined by each insurer's existing information systems and staffing, and the extent to which each insurer already monitors the network demographics particular to the existing service area or region used in connection with the insurer's preferred provider benefit plans.

(ii) Cost to print additional pages for written descriptions of terms and policies or handbooks. The Department anticipates that the insurer will incur a cost for printing reports of network demographics to include in the written description of terms and conditions of the insurer's policies or handbooks in order to comply with the requirements of proposed §3.3705(b)(14). The Department estimates that this cost

could be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(iii) *Cost of market research staff time to research network demographic information.* The Department anticipates that insurers may need to utilize the services of a market research analyst to research preferred provider demographic information to obtain data for the network demographic reports for the insurer's service area or region in order to comply with proposed §3.3705(b)(14). A market research analyst working for an insurer in Texas earns a median hourly wage of $32.04, according to the Texas Workforce Commission *OES Report*, available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=19-3021&compare=2. The Department anticipates that one to 10 hours of market research staff time will be needed for this research depending on the insurer's current practices with respect to monitoring the subject network demographic information. The Department therefore estimates that the insurer could incur annual costs to comply with proposed §3.3705(b)(14) ranging from approximately $32 to $320, depending on the total amount of time that the insurer needs the services of the market research analyst and the amount of existing time the insurer allocates to monitoring the specified demographics. There are also two possible factors that may mitigate this cost. Proposed §3.3706(c), relating to credentialing requirements of

preferred providers, requires insurers to have a process for selection and retention of preferred providers sufficient to ensure that the providers are adequately credentialed. Insurers will therefore have some of the information necessary for compliance with proposed §3.3705(b)(14) as a result of compliance with proposed new §3.3706(c). Also, costs for those insurers that already monitor some or all of the required demographic information will be mitigated based on the extent of that existing monitoring.

Proposed §3.3705(e)(2): Requirement for Internet-based notice concerning network adequacy by service area. Proposed new §3.3705(e)(2) requires insurers that maintain an Internet website for use by prospective consumers or current insureds to provide an online (Internet-based) listing of the state regions, counties or three-digit ZIP Code areas within the insurer's service area that indicates the areas that the insurer has determined meet the required network adequacy requirements and that the insurer has determined do not meet the required network adequacy requirements of this subchapter. The Department anticipates that proposed §3.3705(e)(2) could result in costs to comply for insurers. Though the Department has identified factors attributable to the cost of complying with proposed §3.3705(e)(2), it is not possible for the Department to estimate the total amount of cost attributable to compliance with proposed §3.3705(e)(2) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area(s) and the insurer's current practices for updating its Internet-based website information. The Department anticipates that insurers will

primarily incur a cost to comply with proposed §3.3705(e)(2) based upon the cost to publish the required notice on the insurer's established Internet website. The Department estimates that a range of 10 - 25 hours of desktop publisher staff time would be needed initially to prepare and publish the required notice on the insurer's website. A desktop publisher in Texas earns $19.86 per hour according to the Texas Workforce Commission *OES Report*, as indicated at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=1&indcode=000000&occcode=43-9031&compare=2. Therefore, the cost of a desktop publisher to initially publish the information on the insurer's website would range from $198.60 to $496.50. The Department anticipates that the majority of the work in developing the data that forms the basis of the notice will be available to the insurer as a result of the insurer's ongoing network monitoring activities performed in compliance with proposed §3.3704(e) and §3.3704(f), as previously discussed in the section of the Department's cost analysis entitled "Proposed §3.3704(e) and §3.3704(f): Network adequacy requirements, monitoring, and corrective actions."

The Department anticipates that there will be continuing costs associated with updating the information required to be published for compliance with proposed §3.3705(e)(2), but that the ongoing costs will be less than the costs for the initial reporting. Such updating could require that an insurer incur staff costs for approximately one hour per month as performed by an administrative assistant. An administrative assistant working for an insurer in Texas has a median hourly wage of $20.86 according to the same *OES Report*. Accordingly, the Department estimates that

an ongoing cost of approximately $20.86 per month could be required in updating the insurer's website for compliance with the requirements of proposed §3.3705(e)(2).

Proposed §3.3705(f): Requirement to give notice of rights under a network plan to insureds. Proposed new §3.3705(f) specifies that insurers must provide notice of rights under a network plan in all policies, certificates, and outlines of coverage in at least 12 point font. The Department anticipates that proposed §3.3705(f) could result in costs to comply for insurers. The Department anticipates that proposed §3.3705(f) could result in costs to comply for insurers. The Department anticipates that insurers will avoid any mailing costs that would have been be incurred by the insurer as a result of compliance with proposed §3.3705(f) by providing the notice along with the policy at issuance or renewal. Therefore, the Department's estimate of costs for an insurer to comply with §3.3705(f) is based on: (i) the cost of administrative staff to prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage; and (ii) the cost to print additional pages for printed documents.

(i) Cost of administrative staff to prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage. The Department anticipates that preparation of the required notice of rights for inclusion in policies, certificates and outlines of coverage as specified in proposed §3.3705(f) will likely require a one-time cost of approximately 2 to 10 hours of administrative staff time. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both positions, perform this function. A general operations manager working for an insurer in

Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost of administrative staff ranging from $41.72 to $579.60, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of both positions, prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage to comply with proposed §3.3705(f).

(ii) Cost to print additional pages. The Department anticipates that an insurer will incur a cost for printing the required notice of rights specified in proposed §3.3705(f) in all policies, certificates, and outlines in order to comply with the requirements of proposed §3.3705(f). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper and that each notice of rights will require approximately one or two printed pages. The Department anticipates that the insurer has the information necessary to determine its individual printing costs necessary for compliance with proposed §3.3705(f), including the number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing. An insurer's costs will also vary based upon the number of policies, certificates, and outlines of coverage for which the insurer must include the notice of rights. The Department anticipates that the total cost to comply with proposed §3.3705(f) could also vary depending on the insurer's administrative processes.

Proposed §3.3705(h): Requirement to provide a cost-free listing of all preferred providers to insureds at least annually. Proposed new §3.3705(h) requires insurers to provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers. The Department anticipates that proposed §3.3705(h) could result in costs to comply for insurers. The Department anticipates that the proposed required notice will likely be sent to insureds at the time of policy renewal or issuance in order to avoid additional mailing costs that would otherwise be incurred by the insurer. Therefore, the Department anticipates that the estimated cost for an insurer to comply with §3.3705(f) will depend on cost components including the following: (i) the cost of administrative staff to prepare the required notice of rights; and (ii) the cost to print additional pages.

(i) Cost of administrative staff to prepare the required notice of rights. The Department anticipates that preparation of the required annual notice describing how the insured may access a current listing of all preferred providers on a cost-free basis in accordance with proposed §3.3705(h) will likely require a one-time cost of approximately two hours of administrative staff time. The cost to the insurer for staff time associated with preparation of this notice to comply with proposed §3.3705(h) will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both positions, prepare the required

notice of rights for distribution on issuance and renewal of policies. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost for administrative staff necessary to prepare the notice specified in proposed §3.3705(h) ranging from $41.72 to $115.92, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two positions, perform the functions necessary to prepare the required notice of rights for distribution.

(ii) Cost to print additional pages. The Department anticipates that the insurer will incur an annual cost for printing the required notice describing how the insured may access a current listing of all preferred providers on a cost-free in order to comply with the requirements of proposed §3.3705(f). The Department estimates that this cost will range from approximately $0.06 to $0.08 per page for printing and paper, and that the notice will require less than one page to print. The Department anticipates that the insurer has the information necessary to determine its individual printing costs associated with compliance with proposed §3.3705(h), including the number of pages that need to be printed, in-house printing costs, or out-of-house printing costs. An insurer’s potential printing costs may vary if the insurer does not use in-house printing. An insurer’s potential printing costs could also vary based upon the number of policies issued by the insurer.

Proposed §3.3705(i): Requirement to update preferred provider listings on a quarterly basis. Proposed new §3.3705(i) requires insurers to update their electronic and nonelectronic preferred provider listings every three months. The Insurance Code §1301.1591(b) currently requires any insurer that opts to maintain an Internet site with listings of preferred providers to update the Internet-based listing quarterly. Therefore, insurers that opt to maintain an Internet-based listing of preferred providers, and that are in compliance with that requirement subject to §1301.1591(b), will not incur any additional costs to comply with proposed new §3.3705(i) with respect to those Internet-based listings. The Department anticipates that proposed §3.3705(i) could result in costs to comply for insurers that do not maintain an updated Internet listing of preferred providers. The Department anticipates that the cost to implement proposed §3.3705(i) is contingent on whether an insurer's directory is made available electronically on the Internet. There is no additional cost anticipated for insurers that currently maintain the online listings pursuant to the Insurance Code §1301.1591(b) in order to comply with proposed §3.3705(i) with respect to the Internet-based listings. Insurers that do not provide Internet-based provider listings and that do not currently update their provider listings more often than quarterly may incur additional cost. The Department anticipates that some insurers will incur a cost to comply with proposed §3.3705(i) based on the cost for staff to update nonelectronic versions of the directory. The Department anticipates that drafting updates to the provider directory will likely require approximately four hours of administrative staff time for those insurers that do not already update their listings at least quarterly. An administrative assistant working for

an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission *OES Report.* The Department therefore estimates that an insurer could incur the cost of administrative staff time of 4 hours quarterly, with a total estimated cost of $83.44 per quarter to comply with proposed §3.3705(i). This cost estimate could vary depending on the size of the insurer's network.

Proposed §3.3705(k): Requirement for insurer to pay a claim for services provided by a nonpreferred provider at the preferred provider rate if an insured reasonably relied on an insurer's preferred provider directory in obtaining the services rendered. Proposed §3.3705(k) requires that a claim for services rendered by a nonpreferred provider be paid at the applicable preferred benefit coinsurance percentage if an insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network. Proposed new §3.3705(k) would result in insurers paying increased claim costs if an insured reasonably relies on an inaccurate directory maintained by the insurer. The Department anticipates that insurers could possibly mitigate this potential cost through the addition of provisions in contracts with providers

addressing continuity of reimbursement rates to apply for a specified period following termination of a provider's participation in the network in the circumstances described by §3.3705(k). Such a continuity provision could potentially address those instances in which the insured's scheduled appointment or procedure occurs within 30 days of the insured confirming the provider's status as a preferred provider. The Department anticipates that proposed §3.3705(k) could result in a minimal increased cost to an insurer provided that the insurer maintains an up-to-date listing of providers. It is not possible for the Department to estimate the amount of such increase, however, because there are numerous factors involved that are not suitable to reliable quantification, including the frequency of terminations of preferred provider participation rights and contracts, the frequency of insurer updates to its listings of preferred providers, the method employed by the insurer to notify insureds of changes to the preferred provider panel, and the scope of the difference in reimbursement rates for the services provided for a preferred and a nonpreferred provider.

Proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B): Requirement for insurers to identify in preferred provider listings those hospitals that have agreed contractually to use good faith efforts to accommodate requests from insureds to use preferred providers and to provide information to insureds that support a determination of the status of facility-based physicians or physician groups as preferred or nonpreferred providers. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Proposed §3.3705(l)(1)

requires that the provider information include a method for insureds to identify those hospitals that have contractually agreed with the insurer to: (i) exercise good faith efforts to accommodate requests from insureds to utilize preferred providers; and (ii) in those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, provide the insured with information that is furnished at least 24 hours prior to services being rendered, and sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider. The Department anticipates that proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) could result in costs to comply for insurers. The Department anticipates that the total estimated cost for an insurer to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) could vary based upon a number of factors, including the number of network facilities with preferred provider facility-based physicians and cost components including the following: (i) the cost of an initial identification of those hospitals that have contractually agreed to the requirement specified in proposed §3.3705(l)(1) and §3.3705(l)(1)(B) and annual updates of this identification; (ii) the cost of updating changes to the Internet-based preferred provider listings; (iii) the cost of programming or administrative staff hours to implement changes to nonelectronic preferred provider listings; and (iv) additional printing costs for paper (nonelectronic) listings.

(i) Cost of initial identification of those hospitals that have contractually agreed to the requirements specified in proposed §3.3705(l)(1(A) and§3.3705(l)(1)(B) and annual updates of this identification. The Department anticipates that an the insurer could incur initial costs to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) for approximately ten hours of staff time and subsequent annual costs of approximately one hour to update the initial identification of those hospitals that have contractually agreed with the insurer to use good faith efforts to accommodate requests from insureds to use preferred providers and to furnish information to insureds related to the status of facility-based physicians as preferred or nonpreferred providers. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs these functions. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur initial costs for administrative staff necessary to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) ranging from $208.60 to $579.60, and subsequent annual costs ranging from $20.86 to $57.96, depending on whether initial determinations and updates to the provider information are performed by an administrative assistant or a general operations manager, or a combination of both positions. The Department anticipates that this cost will vary for each insurer depending on the size of its network and its administrative systems for tracking such information.

The Department further anticipates that each insurer has the information necessary to determine its cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(ii) Cost of annual updating changes to the Internet-based preferred provider listings. The Department anticipates that each insurer could incur costs ranging from two to five hours of desktop publishing staff time to prepare changes to the Internet-based preferred provider listings that specify the provider information required under proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) and based upon the determinations described in the previous cost component, entitled "*Cost of initial identification of those hospitals that have contractually agreed to the requirements specified in proposed §3.3705(l)(1)(A) and§3.3705(l)(1)(B) and annual updates of this identification*." Based on the Texas Workforce Commission *OES Report*, a desktop publisher working in Texas earns $19.86 per hour. Therefore, the cost for updating the changes on the insurer's website could range from an annual cost of $39.72 for two hours of time to $99.30 for five hours of time. The Department anticipates that this cost will vary for each insurer depending on the size of its network. The Department further anticipates that each insurer has the information necessary to determine its costs for implementing changes to its Internet-based preferred provider listings based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply. An insurer that does not maintain an Internet-based preferred provider listing will not incur costs for compliance with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) based upon this cost component.

(iii) Cost of implementing annual changes to nonelectronic preferred provider listings. The Department anticipates that insurers could incur annual staff costs to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) associated with implementing changes to nonelectronic preferred provider listings ranging from two to five hours of administrative assistant staff time. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission *OES Report.* Therefore, an insurer could incur annual costs that range from $41.72 for two hours of staff time to $104.30 for five hours of staff time. The Department anticipates that this cost will vary for each insurer depending on the size of its network. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B).

(iv) Cost to print additional pages of listings. The Department anticipates that an insurer could incur an annual cost for printing additional pages in the listings of nonelectronic preferred providers distributed to insureds in order to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B). The Department estimates that this cost could range from approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of insureds and number of additional pages to be printed. The Department further anticipates that each insurer has the information necessary to determine its

estimated total annual cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

Proposed new §3.3705(l)(2): Requirement for insurers to identify in preferred provider listings those hospital locations where more than 10 percent of the dollar amount of claims filed with the insurer by facility-based physicians were not contracted with the insurer. Under proposed §3.3705(l)(2), the information in an insurer's preferred provider listings must include a method for insureds to identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer, by or on behalf of facility-based physicians, other than neonatologists and pathologists, are filed by or on behalf of a physician that is not under contract with the insurer. The Department anticipates that insurers could incur additional costs as a result of compliance with proposed new §3.3705(l)(2). The Department anticipates that the total estimated annual cost for an insurer to comply with proposed new §3.3705(l)(2) could vary depending on the number of preferred provider hospitals in an insurer's preferred provider network, the insurer's internal administrative systems, and cost components including the following: (i) the cost of programming for necessary reports and updates to Internet-based listings of preferred providers; (ii) the cost of administrative staff hours to assess and monitor the contract and hospital privileges status between facility-based physicians and hospitals; and (iii) the cost to print additional notices in nonelectronic listings of preferred providers.

(i) Cost of programming to update Internet-based listings of preferred providers. The Department anticipates that an insurer could incur annual costs to comply with

proposed §3.3705(l)(2) based upon programmer staff time necessary to implement changes to the insurer's Internet-based listings of preferred providers for compliance with the requirement specified in proposed §3.3705(l)(2). The Department anticipates that an insurer could require a range of 10 to 100 hours of a programmer's time to perform this function. Based on the Texas Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department anticipates that the estimated cost to an insurer for programmer staff time would range from $385.10 to $3851, depending upon the amount of time the insurer needs for programming as required for the particular insurer's preferred provider network. The Department has received estimates in the past from insurers indicating that contract programmers could charge as much as $200 per hour. The Department anticipates that this cost for programming to comply with the requirements specified in proposed §3.3705(l)(2) will vary for each insurer depending on how much time is needed for the programming needs of a particular insurer and whether the insurer uses a company staffer or contracts with an outside programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

(ii) Cost of administrative staff hours to assess and monitor the status of contracts and hospital privileges between facility-based physicians and hospitals. The Department anticipates that if it does not opt to implement this subsection through programming, an insurer could incur a monthly cost for an administrative staffer for 2 to

10 hours to monitor and assess claims from facility-based non-contracted physicians in order to comply with the disclosure requirement specified in proposed §3.3705(l)(2). The monthly costs to an insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to perform this assessment and monitoring function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur total cost ranging from $41.72 to $579.60 per month depending on whether an administrative assistant or a general operations manager, or a combination of both, performs the assessment and monitoring and how much time is required based upon the particular insurer's preferred provider network. The Department anticipates that this cost will vary for each insurer depending on these factors. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the requirements of proposed §3.3705(l)(2).

(iii) Cost to print additional notice in nonelectronic listings of preferred providers. The Department anticipates that an insurer could incur a cost to print additional notices in nonelectronic listings of preferred providers indicating those hospitals at which more than ten percent of claims were from facility-based physicians that are not under contract with the insurer in order to comply with the disclosure requirement specified in

proposed §3.3705(l)(2). The Department estimates that this cost could be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that the insurer has the information necessary to determine its individual costs associated with printing the disclosure in nonelectronic preferred provider listings for compliance with proposed §3.3705(l)(2), including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. The Department anticipates that an insurer's printing costs may vary if the insurer elects to use out-of-house printing to comply with the requirements specified in proposed §3.3705(l)(2).

Proposed §3.3705(l)(4): Requirement for insurers to identify in all preferred provider listings whether each preferred provider is accepting new patients. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Under proposed §3.3705(l)(4), the provider information must indicate whether each preferred provider is accepting new patients. The Department anticipates that proposed §3.3705(l)(4) will not result in a new cost to most insurers because the disclosure is currently required by the Insurance Code §1301.1591 with respect to Internet-based preferred provider listings, and the Department expects that most insurers will be able to print the same information about whether preferred providers are accepting new patients in nonelectronic preferred provider listings as is included in Internet-based listings at minimal cost. Nevertheless, since §1301.1591 does not require such information be provided in listings of preferred providers if the insurer does not maintain an Internet

site, proposed new §3.3705(l)(4) could result in new costs to insurers without Internet sites. The Department estimates that the insurer could incur a cost of administrative staff time ranging from two to three hours per month as necessary to compile information provided by providers about whether they are accepting new patients. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs this monitoring function for compliance with the disclosure requirement specified in proposed §3.3705(l)(4). A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur monthly costs to comply with proposed §3.3705(l)(4) for an administrative assistant ranging from $41.72 to $62.58 or the cost of a general operations manager ranging from $115.92 to $173.88. The Department anticipates that this monthly cost will vary for each insurer depending on the size of its network, how many hours are needed to obtain the required information and make the necessary changes to the provider listing, and whether the work is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost for compliance with proposed §3.3705(l)(4) based on these factors and any other factors that the insurer is aware of that will impact the insurer’s total annual cost to comply.

Proposed §3.3705(l)(5): Requirement that insurers identify in all preferred provider listings those preferred providers who are participating in quality of care regional peer review programs. Proposed §3.3705(l)(5) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Under proposed §3.3705(l)(5), the provider information must designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program. The Department anticipates that proposed §3.3705(l)(5) could result in costs to comply for insurers. The Department anticipates that the insurer could incur costs associated with identifying which providers are participating in the peer review programs and updating the preferred provider listings with this information. Though the Department has identified the cost factors that follow as attributable to the cost of compliance with proposed §3.3705(l)(5), it is not possible for the Department to estimate the total annual amount of costs attributable to proposed §3.3705(l)(5) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the insurer's internal administrative processes. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) could be applicable to estimating the cost for compliance with proposed §3.3705(l)(5) if the insurer elects to

comply with proposed §3.3705(l)(5) by means of contract requirements in contracts between the insurer and preferred providers. Because the cost methodology and components are the same if this approach to compliance with the requirements of proposed §3.3705(l)(5) is used by the insurer, the following is a summary of the Department's analysis (which is detailed in this Cost Note under the subheading for "Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)"): (i) cost of less than one hour of administrative staff wages necessary to assist with drafting, updating, and reviewing contracts and amendments, per contract amended; (ii) cost of less than one hour of legal drafting and review of contract terms and representation in contract negotiations in connection with reviewing new or amended contracts, per contract amended; (iii) cost to print new contracts or amendments to existing contracts; and (iv) cost to transmit new contracts or amendments to existing contracts to physicians and providers by mail or electronically. Additionally or alternatively, the Department anticipates that insurers could incur costs to comply with proposed §3.3705(l)(5) based upon the cost of staff time necessary to identify preferred providers participating in regional peer review programs and make applicable notes in preferred provider listings. The Department anticipates that the total annual costs for each insurer that result from compliance with proposed §3.3705(l)(5) could depend largely on the size of the insurer's network and the insurer's internal business practices, such as the extent that to which the insurer negotiates individual contract terms on a case by case basis. The Department estimates that an insurer could incur a cost for administrative staff time of two to three hours per month to compile information provided by preferred providers about provider

participation in peer review programs. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs this compilation function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur the monthly cost of administrative staff to perform this compilation and monitoring function to comply with the requirements of proposed §3.3705(l)(5) for an administrative assistant ranging from $41.72 to $62.58 or for a general operations manager ranging from $115.92 to $173.88. The Department anticipates that this monthly cost will vary for each insurer depending on how many hours are needed and whether the work is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost to comply with the requirements of proposed §3.3705(l)(5) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

Proposed new §3.3705(l)(6) and §3.3705(l)(7): Requirement to provide disclosures in preferred provider listings directories and the identity of preferred provider facility-based physicians who are able to provide services at preferred provider facilities. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of

information made available by the insurer. Under proposed §3.3705(l)(6), the provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to (i) information about the provider's contract status; and (ii) whether the provider is accepting new patients. Under proposed §3.3705(l)(7), the provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities. The Department anticipates insurers could incur additional costs as a result of proposed new §3.3705(l)(6) and §3.3705(l)(7). The Department has estimated these two sets of anticipated compliance costs as a single cost for the insurer because insurers could potentially comply with them both through a notice to insureds contained in the provider listing. The estimated total cost for an insurer to comply with proposed new §3.3705(l)(6) and §3.3705(l)(7) could vary depending on the insurer's internal procedures. The Department's estimated total annual cost for an insurer to comply with proposed new §3.3705(l)(6) and §3.3705(l)(7) includes the following potential cost components: (i) the cost of administrative staff hours to implement changes to preferred provider listings; and (ii) the cost of responding to additional complaints and inquiries.

(i) Cost of administrative staff hours to implement changes to preferred provider listings. The Department anticipates that the insurer could incur a cost for administrative staff for compliance with proposed §3.3705(l)(6) and §3.3705(l)(7) for the cost of one to four staff hours as necessary to implement changes to the insurer's preferred provider listings by amending all listings to include information about: (i) how

insureds may notify the insurer about inaccurate listings; and (ii) how insureds may ascertain the information concerning facility-based physicians at preferred provider facilities. The insurer may opt to have an administrative assistant or a general operations manager, or a combination of both, implement the changes to the Internet-based preferred provider listings. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost for administrative staff ranging from $20.86 to $231.84, depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to implement the changes to the listings of preferred providers. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the number of hours that is needed to implement the disclosure requirements of proposed §3.3705(l)(6) and §3.3705(l)(7) and based upon the insurer's existing administrative practices concerning the inclusion of this information in preferred provider listings. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(ii) Cost of handling additional complaints and inquiries. The Department anticipates that insurers could experience an increase in complaints and inquiries from insureds as a result of compliance with the disclosure requirements of proposed

§3.3705(l)(6) and §3.3705(l)(7) because insureds may have better information about how to communicate with the insurer concerning the information included in the insurer's preferred provider listings as a result of the new disclosure requirements. Insurers that do not already provide such disclosures will be required to have staff available to take information about inaccurate preferred provider listings and to provide information about facility-based physicians available to provide services at preferred provider facilities. The Department anticipates that insurers could comply with the requirements specified in proposed §3.3705(l)(6) and §3.3705(l)(7) by using the telephone lines and addresses for correspondence that the insurer presently uses to receive and respond to complaints and inquiries. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the *OES Report.* The Department anticipates that the number of additional staff hours necessary to comply with §3.3705(l)(6) and §3.3705(l)(7) by responding to inquiries and complaints from insureds could vary based upon the extent to which this information has been previously made available by the insurer to its insureds and the adequacy of the insurer's preferred provider network.

Though the Department has identified factors that may be attributable to the cost of compliance with the disclosure requirements specified in proposed §3.3705(l)(6) and §3.3705(l)(7), it is not possible for the Department to estimate the total amount of costs attributable to proposed §3.3705(l)(6) and §3.3705(l)(7) because there are numerous factors involved that are not suitable to reliable quantification by the Department,

including issues such as the accuracy of the insurers' provider listings, the numbers of insureds, and the numbers of preferred facility-based providers.

Proposed §3.3705(l)(8): Requirement that provider information must be provided in fonts of not less than 10-point type. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(8) the provider information must be provided in fonts of not less than 10-point type. The Department anticipates that proposed §3.3704(l)(8) could result in costs to comply for insurers. If the carrier currently utilizes a font smaller than 10-point in its provider listing, the Department anticipates that making the necessary changes to a provider listing with noncompliant fonts could require a cost to comply with the requirement specified in proposed §3.3704(l)(8) for a range of 4 to 6 hours of staff time for an administrative assistant if necessary to update the font requirement. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission *OES Wage Report.* Thus, the Department anticipates that an insurer could incur estimated compliance costs resulting from proposed §3.3704(l)(8) that range between approximately $83.44 and $125.16 as a one-time cost for staff to reformat the insurer's preferred provider listings. The cost to an insurer of compliance with proposed §3.3704(l)(8) could also vary depending on the internal administrative procedures of the insurer and the size of the insurer's preferred provider listing. The Department anticipates that insurers have the information

necessary to calculate their costs of compliance with proposed §3.3704(l)(8) as appropriate to the insurer's individual circumstances.

Proposed §3.3705(l)(9) and §3.3705(l)(10): Requirements that insurers disclose those facilities at which the insurer has no contracts with facility-based physicians and those facilities at which the insurer has a contract with facility-based physician groups which have an exclusive contract with the facility. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(9), the provider information must specifically identify those facilities at which the insurer has no contracts with a particular type of facility-based provider, specifying the applicable provider type. Under proposed §3.3705(l)(10), the provider information must specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type. The Department anticipates insurers could incur additional costs as a result of proposed new §3.3705(l)(9) and §3.3705(l)(10). The Department has addressed the estimated cost to an insurer for compliance with proposed §3.3705(l)(9) and §3.3705(l)(10) jointly because the Department anticipates that insurers are likely to implement the steps necessary to comply with §3.3705(l)(9) and §3.3705(l)(10) in a joint fashion for purposes of efficiency. The Department has determined that the total estimated annual cost for an insurer to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) could range from approximately $334 to $2319. This cost estimate is based upon the

following components: (i) the cost of administrative staff as necessary to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10); and (ii) the cost to implement changes to preferred provider listings.

(i) Cost of administrative staff to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10). The Department anticipates that an insurer could incur monthly cost for administrative staff as necessary to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10): (i) circumstances under which there are facilities for which the insurer has no contracts with a particular type of facility-based provider; and (ii) circumstances under which there are facilities for which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility. Such monitoring of circumstances could require an insurer to incur a cost to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) based upon an estimated one to two hours of staff time per month depending on the procedures developed by the insurer to obtain the information and the number of facilities in the insurer's network. The insurer may opt to have an administrative assistant or a general operations manager, or a combination of both, conduct the monitoring for the existence of these circumstances at facilities. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur costs to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) for

the cost of administrative staff ranging from $20.86 to $115.92 per month, depending on whether an administrative assistant or general operations manager, or a combination of both, does the monitoring and whether the monitoring requires one or two hours of staff time. The Department anticipates that this cost will also vary for each insurer depending on the salary level of the staff doing the monitoring and how much time such monitoring requires based upon the unique composition of the insurer's network. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total monthly cost to comply.

(ii) Cost to implement changes to preferred provider listings. The Department anticipates that an insurer could incur a cost for administrative staff ranging from one to four hours quarterly to comply with proposed new §§3.3705(l)(9) and 3.3705(l)(10) by updating preferred provider listings with new information about the status of facility-based providers at preferred provider facilities. The insurer may opt to have an a general operations manager, or a combination of both, perform this update function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur a cost to comply with proposed §§3.3705(l)(9) and 3.3705(l)(10) for administrative staff ranging from $20.86 to $231.84 per quarter, depending on whether an administrative assistant or a general operations manager, or a combination of both,

is used to implement the changes to the provider listings. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

Proposed §3.3705(l)(11): Requirement to specify the date on which preferred provider listing information was provided to the insured. Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(11), the provider listing must specify the date on which the preferred provider information specified in proposed §3.3705(l) was provided to the insured. The Department anticipates that proposed §3.3705(l)(11) could result in costs to comply for insurers. The Department anticipates that the cost for an insurer to comply with §3.3705(l)(11) could vary depending on whether it already dates its provider listings and the complexity of its Internet-based provider listings and will also depend on the following cost components: (i) the cost of programming for Internet-based preferred provider listings; and (ii) the cost of administrative staff to implement changes to nonelectronic preferred provider listings.

(i) Cost of programming for Internet-based preferred provider listings. The Department anticipates that computer programming time could be needed on a one-time basis for programming Internet-based preferred provider listings to comply with proposed new §3.3705(l)(11). The Department estimates that a programmer could require two to 40 hours to perform the requisite programming. According to the Texas

Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department anticipates that the estimated cost for programming staff necessary for compliance with proposed §3.3705(l)(11) could range from $77.02 to $1540.40. The Department has received estimates in the past from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed based upon the existing information processing infrastructure in use by each insurer and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the dating requirement specified in proposed §3.3705(l)(11).

(ii) Cost to implement changes to nonelectronic preferred provider listings. The Department anticipates that most insurers already date their nonelectronic preferred provider listings and will not incur any cost as a result of §3.3705(l)(11) with respect to the nonelectronic listings. If an insurer does not presently date its nonelectronic preferred provider listings, however, the Department anticipates that an insurer could incur costs for the administrative staff time needed in order to bring the listing into compliance with proposed §3.3705(l)(11). The Department estimates that it would take less than one hour of administrative time to update the date of the preferred provider

listing each time the preferred provider listing is updated, which must be at least quarterly pursuant to proposed §3.3705(i). The Department anticipates that an insurer is likely to opt to have either an administrative assistant or general operations manager, or a combination of both, implement the dating requirement as specified in §3.3705(l)(11). A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur quarterly costs of compliance with proposed §3.3705(l)(11) for administrative staff at or below a range of $20.86 to $57.96 each time a provider listing is updated. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed for implementing the changes and whether performance of this function is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost for compliance with proposed §3.3705(l)(11) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

Proposed §3.3705(m): Requirement for insurer to provide notice to each individual and group policy holder that the preferred provider benefit plan relies upon an access plan as specified in proposed §3.3709. Proposed new §3.3705(m) requires insurers operating a preferred provider benefit plan that relies upon an access plan as specified in proposed §3.3709 to provide notice of this fact to each individual

and group policy holder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes made available by the insurer pursuant to §3.3705(e)(2). The Department anticipates that proposed §3.3705(m) could result in costs to comply for insurers. The Department has determined that the total estimated cost for issuance of the notice at policy issuance and at least 30 days prior to renewal of an existing policy as required by §3.3705(m) will vary depending on the adequacy of the insurer's network and the number of policyholders, but will be based on the following cost components: (i) the cost of any programming to automate issuance of the required notices; (ii) the cost of administrative staff to provide the notices, if not automated; and (iii) the cost to print and issue the required notices.

(i) Cost of programming to automate issuance of the required notices. The Department anticipates that an insurer could incur costs for reprogramming its computer systems to include the notice of use of an access plan in or with other documents issued at policy issuance and at the time of renewal to comply with proposed new §3.3705(m). According to the Texas Workforce Commission *OES Report,* computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department estimates that a programmer could require from two to 40 hours to do the requisite programming. Therefore, the Department estimates the programming cost incurred by the insurer to comply with proposed §3.3705(m) could range from approximately $77 to $1540.40. The Department has in the past received estimates from insurers indicating that fees for contract programmers could cost as

much as $200 per hour or more. The Department further estimates that an insurer's total programming cost to comply with proposed §3.3705(m) will vary depending on the insurer's computer systems, whether the insurer uses a company staff programmer or a contract programmer.

(ii) Cost of using staff to issue the required notices, if not automated. The Department anticipates an insurer could alternatively utilize staff services to issue the access plan notices for compliance with proposed §3.3705(m) if issuance is not automated. The Department estimates that one or more hours of additional administrative staff time could be needed per month to issue the notices manually. The Department anticipates that an insurer would opt to utilize an administrative assistant to perform this notification. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report as indicated in the Texas Workforce Commission *OES Report*. The Department therefore estimates that an insurer could incur costs for administrative staff time of at least $20.86 to issue the notice manually. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed per month to issue the notices, the number of policyholders, and the internal administrative processes of the insurer. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3705(m).

(iii) Cost to print and issue the required notices. The Department anticipates that an insurer could incur costs for printing the notices concerning the use of an access plan as required by §3.3705(m). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of notices needed, in-house printing costs, or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing. The Department does not anticipate that insurers will incur an additional mailing cost for the required notices, because the notices may be issued in or with other documents at the time of policy issuance or renewal. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

Proposed §3.3705(n): Requirement for insurers to provide notice of contract termination and the resulting substantial decrease in availability of preferred facility-based physicians. Under proposed §3.3705(n)(1), an insurer is required to provide notice of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility. "Substantial decrease" is defined in the proposed rule to occur when (i) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or (ii) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the

preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination. However, under proposed §3.3705(n)(2), no notice is required if alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in proposed §3.3705(n)(1) are made available to insureds at the facility such that the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease. Proposed §3.3705(n)(3) requires an insurer to prominently post notice of §3.3705(n)(1) termination and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds. Proposed §3.3705(n)(4) requires that the notice of the termination and of the decrease in availability of providers must be maintained on the insurer's website for six months from the initial posting or until adequate preferred providers of the same specialty become available to insureds at the facility.

Proposed §3.3705(n)(5) requires an insurer to update its Internet-based preferred provider listing in accordance with certain specified time periods. The Department anticipates that proposed §3.3705(n) could result in costs to comply for insurers based upon the following components: (i) the cost of administrative staff to monitor for applicable notices of terminations; and (ii) the cost of programming to post and remove notices on an insurer's website.

(i) Cost of administrative staff to monitor for applicable notices of terminations. The Department anticipates that administrative staff time could be needed by an insurer

to monitor monthly changes in preferred facility-based physicians as provided to the insurer by contracted facilities pursuant to proposed §3.3703(26)(A). The Department estimates that one hour of administrative time could be needed monthly for this monitoring. The Department anticipates that an insurer is likely to opt to have either an administrative assistant or general operations manager, or a combination of both, conduct such monitoring. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report*. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur costs for administrative staff time ranging from $20.86 to $57.96 per month. The Department anticipates that this monthly cost will vary for each insurer depending on how many hours are needed for monitoring and whether the monitoring is conducted by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total monthly cost to comply with proposed §3.3705(n).

(ii) Cost of programming to post and remove notices from an insurer's website. The Department anticipates that computer programming time will be needed to post and remove notices from the insurer's website to comply with proposed new §3.3705(n). The Department anticipates that a programmer would require approximately half an hour per month to post and remove these notices. Based on the Texas Workforce

Commission *OES Report*, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that the cost for programmer time will be $19.26 per month to comply with proposed §3.3705(n). In addition to the Department's determination of the cost estimate for this component, the Department received from one insurer a cost estimate of $100,000 for programming plus an additional annual expense of $100,000. However, the insurer provided no basis or methodology for this estimate. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the actual amount of time that is needed by the insurer and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

Proposed §3.3705(o): Requirement for insurers to make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services from nonpreferred providers. Under proposed §3.3705(o), an insurer is required to make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services in accordance with the specifications in the proposed rule. Proposed §3.3705(o) requires that insurers must disclose how reimbursement of nonpreferred providers will be determined. If reimbursement is based upon data concerning usual, customary, or reasonable provider charges, the insurer must disclose: (i) the source of

the data; (ii) how the data is used to determine reimbursements; and (iii) the existence of any applicable reductions. If reimbursement is based upon any amount other than full billed charges, the insurer must: (i) disclose that the insurer's reimbursement may be less than the billed charge; (ii) disclose that the insured may be liable to the nonpreferred provider for balance bill amounts; (iii) provide a description of the methodology used to determine the reimbursement amount; and (iv) provide a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service. The Department anticipates that proposed §3.3705(o) could result in costs to comply for insurers. The Department has determined that the cost for an insurer to comply with proposed §3.3705(o) will vary dependent on a number of factors, including the number of insureds, and will also be dependent on the following components: (i) the cost of drafting disclosures; (ii) the cost of printing additional pages for printed documents; (iii) the cost of filing fees for approval of new policies, certificates, and outlines of coverage information; and (iv) the cost of mailing new policies, certificates, and outlines of coverage or endorsements thereof containing the required notices to the Department for approval.

(i) Cost of drafting disclosures. The Department anticipates that insurers will require staff time to draft, on a one-time basis, disclosures as required by proposed new §3.3705(o). The Department estimates that an insurer's staff would require two to ten hours to draft the required disclosures. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer

in Texas earns a median hourly wage of $20.86 according to the same. Therefore, the Department's estimated cost for the staff time required to comply with proposed §3.3705(o) ranges from $41.72 to $579.60. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the amount of time that is needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3705(o).

(ii) Cost to print additional pages. The Department anticipates that the insurer could incur a cost for printing additional pages as necessary to include disclosures in all policies, certificates, and outlines of coverage to comply with the requirements of proposed new §3.3705(o). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of disclosures, number of insureds and number of additional pages to be printed. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly printing cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3705(o), including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(iii) Cost of filing fees for approval of new policy, certificate and outline of coverage information. To comply with proposed §3.3705(o), insurers will need to file for Department approval, on a one-time basis, new policies, certificates and outlines of coverage or endorsements thereof containing the required notices. The Department estimates that the insurer will incur a cost of $100 per form filed with the Department. The cost, however, will vary depending on the number of forms filed by each insurer. The Department anticipates that each insurer has the information necessary to determine its estimated total cost for policy fees required in connection with compliance with proposed §3.3705(o).

(iv) *Cost of mailing new policies, certificates and outlines of coverage or endorsements thereof containing the required disclosures to the Department for approval.* The Department anticipates that the insurer could incur a cost for mailing new policies, certificates and outlines of coverage or endorsements to the Department for approval, as required for compliance with proposed §3.3705(o). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each new policy, certificate and outline of coverage or endorsement thereof containing the required

disclosures that do not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per disclosure mailed to the Department. The Department anticipates that the total cost will vary for each insurer depending on the number of disclosures, number of additional pages to be mailed, and the business practices of the insurer. The Department anticipates that each insurer has the information necessary to determine its estimated total cost for mailing new policies, certificates and outlines of coverage or endorsements to the Department for approval.

Proposed §3.3705(p): Requirement for plan designations. Proposed new §3.3705(p) requires that any plan that uses a preferred provider service delivery network that does not comply with proposed network adequacy requirements for hospitals disclose: (i) on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network plan documents; and (ii) on the cover page of any nonelectronic provider listing describing the network that the plan has a “Limited Hospital Care Network”. The Department anticipates that proposed §3.3705(p) could result in costs to comply for insurers.

The Department has determined that the total estimated cost for an insurer to comply with §3.3705(p) will vary based on how often the insurer’s designation changes and the number of insureds and will also depend on the cost of drafting designations for use in policy documents.

The Department anticipates that insurers will require staff time to make amendments to insurance documents and preferred provider listings as provided in proposed §3.3705(p) each time the status of the network changes. The Department

estimates that an insurer's staff would require one to two hours to make the required clerical changes. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. Therefore, the estimated cost for the staff time an insurer could require ranges from $20.86 to $115.92. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the amount of time that is needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost to prepare documents that comply with proposed §3.3705(p) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply. The Department anticipates that an insurer will file this information with the Department when it files the its forms pursuant to implementation of §3.3705(o).

Proposed §3.3705(q): Loss of Status as an Approved Hospital Care Network. Proposed new §3.3705(q) specifies that if a preferred provider benefit plan designated as an Approved Hospital Care Network (*AHCN)* under proposed §3.3705(p) no longer complies with the network adequacy requirements for hospitals under proposed §3.3704 and does not correct such non-compliance within 30 days, the insurer is required to: (i) notify the Department in writing of its change in status, (ii) cease marketing as an *AHCN*; (iii) and inform insureds of the change at the time of renewal. The Department anticipates that proposed §3.3705(q) could result in costs to comply for insurers. The Department has determined that the total cost for an insurer to

comply with §3.3705(q) could vary depending on a number of factors, such as how often the insurer's designation changes and the number of insureds, and will also be based upon the following components: (i) the cost to print notices for insureds; (ii) the cost to notify the Department in writing; and (iii) the cost of administrative staff to monitor, prepare, and transmit the required notices to insureds.

(i) Cost to print notices for insureds. The Department anticipates that an insurer could incur a cost for printing notices for insureds at the time of renewal to comply with proposed new §3.3705(q). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of insureds and the number of required notices. The Department further anticipates that each insurer has the information necessary to determine its estimated total printing cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3709(q). The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(ii) Cost to notify the Department. The Department anticipates that the insurer could incur a cost for notifying the Department, as required for compliance with proposed §3.3705(q), including mailing notices to the indicated address. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for

printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard 5 digit zip code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each notice that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per notice mailed to the Department. The Department anticipates that each notice will be no more than one page and that the total cost will vary for each insurer depending on how often such notices will have to be filed with the Department.

(*iii) Cost to monitor, prepare, and transmit the required notices to insureds.* The Department anticipates that an insurer could incur a monthly cost for an administrative staffer for one to three hours per month: (*a*) to monitor and assess whether its preferred provider benefit plan designated as an Approved Hospital Care Network (*AHCN)* under proposed §3.3705(q) complies with the network adequacy requirements for hospitals under proposed §3.3704; and (b) to prepare and add the required notices to the renewal documents that are being sent to the insured. The monthly costs to an insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to perform the requisite functions. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96,

according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur total cost ranging from $20.86 to $173.88 per month depending on whether an administrative assistant or a general operations manager, or a combination of both, performs the requisite functions. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed to monitor changes; how many insureds must receive the required notice; and the amount of time that it takes to prepare and include the required notices in an insured's renewal documents. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the requirements of proposed §3.3705(q).

IV. Cost to insurers concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process.

Proposed §3.3706(a)(5): Prohibition against avoiding high risk populations when selecting participating preferred providers. Under proposed §3.3706(a)(5), selection standards used by insurers in choosing participating preferred providers must not directly or indirectly: (i) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or (ii) exclude a physician or provider because the physician or

provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization. The Department has determined that the cost for insurers to comply with proposed §3.3706(a)(5) will be contingent on the adequacy of the insurer's network, the size of the service area, and whether the insurer's current practices would violate the proposed prohibition in particular parts of the state. The Department does not anticipate any additional costs and requested input from insurers and other stakeholders on any additional costs they anticipate would result from complying with proposed new §3.3706(a)(5). The Department did not receive any input. The Department anticipates that any cost to comply with proposed §3.3706(a)(5) will be minimal because any impact in requiring additional contracts with providers in high risk areas may be offset by the lower contract rates that may be obtained when more providers are contracted in the service area. It is not possible for the Department to provide any precise estimate for such minimal cost because the factors involved, such as physician and provider fees and insurer reimbursement rates, vary widely and are not suitable to reliable quantification.

Proposed §3.3706(c): Requirement to have a documented process for selection and retention of preferred providers that are adequately credentialed. Under proposed §3.3706(c), an insurer is required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. Proposed new §3.3706(c) requires that, at a minimum, an insurer's credentialing standards are required to meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC. The

Department anticipates that an insurer could incur costs associated with selecting and retaining adequately credentialed preferred providers. Any additional cost that could be incurred will depend on the insurer's current credentialing standards. If an insurer is currently following the standards promulgated by the NCQA or URAC, the Department anticipates that there should be no additional cost for compliance. The Department has determined that, if an insurer's current standards are not compliant with proposed §3.3706(c), any cost for complying will depend on several factors, including the size of the insurer, the insurer's service area, the size of the insurer's network, the type of provider being credentialed, the cost of accessing databases used in credentialing, and whether the insurer handles its own credentialing or if the insurer delegates its credentialing to a credentialing service. The Department asked insurers for input on whether their standards are compliant with proposed §3.3706(c), and if they are presently credentialing providers. The Department did not receive any input indicating that there would be an increased cost resulting from proposed §3.3706(c). The Department, however, anticipates that proposed §3.3706(c) could result in costs to comply for insurers.

The Department anticipates that an insurer may incur costs for time spent researching credentials and for fees for accessing credentialing databases as a result of compliance with proposed §3.3706(c). The Department has determined that an insurer may spend up to one hour per provider researching physician and provider credentials with an additional estimated access cost of $10.00 per physician to access the various credentialing databases. The Department anticipates that an insurer may opt to have

an administrative assistant perform these tasks. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission *OES Report.* Therefore, the Department estimates that an insurer could incur administrative staff costs of approximately $30.86 per provider in verifying credentials. as a result of compliance with proposed §3.3706(c). The Department anticipates that this monthly cost component will vary for each insurer depending on how many providers are researched for credentialing. The Department further anticipates that each insurer has the information necessary to determine its approximate estimated cost to comply with proposed §3.3706(c).

V. Cost to insurers concerning waiver requirements due to failure to contract in local markets.

Proposed §3.3707(b): Waiver of network adequacy standards due to failure to contract in local markets. Under proposed §3.3707(a), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the insurer may seek a waiver from one or more network adequacy requirements. Proposed new §3.3707(b) requires an insurer seeking a waiver to file the request with the Department and submit a copy of the request to any physician or provider named in the waiver at the same time that the request is filed with the Department. The insurer may use any reasonable means to submit the copy of the request to any provider or physician named in the request and is required to maintain proof of the submission. The Department anticipates that proposed

§3.3707(b) could result in costs to comply for insurers. The Department has determined that the total estimated cost for an insurer to comply with §3.3707(b) will vary depending on factors such as which local markets are included in the insurer's service area, the availability of physicians and providers in that service area, and the negotiating positions of the insurer and the available physicians and providers. The cost to comply with proposed §3.3707(b) could also vary according to the following cost components: (i) the cost to draft the waiver request; and (ii) the cost of sending the waiver to the Department and any physician or provider named in the request.

(i) Cost to draft waiver requests. The Department anticipates that an insurer could incur a cost for administrative staff as necessary to draft waiver requests to comply with proposed §3.3707(b). The Department has determined that an insurer may require from two to four hours to handle the tasks involved in drafting each specific waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff cost as a result of compliance with proposed §3.3707(b) ranging from $41.72 to $231.84 for each waiver requested. The Department anticipates that this cost will vary for each insurer depending on the number of waiver requests that

must be drafted and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing the waiver request to comply with proposed §3.37907(b)

(ii) Cost to transmit waiver requests by mail to the Department and any physician or provider named in the waiver requests. The Department anticipates that an insurer could incur a cost to transmit waiver requests to the Department, physicians, and providers as required in proposed §3.3707. The Department anticipates that an insurer could incur a cost for printing each page of the waiver request. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this cost estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit the requisite waiver requests by mail in accordance with the requirements of proposed §3.3707(b) will vary depending on the total number of waiver requests, the number of physicians and providers named in the request, and the business practices of the insurer. Further, insurers may opt to use less expensive

alternatives than mail for transmission of waiver requests to physicians and providers as permitted under §3.3707(b).

Proposed §3.3707(e): Requirement to apply for renewal of a waiver request annually. Under proposed §3.3707(e), an insurer is required to apply annually for renewal of a waiver that is granted by the Department pursuant to proposed §3.3707(e), and the insurer must submit the request for waiver at the same time that the insurer files the annual network adequacy report required under proposed §3.3709. The Department anticipates that insurers could incur costs to comply with proposed §3.3707(e). The Department has determined that the total estimated cost for an insurer to comply with proposed §3.3707(e) could vary depending on the factors relevant to the decision to file the initial request for a waiver pursuant to proposed §3.3707(d). The cost could also vary according to the following cost components: (i) the cost to draft the waiver renewal request; and (ii) the cost of sending the waiver renewal request to the Department and any physician or provider named in the request.

(i) Cost to draft waiver renewal requests. The Department anticipates that an insurer could incur a cost for administrative staff to draft waiver renewal requests. as necessary to comply with proposed §3.3707(e). The Department has determined that an insurer may require as much as one hour per specific waiver request per year to handle the tasks involved in drafting the waiver renewal request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an

insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur staff costs to comply with proposed §3.3707(e) of up to $57.96 per waiver renewal. The Department anticipates that this annual cost will vary for each insurer depending on the number of waiver renewal requests that must be drafted and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing them.

(ii) Cost to transmit waiver renewal requests by mail to the Department. The Department anticipates that an insurer will incur a cost if the insurer sends the Department the waiver renewal request to comply with the requirements of proposed §3.3707(e). The Department estimates that this cost could be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver renewal request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more

than $0.28 per mailing. However, the total cost to the insurer to transmit the requisite waiver renewal requests by mail to comply with proposed §3.3707(e) will vary depending on the total number of waiver renewal requests, the manner of transmission of the requests to physicians and providers, the number of physicians and providers names in the renewal requests, and the business practices of the insurer.

VI. Cost to insurers for payment of nonpreferred provider claims; related disclosures and waivers.

Proposed §3.3708: Requirements for reimbursements for nonpreferred provider claims when no preferred provider is reasonably available, requirements concerning methodologies used to determine reimbursement of nonpreferred providers generally, and required disclosures. Under proposed §3.3708(a), an insurer must comply with the proposed §3.3708(b) requirements when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances requiring emergency care and other certain specified circumstances. Under proposed §3.3708(b), when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, the insurer is required to: (i) pay such claim at the preferred benefit coinsurance level; and (ii) credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. Under proposed §3.3708(c), an insurer is required to calculate reimbursements of all nonpreferred providers for services that are covered under the health insurance policy pursuant to an

appropriate methodology. Under proposed §3.3708(c)(1), insurers that base reimbursements upon usual, reasonable, or customary charges are required to use a methodology that is based on the generally accepted industry standards and practices for determining the customary billed charge for a service that fairly and accurately reflects market rates, including geographic differences in costs. Alternatively, under proposed §3.3708(c)(2), insurers that base reimbursements on claims data are required to use a methodology that is based upon sufficient data to constitute a representative and statistically valid sample. Proposed §3.3708(c)(3) requires that either reimbursement methodology used by an insurer must be updated no less that once per year. Proposed §3.3708(c)(4) prohibits the insurer from using data that is more than three years old. Proposed §3.3708(c)(5) requires that the insurer's methodology must be consistent with nationally recognized and generally accepted bundling edits and logic. Proposed §3.3708(d) requires that an insurer pay all covered services at least at the plan's basic level of coverage, regardless of where the services are provided. Proposed §3.3708(e) requires that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available, the insurer is required to include a notice with each explanation of benefits that the insured has a right to request the following information for comparison purposes: (1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished; (2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers; and (3) the amount that would be paid under Medicare for the service.

Proposed §3.3708(f) provides a method for an insurer to apply for a six-month waiver of the requirements of §3.3708(e). The Department anticipates that proposed §3.3708 could result in costs for insurers. The Department anticipates that the insurer could incur cost in complying with proposed new §3.3708(b), relating to reimbursement of nonpreferred provider claims when no preferred provider is reasonably available, and in complying with proposed new §3.3708(c), relating to the utilization of the required methodologies to determine reimbursements of all nonpreferred providers. The cost could be based upon the following components: (i) the cost of programming the insurer's computer system to pay claims as required under proposed §3.3708(b); (ii) the cost of implementing any required changes to reimbursement methodologies and updating methodologies as required; (iii) the cost of additional credit for insureds' deductibles for out-of-pocket amounts, if applicable; (iv) the cost of acquisition of additional data concerning usual, reasonable, or customary charges if necessary; (v) the cost of acquisition of additional claims data if necessary; (vi) the cost of additional reimbursement amounts, if applicable, resulting from the update of reimbursement methodologies; (vii) the cost of paying for all covered services at least at the plan's basic level of coverage, regardless of where the services are provided; (viii) the cost of including a notice with each explanation of benefits relating to services rendered by a nonpreferred provider of the insured's right to request information for comparison purposes; (ix) the cost of providing information on request regarding reimbursement rates pursuant to other methodologies; and (x) the cost to apply for a temporary waiver of the requirements in proposed §3.3708(e).

(i) Cost of programming the insurer's computer system to pay claims as required under proposed §3.3708(b). The Department anticipates that an insurer's cost for programming its computer system to comply with the requirement of proposed §3.3708(b) will depend on the computer system used by each particular insurer. The Department anticipates that there could be a one-time programming cost for an insurer to program its computer systems to pay the specified claims of nonpreferred providers at the preferred benefit coinsurance level and credit out-of-pocket amounts toward the insured's deductible and annual out-of-pocket maximum. The Department anticipates that the number of required programming hours necessary to comply with proposed §3.3708(b) range from 10 hours for minimal programming to 100 hours for complex programming. Based on the Texas Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that an insurer's cost for computer programming time necessary to comply with proposed §3.3708(b) could range from approximately $385.10 to $3851.00. Additionally, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the cost of programming a computer system to pay claims as required by proposed §3.3708(b) will vary based on several factors, including the complexity of the insurer's current computer system, whether the insurer employs in-house programmers or contract programmers, and the number of hours needed to program the computer system.

(ii) Cost of implementing any required changes to reimbursement methodologies and updating methodologies as required. The Department anticipates that insurers could incur one-time initial costs in changing claims payment systems to comply with the methodological requirements in proposed §3.3708(c) if the insurer's reimbursements do not already conform to the requirements of the proposed rule. The Department estimates that these costs could include one to 300 hours of staff time to make any necessary changes to the insurer's reimbursement methodologies to conform to the requirements of §3.3708(c). The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report*. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur staff costs to comply with proposed §3.3708(b) that range from $20.86 to $17,388 for revision of the insurer's payment methodologies. The Department anticipates that this one-time cost will vary for each insurer depending on the insurer's current reimbursement methodologies and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing them. An insurer's costs of compliance with §3.3708(c) could also include programming costs for an insurer to program its computer systems to process specified nonpreferred provider claims and to automate updating functions in accordance with any changes in reimbursement

methodologies. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 200 hours to address complex programming needs. Based on the Texas Workforce Commission *OES Report*, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department has received estimates from insurers in the past indicating that the cost of contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract programmer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost to implement changes to its reimbursement methodologies based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

(iii) Cost of additional credit for insured's out-of-pocket amounts, if applicable. The Department anticipates that the cost of compliance with the requirement in proposed §3.3708(b)(2) that insurers credit to the insured's deductible and annual out-of-pocket maximum any out-of-pocket amounts actually paid to nonpreferred providers in cases where a preferred provider was not reasonably available will depend on: (a) the adequacy of the insurer's network; (b) the incidence of balance billing by

nonpreferred providers; (c) and payment of balance billed amounts by insureds; (d) the method used by the insured to submit claims; (e) the procedure used by the insurer to accept claims; and (f) the procedure used by the insurer to credit the out-of-pocket amounts appropriately. The Department anticipates that an insurer's primary cost of compliance will be staff time to receive and verify evidence of out-of-pocket payments by insureds and credit such amounts to insureds' deductibles and annual out-of-pocket maximum in the insurer's data systems. The Department has previously attempted to study the incidence of balance billing but has been unable to estimate its frequency. This is discussed in the Department's report entitled *Report of the Health Network Adequacy Advisory Committee, at page 15, January 2009, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc.* Therefore, the Department is unable to provide a reliable estimate for an insurer's compliance with this requirement.

(iv) Cost of acquisition of additional data concerning usual, reasonable, or customary charges if necessary. The Department anticipates that some insurers in order to comply with proposed new §3.3708(c)(1) may incur annual costs to acquire additional data for determining usual, reasonable, or customary charges in accordance with proposed §3.3708(c). The Department anticipates that the total amount of this cost will depend on several factors, including the insurer's current reimbursement methodologies, the size of the insurer, the service areas the data will be required to cover, and other facts specific to each insurer. The Department further anticipates that each insurer either has the information necessary or has access to the information

necessary to determine its estimated cost to acquire data concerning usual, reasonable, or customary charges based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

(v) Cost of the acquisition of additional claims data, if necessary. The Department anticipates that the cost to insurers to comply with proposed new §3.3708(c)(2) through the use of claims data will be negligible for insurers already utilizing such data. Insurers that base reimbursements on claims data prospectively may incur initial one-time costs to adapt their computer systems to acquire such internal claims data. The Department anticipates that the total amount of this initial one-time cost will depend on several factors, including the insurer's current reimbursement methodologies, the size of the insurer, and the format of the insurer's current claims data. These costs could include programming costs for insurers to program their computer systems to comply with the requirements relating to the utilization of updated claims data as specified in proposed §3.3708(c). Based on the Texas Workforce Commission *OES Report*, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department has received estimates in the past from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the number of hours required for such programming will likely vary considerably for each insurer depending on the factors noted herein. The Department anticipates that each insurer either has the information necessary or has access to the information to determine its estimated total one-time

cost to acquire additional claims data based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

(vi) Cost of additional reimbursement amounts, if applicable, resulting from the update of reimbursement methodologies. The Department anticipates that some insurers may incur additional claims costs to comply with proposed new §3.3708(c) due to revisions to their reimbursement methodologies. For example, the requirement to update data no less than once per year and not the prohibition against the use of data more than three years old might result in higher average claims data, potentially resulting in higher reimbursements of nonpreferred providers. The amount of the increase in reimbursements will depend on factors unique to each insurer, such as the data the insurer currently utilizes. Similarly, reimbursement rates could rise if the insurer's current reimbursement methodologies have not been based on generally accepted practices as required in proposed §3.3708(c)(1); have not fairly and accurately reflected market rates, including geographic differences in costs, as required in proposed §3.3708(c)(1); have not been based on sufficient data to constitute a representative and statistically valid sample, as required in proposed §3.3708(c)(2); have included data that is more than three years old, as prohibited in proposed §3.3708(c)(4); or have not been consistent with nationally recognized and generally accepted bundling edits and logic as required in proposed §3.3708(c)(5). The Department anticipates that each insurer has the information necessary or has access to the information to determine its estimated total costs for increased reimbursement

based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

(vii) Cost of paying for all covered services at least at the plan's basic level of coverage, regardless of where the services are provided. The Department does not anticipate that there will be a cost to insurers for implementation of §3.3708(d), which requires that carriers pay all covered basic benefits at least at the basic level of coverage for all covered services, regardless of where the services are provided. It is the Department's understanding that this is the current practice of insurers. However, if it was not the current practice of an insurer, the Department anticipates that each insurer would have the information necessary to determine its estimated total costs resulting from its implementation of proposed §3.3708(d), based on factors such as the size of the carrier, the current incidence of claims denied on this basis, and the dollar amount of claims denied on this basis.

(viii) Cost of including a notice with each explanation of benefits relating to services rendered by a nonpreferred provider of the insured's right to request information for comparison purposes. The Department anticipates that some insurers could incur costs in complying with proposed new §3.3708(e), which requires that, when services are rendered to an insured by a nonpreferred provider because a preferred provider is not reasonably available, the insurer is required to include a notice on each explanation of benefits that the insured has a right to request information as specified in proposed §3.3708(e) for comparison purposes. Insurers could incur costs for costs to their computer systems to provide this notice with appropriate explanations of benefits

to insureds when claims are adjudicated. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 100 hours to address complex programming needs. Based on the Texas Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost insurers as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract programmer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(ix) Cost of providing information on request regarding reimbursement rates pursuant to other methodologies. The Department anticipates that some insurers could incur costs in complying with proposed new §3.3708(e) when insureds make requests for the listed information about reimbursement amounts determined under different methodologies, including: (1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished; (2) the amount for the service calculated using the same method the insurer generally uses to determine

payments for basic benefits provided by nonpreferred providers; and (3) the amount that would be paid under Medicare for the service. Pursuant to §3.3708(e), insurers could incur cost in developing programming to provide, on request, the specified information. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 300 hours to address complex programming needs. Based on the Texas Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract programmer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(x) Cost to apply for a temporary waiver of proposed §3.3708(e). The Department anticipates that some insurers could incur cost in complying with proposed new §3.3708(f) in applying for a temporary waiver of the requirement to include a notice with each explanation of benefits that the insured has the right to request specified

comparison data when services are rendered to the insured by a nonpreferred provider because no preferred provider is reasonably available to the insured. The Department anticipates that an insurer could incur a cost to comply with proposed §3.3709(f) for administrative staff to draft the waiver request. The Department has determined that an insurer may require from two to five hours to handle the tasks involved in drafting the waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report*. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff costs ranging from $41.72 to $289.80 to submit the waiver request. The insurer could also incur a cost to transmit the waiver request. The Department anticipates that an insurer could incur a cost for printing each page of the waiver request as a result of compliance with proposed §3.3708(f). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six

pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit by mail the requisite waiver requests in accordance with proposed §3.3708(f) could vary for each insurer.

VII. Cost to insurers for annual network adequacy and access plan reports.

Proposed §3.3709(a) – (e): Requirement to file a network adequacy report and local market access plan, if applicable, with the Department annually before April 1 and prior to marketing any plan in a new service area. Proposed new §3.3709(a) requires an insurer to file an annual network adequacy report with the Department on or before April 1st of each year and prior to marketing any plan in a new service area. Proposed new §3.3709(b) and (c) specify the content required for inclusion in the annual report. Proposed new §3.3709(d) requires an insurer to submit a local market access plan if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements in §3.3704. Proposed new §3.3709(e) specifies the required content of the access plan. The Department anticipates that proposed §3.3709(a) – (d) could result in costs to comply for insurers. The Department anticipates that the insurer could incur costs associated with the requirement to file a network adequacy report and to file a local market access plan, as part of that report, if applicable. The Department anticipates that an insurer may incur a cost to comply with proposed §3.3709(a) – (d)

based upon the following components: (i) the cost of administrative staff to draft the annual adequacy report, including network data and the access plan; (ii) the cost of programming for necessary reports and increased requirements for complaint tracking; and (iii) the cost of implementation of procedures to assist insureds to obtain services when no preferred provider is reasonably available.

(i) Cost of administrative staff to draft the annual network adequacy report, including local market access plan. The Department anticipates that an insurer could incur cost for drafting of the annual report to comply with proposed new §3.3709 and any local market access plan to comply with proposed new §3.3709. The Department anticipates that an insurer is likely to opt to have either an administrative assistant or a general operations manager, or a combination of both, draft the requisite reports. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report*. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department anticipates that it could take from approximately 10 to 15 hours annually to draft the required annual report and an additional 20 to 40 hours annually to draft any required local market access plan. The Department therefore estimates that an insurer could incur the cost of administrative staff ranging from $625.80 to $3187.80 per year. The Department anticipates that this annual cost will vary for each insurer depending on the size of the insurer's service area, the adequacy of its network, the number of specific inadequacies identified in its network, and whether the tasks are performed by an administrative assistant or a

general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost to comply with proposed §3.3709 based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

(ii) Cost of programming for necessary reports and increased requirements for complaint tracking. The Department anticipates that an insurer could incur a one-time cost for programming its systems to be able to produce required data pursuant to §3.3709 to be included in annual network adequacy and any necessary local market access plan reports. According to the Texas Workforce Commission *OES Report*, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department anticipates that a programmer could require from 10 to 100 hours for the requisite programming. The Department therefore estimates that the programming cost could range from $385.10 to $3851.00. In addition to the Department's determination of cost estimates for this component, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total one-time cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated

total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

(iii) Cost of implementing of procedures to assist insureds to obtain services when no preferred provider is reasonably available. The Department anticipates that an insurer could incur an additional cost in implementing procedures to assist insureds in obtaining services when no preferred provider is reasonably available, as required by §3.3709(e). The cost of implementing such procedures will depend on a number of factors, including the adequacy of the insurer's provider network, the size of the insurer, and its internal processes. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

Proposed §3.3709(f)(1)(A): Requirement to establish and implement documented procedures to identify requests for preauthorization of services for insureds that require services of physicians or providers not contracted with the insurer. Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(1)(A), an insurer must utilize a documented procedure to identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer. The Department anticipates that proposed new §3.3709(f)(1)(A) could result in costs to comply for insurers. The

Department anticipates that an insurer could incur an initial one-time programming cost associated with establishing and implementing procedures to identify preauthorization requests from insureds for use in all service areas for which a §3.3709(d) local market access plan is submitted.

Cost of programming to identify insured's preauthorization requests. The Department anticipates that an insurer could incur costs for a computer programmer to program a system to identify preauthorization requests from insureds to comply with proposed new §3.3709(f)(1)(A). Based on the Texas Workforce Commission *OES Report*, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department estimates that a programmer could require from five to fifty hours to perform the requisite programming. Therefore, the Department estimates that the cost for such programming could range from $192.55 to $1925.50. In addition to the Department's determination of cost estimates for this component, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

Proposed §3.3709(f)(1)(B): Requirement to establish and implement a documented procedure to furnish insureds a pre-service estimate of the amount the insurer will pay the nonpreferred physician or provider; and to notify the insured of potential liability to physician or provider for additional amounts. Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Proposed §3.3709(f)(1)(B) requires an insurer to establish and implement documented procedures for use in all service areas for which a local market access plan is submitted to furnish insureds an estimate of the amount the insurer will pay the nonpreferred physician or provider prior to rendition of health care services.

The Department anticipates that proposed §3.3709(f)(1)(B) could result in a one-time cost to an insurer to program its computer systems to derive an estimate of payment amounts. The Insurance Code §1456.007 currently requires that an insurer provide, within 10 days of a request, an estimate of what it will pay for services rendered by an out-of-network provider. Section 3.3709(f) requires that for services that are the subject of an access plan, the insurer must be able to provide such information prior to services being rendered. The Department anticipates that the number of programming hours to comply with proposed §3.3709(f)(1)(B) may range from 10 hours for minimal programming to 100 hours for complex programming. Based on the Texas Workforce Commission *OES Report*, computer programmers working for insurers Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that the cost for

computer programming time could range from approximately $385.10 to $3851. Additionally, the Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that costs will vary depending on the insurer's current compliance with the Insurance Code §1456.007, the complexity of the insurer's current computer systems, whether the insurer uses a company staff computer programmer or a contract programmer and the number of hours needed for the requisite computer programming. The Department further anticipates that each insurer has the information necessary to determine its estimated cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3709(f)(1)(B).

Proposed §3.3709(f)(2): Requirement to utilize a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(2)(A), an insurer is required to utilize a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured. Under proposed §3.3709(f)(2)(B), an insurer is required to utilize a documented procedure to make initial and, if required, subsequent payment of such

claims at the preferred benefit coinsurance level. The Department anticipates that proposed new §3.3709(f)(2) could result in costs to comply for insurers. The anticipated costs for complying with proposed §3.3709(f)(2) are based on the cost of programming to supplement an access plan.

Cost of programming to supplement an access plan. The Department anticipates that an insurer could incur an initial one-time cost for programming needed to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured and make initial and, if required, subsequent payment to such claims at the preferred benefit coinsurance level, to comply with §3.3709(f)(2). The Department estimates that a programmer would require 10 to 100 hours to program the database to generate the correct payment to nonpreferred providers. Based on the Texas Workforce Commission *OES Report*, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. Therefore, the estimated one-time cost for a programmer's time would range from $385.10 to $3851.00. In addition to the Department's determination of cost estimates for this component, the Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's initial one-time cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed, whether the insurer uses a company staff programmer or a contract programmer, and how the insurer currently complies with the Insurance Code §1301.005, which requires insurers to reimburse nonpreferred providers at the same

percentage level of preferred providers if services are not available through a preferred provicer in the service area. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

Proposed §3.3709(i): Requirement to establish an access plan within 30 days of the date on which the network becomes noncompliant with the network adequacy requirements specified in §3.3704. Under proposed §3.3709(i), if the status of a preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the plan no longer complies with the network adequacy requirements specified in §3.3704 for a specific service area, the insurer is required to establish an access plan within 30 days of the date on which the network becomes non-compliant. The Department anticipates that only a few insurers will be required to comply with proposed §3.3709(i) because only those insurers that are in violation of the §3.3704 network adequacy standards for a specific service area will be required to establish an interim access plan. The Department assumes that most if not all insurers will comply with the rule. However, for any insurer that is required to comply with proposed §3.3709(i), the Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3709(d) (relating to the requirement to file a local market access plan with the Department annually) could be applicable to estimating the cost for compliance with proposed §3.3709(i) if the insurer's preferred provider service delivery network utilized

in any preferred provider benefit plan changes such that the insurer is required to establish an access plan. Specifically, the Department's cost analysis of §3.3709(d) (which is detailed in this Cost Note under the subheading for "Proposed§3.3709(a) and §3.3709(d)") in terms of administrative staff to draft access plan, would also be applicable to §3.3709(i). Interim access plans required under §3.3709(i) are only required to be filed with the Department upon request.

VIII. Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements

Proposed §3.3713(a), (b), and (d): Requirement to electronically submit to the Department information concerning the effects of uncompensated care. Under proposed §3.3713(a), effective seven years from the effective date of proposed §3.3713, an insurer is required to submit to the Department on the first business day of each July information concerning the effects of uncompensated care including: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. Under proposed §3.3713(b), the information concerning the effects of uncompensated care are required to be submitted to the Department electronically in a format acceptable to the Department, and the acceptable formats include Microsoft Word and Excel documents. Under proposed §3.3713(d), an insurer is required to include in facility contracts provisions permitting the insurer to obtain the information necessary to complete the required financial analysis. While full implementation of proposed §3.3713(a), (b), and

(d) is required as of seven years from the effective date of the section, the Department anticipates that insurers could begin to incur compliance costs within the first five years of the effective date.

The Department anticipates that an insurer could incur cost in complying with proposed §3.3713(a), (b), and (d). The estimated cost is based upon the following cost components: (i) programming to compile data to reflect the uncompensated care costs of contracted preferred provider facilities; (ii) staff time to begin preparations to draft required documents; and (iii) amendment of facility contracts to facilitate obtaining required data.

(i) *Cost of programming to compile data to reflect the uncompensated care costs of contracted preferred provider facilities.* The Department anticipates that insurers may incur an initial one-time cost for programming in order to comply with proposed new §3.3713(a). These costs could include programming costs for insurers to program their computer systems to compile the data received from contracted preferred provider facilities regarding their uncompensated care costs. Based on the Texas Workforce Commission *OES Report*, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the number of hours required for such programming will likely vary for each insurer depending on the number of contracted preferred provider facilities, the insurer's current computer systems, whether the insurer

gradually implements the requirement for its contracted preferred providers to report uncompensated care costs, and the extent to which the insurer already monitors uncompensated care costs of contracted preferred providers. The Department anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(ii) *Cost of staff time to begin preparations to draft required documents.* The Department anticipates that insurers may incur staff costs in preparing to draft the documents that will be required in years seven and beyond after the effective date of the rule. The Department anticipates that an insurer is likely to opt to have both an administrative assistant and a general operations manager work on the necessary preparations. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report*. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department anticipates that it could take up to 10 hours annually for both the administrative assistant and the manager to do the necessary preparatory work. The Department therefore estimates that an insurer could incur the cost of administrative staff of approximately $579.60 per year for a general operations manager and $208.60 per year for an administrative assistant for a total of approximately $788 per year. The number of hours will likely vary for each insurer depending on the number of contracted facilities and how the insurer chooses to implement the requirements. The Department anticipates that each insurer

has the information necessary to determine its estimated cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

(iii) *Cost of amending facility contracts to mandate that facilities provide required information.* The Department estimates that the total cost for an insurer to include the contract provisions required pursuant to §3.3713(d) may involve the following components, which are discussed in greater detail in the following cost analysis: (a) cost of less than one hour of administrative staff wages necessary to assist with drafting, updating, and reviewing contracts and amendments, per contract amended; (b) cost of less than one hour of legal drafting and review of contract terms and representation in contract negotiations in connection with reviewing new or amended contracts, per contract amended; (c) cost to print new contracts or amendments to existing contracts; and (d) cost to transmit new contracts or amendments to existing contracts to physicians and providers by mail or electronically. These costs may additionally vary as a result of pass-through costs from facilities.

(a) Cost of administrative staff wages for drafting and basic review related to contracts. The Department anticipates that an insurer's administrative staff will do most if not all of the drafting and basic review of new contracts or amendments to existing contracts. The Department anticipates that this drafting will likely require on average less than one hour of administrative staff time per contract modified. The cost to an insurer may vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both,

review the new or amended contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur an average annual cost of staff wages for drafting and basic review of contracts of less than $57.96 per contract, with variation anticipated depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, draft and review the new or amended contract language templates. The cost could also vary depending upon whether the contracting practices of an insurer require review of multiple or single contract templates, the extent to which contracts vary, and, if multiple contract templates or unique contracts are used, the number of such templates or unique contracts.

(b) Cost of legal staff. The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding each new contract or amendment of existing contracts that includes the provisions specified in proposed §3.3713(d). The Department anticipates that the legal review service from a lawyer will consist mainly of reviewing new or amended contracts drafted by the insurer's administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce *OES Report.* Therefore, the

Department estimates that an insurer might incur an average annual cost of less than $51.11 in legal costs on average for each new or amended contract reviewed. The cost could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, the number of such templates or unique contracts, and the insurer's position in contract negotiations. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost for contracting with an attorney in private practice for the legal review will likely vary from and might exceed the stated salaried hourly wage.

(c) Cost to print new contracts or amendments. The Department anticipates that an insurer could incur cost for printing new contracts or amendments to existing contracts in order to include contract requirements in facility contracts as specified in proposed §3.3713(d). The Department estimates that there will likely be approximately one page per contract and that the cost would be approximately $0.06 to $0.08 per page for printing and paper; the total cost will depend on the total number of pages and on the number of contracts the insurer chooses to amend. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, and in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

(d) Cost to transmit new contracts or amendments. The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail to include the contract provisions in facility contracts as specified in proposed §3.3713(d). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each contract or amendment of existing contracts that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract or per set of amendments of existing contracts. However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts or amendments, whether this cost is in addition to or subsumed in the cost of mailing contracts with new language pursuant to other portions of this proposed rule, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or amendments to existing contracts would be incurred by an insurer that opts to transmit new contracts or amendments electronically. These costs would simply be part of the ongoing information technology equipment and service costs of the insurer.

Though the Department has identified factors attributable to the cost of implementing proposed new §3.3713(d), it is not possible for the Department to estimate the total amount of cost attributable to proposed new §3.3713(d) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of existing preferred provider contracts.

Proposed §3.3713(c): Requirement to make the information concerning the effects of uncompensated care as reported to the Department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage. Under proposed §3.3713(c), effective eight years from the effective date of proposed §3.3713, an insurer is required to make the information concerning the effects of uncompensated care as reported to the Department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage, concerning the effects of uncompensated care including (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. While full implementation of proposed §3.3713(c) is required as of eight years from the effective date of the section, the Department anticipates that insurers could begin to incur compliance costs within the first five years of the effective date.

The Department anticipates that an insurer could incur costs associated with making the required information concerning the effects of uncompensated care as reported to the Department publicly available and providing such notice in all policies, certificates, and outlines of coverage. The Department anticipates that, because the proposed required notices will likely be sent to insureds at the time of policy renewal or issuance, no additional mailing costs will be incurred by the insurer. Therefore, the estimated cost for an insurer to comply with §3.3713(c) will depend on the cost of (i) administrative staff to prepare and include the required notice in all policies, certificates, and outlines; (ii) printing of notice of availability to be included in each policy, certificate, and outline of coverage; (iii) filing fees for Department approval of new policy, certificate and outline of coverage information; and (iv) printing and transmitting of the new policy, certificate and outline of coverage documents by mail to the Department.

(i) Cost of administrative staff to include the required notice in all policies, certificates, and outlines. The Department anticipates that preparing the required information concerning the effects of uncompensated care for public availability and providing such notice in all policies, certificates, and outlines of coverage as required in proposed §3.3713(c) will likely require a one-time cost of approximately 2 to 10 hours of administrative staff time. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, prepare the required notice and include the notice in all policies, certificates, and outlines. A general operations manager working for an insurer in Texas

earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur the one-time cost of administrative staff ranging from $41.72 to $579.60, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, to prepare the required information and include the required notice in all policies, certificates, and outlines.

(ii) Cost to print required notice of availability. The Department anticipates that the insurer will incur a cost for printing the required notice of the availability of the information concerning the effects of uncompensated care to be included in all policies, certificates, and outlines in order to comply with the requirements of proposed §3.3713(c). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper, and that the notice will take less than one page to print. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs, or out-of-house printing costs.

(iii) Cost of filing fees for approval of new policy, certificate and outline of coverage information. To comply with proposed §3.3713(c), insurers may need to file for Department approval, on a one-time basis, new policies, certificates and outlines of coverage, or endorsements thereto containing the required notice. The Department estimates that the insurer could incur a cost of $100 per form filed with the Department.

The cost, however, will vary depending on the number of forms filed by each insurer and whether the form is already being submitted to the Department due to other requirements of this proposed. The Department anticipates that each insurer has the information necessary to determine its estimated total cost to comply.

(iv) Cost to print and transmit new policy, certificate and outline of coverage documents by mail to the Department. The Department anticipates that the insurer will incur a cost if an insurer opts to transmit the amended documents to the Department by mail. The Department anticipates that an insurer could incur a cost for printing each page. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each amended document that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per document. However, the total cost to the insurer to transmit by mail the requisite documents in accordance with proposed §3.3713(c) will vary depending on the total number of documents amended, total number of pages printed and mailed, whether document amendments

relating to multiple requirements of this proposed rule could be filed in a single mailing, and the business practices of the insurer.

Proposed §3.3713(e): Waiver from some or all of the §3.3713 requirements relating to the submission and disclosure of information concerning the effects of uncompensated care. Under proposed §3.3707(e), an insurer may apply for a six-month waiver from some or all of the §3.3713 requirements regarding uncompensated care costs of contracted preferred providers by submitting to the Department, as specified under proposed §3.3713(e)(1), a waiver application on 8 ½ by 11 inch paper that is legible, in typewritten, computer-generated, or printer's proof format; and signed by an officer of the insurer. Proposed §3.3713(e)(2), specifies the Department address to which the waiver application must be mailed. Under proposed §3.3713(e)(3), an application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including: (i) undue hardship, including financial or operational hardship; (ii) the geographical area in which the insurer operates; (iii) total number of insureds covered by the insurer and the number of insureds impacted by the waiver; (iv) specification of the insurer's plan to achieve compliance with the §3.3713(a) – (d) requirements, including identification of actions already taken and those planned to be taken; and (v) the estimated cost of compliance with §3.3713(a) – (d) and an estimate of the increased cost for compliance at an earlier date. The Department anticipates that submission of the waiver application contemplated by proposed §3.3713(e) could result in costs to comply for insurers.

The Department has determined that an insurer that opts to apply for a §3.3713(e) waiver could incur costs to prepare and submit the waiver. The Department's estimate is based upon the following cost components: (i) drafting of the waiver request; and (ii) mailing the waiver request to the Department

(i) Cost to draft the waiver request. The Department anticipates that an insurer could incur a one-time cost for administrative staff to draft the waiver request to comply with proposed §3.3713(e). The Department has determined that an insurer may require from four to six hours of staff time to handle the tasks involved in drafting the waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff cost ranging from $83.44 to $347.76 in preparation of the waiver request. The Department anticipates that this cost will vary for each insurer depending on the complexity of the waiver request that must be drafted and whether the insurer opts to have an administrative assistant or general operations manager perform the tasks involved in preparing the waiver request. The Department further anticipates that each insurer has the information necessary to determine its estimated cost based on

these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3713(e).

(ii) Cost to mail waiver request to the Department. The Department anticipates that an insurer that elects to file a waiver request could incur a cost to mail the waiver request to the Department as required by proposed §3.3713(e)(2. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request submitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit by mail the requisite waiver requests in accordance with proposed §3.3713(e)(2) will vary depending on the complexity of the waiver request and the business practices of the insurer. The Department anticipates that each insurer has the information necessary to determine its estimated mailing cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3713(e)(2).

The Department does not anticipate any additional cost to persons required to comply with the proposed amendments and new sections of this proposal. Any other costs to such persons for each year of the first five years the proposed amendments and new sections will be in effect are the result of existing statutory requirements and regulations and not the result of the adoption, enforcement, or administration of the proposed amendments and new sections.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small or micro 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 §2006.001(1) does not specify a maximum level of gross receipts for a "micro business." 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

In accordance with the Government Code §2006.002(c), the Department has determined that the proposed amended sections if adopted might have an adverse economic effect on approximately five health plan issuers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that would be required to comply with the proposed new sections and amendments. The estimated number of small and micro businesses is based on an analysis of the results of a survey of insurers with preferred provider health benefit plan products on file with the Department. In that survey, five health plan issuers indicated that they qualify as small businesses.

The Department has identified eight sets of requirements that may result in compliance costs to small and micro-business insurers. These costs will result only to those small and micro-business insurers that offer preferred provider benefit plans in Texas. These sets of requirements are: (i) proposed §3.3703 concerning contract requirements; (ii) proposed §3.3704 concerning network adequacy requirements and insureds' freedom of choice; (iii) proposed §3.3705 concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations; (iv) proposed §3.3706 concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process; (v) proposed §3.3707 concerning waiver requirements due to failure to contract in local

markets; (vi) proposed §3.3708 concerning payment of certain basic benefit claims and related disclosures and waivers; (vii) proposed §3.3709 concerning the annual network adequacy and access plan reports; and (viii) proposed §3.3713 requiring submission and disclosure of information concerning the effect of uncompensated care and waiver to that requirement. These costs are more fully discussed in the Public Benefit/Cost Note part of this proposal, as is the potential use of a PPO network as an alternative means to achieve compliance.

Regulatory Flexibility Analysis

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 flexibility 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.

I. Cost to insurers concerning contract requirements. ***Proposed §3.3703(a)(23) and §3.3703(a)(24): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred***

providers and of ownership interest in the facility to which the insured is being referred.

Proposed new §3.3703(a)(23)(A) and (B) specify that a contract between an insurer and a non-institutional preferred provider may contain, at the insurer's option, provisions requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or provider has an ownership interest in the facility to which the insured is being referred. Proposed new §3.3703(a)(24) specifies that contractual provisions permitted in new §3.3703(a)(23)(A) and (B) must allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers. The cost of compliance with proposed new §3.3703(a)(23)(A) and (B) will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though proposed new §3.3703(a)(23)(A) and (B) may have an adverse economic effect on small or micro businesses that elect to include new permitted contractual terms, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code because small or micro businesses are not required by statute or by this proposed rule to make any contractual changes as a result of proposed 3.3703(a)(23)(A) and (B). Therefore,

those small and micro businesses that modify their preferred provider contracts to include the new permitted provisions do so at their own choice, and as a result they agree to bear the additional costs required for compliance with proposed new §3.3703(a)(23)(A) and (B).

The limitations on such optional contractual provisions stated in new §3.3703(a)(24) reflect the current statutory prohibition in the Insurance Code §1301.067 that prohibits insurers from interfering with the relationship between the patient and their physician, and the current requirements in the Insurance Code §§1301.005 and 1301.006, that require all covered health care services be made available and accessible. In accordance with the Government Code §2006.002(c-1), the Department has determined that §3.3703(a)(24) does not require a regulatory flexibility analysis because the proposed provision reflects current statutory provisions and provides exceptions to the use of newly permitted optional contractual provisions. Therefore, the small or micro-business insurer will not incur any costs for compliance that they do not opt to incur.

Proposed §3.3703(a)(25): Contract provisions between an insurer and a preferred provider that mandate that a preferred provider comply with all applicable requirements of the Insurance Code §1661.005. Proposed §3.3703(a)(25) specifies that a contract between an insurer and preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005, relating to refunds of overpayments from enrollees. (Note: Some statutory provisions referenced in this proposal use the term “enrollees” and

some use the term “insureds”; but the Department interprets these two terms to have the same meaning for purposes of this proposal.) The Insurance Code §1661.005, effective May 30, 2009, mandates that a physician, hospital, or other health care provider that receives an overpayment from an enrollee refund such overpayment within 30 days of the date the determination an overpayment was made. Proposed new §3.3703(a)(25) mandates that this statutory requirement be included in any contract between an insurer and a preferred provider. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department’s cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the proposed new §3.3703(a)(25) may have an adverse economic effect on small or micro businesses, it is neither legal nor feasible to waive the provisions of the subsection for small or micro businesses. It is the Department’s position that to waive or modify the requirements of the subsection for small or micro businesses could be interpreted as permitting providers to violate the statutory requirement of the Insurance Code §1661.005 to return overpayments timely. Further, the Department does not directly regulate providers or their billing practices and thus has no direct authority to enforce the requirements of §1661.005 absent a contractual requirement that the Department may require an insurer to enforce. Only by requiring all provider contracts to contain this prohibition, regardless of the size of the insurer, will

the Department be able to enforce the requirements of §1661.005 and protect the economic welfare of insureds. Nevertheless, the Department considered exempting small and micro businesses from this requirement, but concluded that this would lead to confusion on the part of providers, who in virtually every case will also be contracted with insurers that do not qualify as small or micro businesses, and will be required by their contracts with those insurers to comply with the Insurance Code §1661.005. Further, without the requisite contractual requirement that all insurers, regardless of size, return overpayments to their insureds, those insureds who have coverage through small or micro-business insurers would not be able to request the assistance of their insurer in seeking return of the overpayment through enforcement of the contractual provision. Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that there are no regulatory alternatives to new §3.3703(a)(25) that would meet the objectives of the law and this regulation and be consistent with the health and economic welfare of the state.

Proposed §3.3703(a)(23)(A) and (B): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred providers and of ownership interests in facilities to which the insured is being referred. Proposed new §3.3703(a)(23)(A) and (B) specify that a contract between an insurer and a non-institutional preferred provider may contain provisions at the insurer's option requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or

provider has an ownership interest in the facility to which the insured is being referred. The Department anticipates that proposed §3.3703(a)(23)(A) and (B) could result in costs to comply for small and micro-business insurers. The cost of compliance with these provisions will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

As required by §2006.002(c-1) of the Government Code, the Department considered alternatives to proposed §3.3703(a)(26) that would minimize adverse impact on small or micro businesses. For example, the Department considered exempting small and micro-business insurers from one or more of the provisions of proposed §3.3703(a)(23)(A) and (B) altogether and considered modifying the contract requirements for small and micro-business insurers, but concluded that such alternatives would not adequately achieve the purpose of the proposed rule to provide important information to consumers and thereby protect all insureds in Texas regardless of the size of their insurer. Additionally, exempting small and micro-business insurers from proposed §3.3703(a)(23)(A) and (B) would limit the insurers' ability to comply with the requirement in proposed §3.3705(n) that the insurer notify insureds of a substantial decrease in the availability of preferred facility-based physicians at preferred provider facilities. This would likely result in insureds of small and micro-business insurers being balance billed by new facility based physician groups without adequate notice to the insured and without recourse by the insured based on any lack of notice. Similarly,

exempting small and micro-business insurers from proposed §3.3703(a)(23)(A) and (B) could limit their insureds from being able to obtain information about facility-based physicians' typical billed charges. It would also limit the Department's ability to obtain comprehensive information about facility-based physician fees. The Department also considered modifying the requirements of proposed §3.3703(a)(23)(A) and (B) in the case of small and micro-business insurers. For instance, the Department considered extending the period of time for facilities to provide insurers notice of the departure of a facility-based physician group. However, the Department determined that this would reduce the protections to insureds of small and micro-business insurers with no significant financial savings to the small or micro-business insurers in terms of contracting costs. Similarly, permitting facility-based physicians to disclose less information about their billed charges in the context of a small or micro-business insurer or provide less information to the Department in response to surveys would significantly limit public access to billing information with little or no cost savings to small or micro-business insurers.

II. Cost to insurers concerning network adequacy requirements.

Proposed §3.3704(e) and (f): Network adequacy requirements, monitoring, and corrective actions. Proposed new §3.3704(e) requires that each preferred provider benefit plan include a health care delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements mandated in proposed §3.3704. Proposed new §3.3704(f) requires that each insurer monitor compliance with the network adequacy requirements of proposed

§3.3703(e) on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. The Department anticipates that proposed §3.3704(e) and (f) could result in costs to insurers to comply. The cost of compliance with the proposal will not vary between large insurers and small or micro-business insurers, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to the proposed §3.3704(e) and (f) that would minimize adverse impact on small or micro-business insurers. For example, the Department considered exempting small and micro-business insurers from one or more of the provisions of proposed §3.3704(e) and (f) altogether and considered modifying the network requirements for small and micro-business insurers, but concluded that such alternatives would not adequately achieve the purpose of the proposed rule to ensure, pursuant to the Insurance Code §1301.005 and §1301.006, that all insureds in Texas have reasonable access to preferred provider benefits and that adequate contracted personnel, specialty care, and facilities are available and accessible to all such insureds. Exempting small and micro businesses from the network requirements in proposed §3.3704(e) or even reducing the network requirements for those insurers within their service areas could result in additional costs and potentially less access to care for insureds of small or micro-business insurers. Consumers are generally unable to shop for health insurance on the basis of the adequacy of a network, both because they generally do not know what types of care they will require in the future and

because it is difficult to recognize when there are gaps in the adequacy of a network. Section 1301.006 of the Insurance Code requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. The intent of this statutory requirement is that consumers can expect that an adequate network will be provided, regardless of the size of the insurer. Further, if a small or micro-business insurer is unable to contract for an adequate network, there are alternatives under the proposed rule that enable such an insurer to apply for a waiver of network requirements or file an access plan to ensure that care will be available. Additionally, pursuant to proposed §3.3704(g), a small or micro-business insurer will be able to elect to operate in a limited service area, thus limiting the amount of contracting that will be necessary for compliance, and thereby exempt itself to some extent from network adequacy requirements. For these reasons, the Department has determined, in accordance with the Government Code §2001.006(c-1), that there are no alternative methods of accomplishing the objective of network adequacy for all insureds in Texas, regardless of the size of the insurer, while minimizing any adverse economic impact on small or micro businesses.

III. Cost to insurers concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations.

Proposed §3.3705(b)(14), (e)(2), (f), (h), (i), (k), (l)(1),- (l)(2), (l)(4) – (l)(11), and (m) – (q). Proposed amendments to §3.3705 impose a number of new requirements on insurers relating to mandated communications with the public. Proposed §3.3705(b)(14) requires that an insurer offering a preferred provider benefit plan provide information that is updated at least annually regarding the demographics of the insurer's network as part of the written description of the insurer's policy terms and conditions that the insurer must furnish upon request to current and prospective group contract holders and insureds. Proposed new §3.3705(e)(2) requires insurers that maintain an Internet website for use by prospective consumers or current insureds to provide an online (Internet-based) listing of state regions, counties or three-digit ZIP Code areas within the insurer's service area that indicates the areas that the insurer has determined that meet and that do not meet the network adequacy requirements. Proposed new §3.3705(f) specifies that insurers must provide a notice of rights under a network plan in all policies, certificates, and outlines of coverage in at least 12 point font. Proposed new §3.3705(h) requires insurers to provide notice to insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. Proposed new §3.3705(i) requires insurers to update their electronic and non-electronic preferred provider listings every three months. Proposed new §3.3705(k) requires insurers pay out of network claims at the preferred coinsurance level if an insured reasonably relies on an inaccurate listing maintained by the insurer. Proposed new §3.3705(l)(1) requires insurers to provide a method for insureds to identify those hospitals that have contractually agreed with the insurer to exercise good faith efforts to

accommodate requests from insureds to utilize preferred providers and to provide information to insureds that support a determination of the status of facility-based physicians or physician groups as preferred or nonpreferred providers. Proposed new §3.3705(l)(2) specifies that in all preferred provider listings, the insurer must include a method for insureds to identify those hospitals at which more than ten percent of the dollar amount of total claims filed with the insurer were by or on behalf of physicians not under contract with the insurer. Proposed §3.3705(l)(4) requires an insurer to indicate whether each preferred provider is accepting new patients in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Proposed new §3.3705(l)(5) requires insurers to provide notice in all preferred provider listings of those preferred providers that have notified the insurer of participation in a regional quality of care peer review program. Proposed new §3.3705(l)(6) specifies that an insurer is required to provide a method by which insureds may notify the insurer of inaccurate information in the preferred provider directory. Proposed new §3.3705(l)(7) requires an insurer's preferred provider directory contain information on how insureds can identify facility-based physicians that are able to provide services at preferred provider facilities. Proposed §3.3705(l)(8) requires that in all preferred provider listings, including any Internet-based postings of information made available by the insurer, the provider information must be provided in fonts of not less than 10-point type. Proposed new §3.3705(l)(9) requires an insurer's preferred provider listing specifically identify those facilities at which the insurer has no contracts with the applicable type of facility-based physician. Proposed new

§3.3705(l)(10) requires an insurer's preferred provider listing specifically identify those facilities at which the insurer has a contract with facility-based physicians that have an exclusive contract with the facility and to specify the physician type. Proposed §3.3705(l)(11) requires an insurer to specify in its provider listings the date on which each required element of information is provided to the insured. Proposed new §3.3705(m) requires insurers operating a preferred provider benefit plan that relies upon an access plan to provide notice of this fact to each individual and group policy holder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. Proposed new §3.3705(n) requires insurers provide notice on their website and in their online preferred provider listing of a substantial decrease in preferred facility-based physicians. Proposed §3.3705(o) requires that insurers make disclosures in all insurance policies, certificates, and outlines of coverage concerning the method of reimbursement of basic benefit services from nonpreferred providers. Proposed new §3.3705(p) specifies that any plan that uses a preferred provider service delivery network that does not comply with proposed network adequacy requirements for hospitals to disclose on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network that the plan has a "Limited Hospital Care Network." Proposed new §3.3705(q) specifies that if a preferred provider benefit plan designated as an Approved Hospital Care Network (AHCN) no longer complies with the network adequacy requirements for hospitals under §3.3704 and does not correct such noncompliance within 30 days, the insurer is required to notify the

Department in writing, cease marketing as an AHCN, and inform insureds of the change at the time of renewal.

The Department anticipates that the proposed amendments to §3.3705 will result in costs to comply for small and micro-business insurers. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to the proposed §3.3705 amendments that would minimize adverse economic impact on small or micro businesses. The Department considered exempting small or micro businesses from all or part of the new proposed requirements in §3.3705 but concluded that such exemptions would not adequately achieve the purpose of the proposed new requirements to ensure that consumers receive necessary information about health benefit plans so that they may conduct adequate comparisons and make informed decisions concerning the selection or retention of a health care plan. If the Department exempted small or micro businesses from any or all of the proposed §3.3705 requirements, the insureds of those small and micro-business insurers would be greatly disadvantaged. For example, if the Department exempted small or micro businesses from the requirement to provide network demographics, as required by proposed §3.3705(b)(14), consumers would be unable to make an "apples to apples" comparison of health plans when shopping for coverage. Another example is that while consumers would be able to determine the

ratio of current insureds to pediatricians for large carriers, consumers would be unable to do so for small carriers. Similarly, consumers would be able to learn where within the state large carriers' networks are inadequate, as required by §3.3705(e)(2), but would be unable to do so for small carriers. Exempting small or micro-business insurers from §3.3705(k), which contains a remedy for consumers that rely upon recently obtained provider directories, could result in insureds of those plans being less able to rely upon the accuracy of those documents and less likely to have a remedy if a carrier fails to regularly update them. Exempting small or micro-business insurers from the requirements of §3.3705(o), which provides significant transparency regarding how insurers determine their out-of-network reimbursements could result in small or micro-business insurers utilizing inappropriate reimbursement methodologies, and thereby impose potentially significant and unexpected out of pocket expenses. Reducing or eliminating the notices to insureds of small and micro-business insurers that are required in §3.3705 could increase those insureds' potential liability for balance bill amounts. Exempting small or micro-business insurers from the new requirements of §3.3705 would result in their insureds not receiving information necessary to compare different health plans, understand the benefits and limitations of the health plans they enroll in, or to make informed choices regarding where they obtain their health care.

Therefore, the Department has reviewed each new requirement in §3.3705 and has determined that there are no alternatives to the proposed new requirements that would be sufficiently protective of the health and economic welfare of those consumers

insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

IV. Cost to insurers concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process

Proposed §3.3706(a)(5): Prohibition against avoiding high risk populations when selecting participating preferred providers and proposed §3.3706(c): Requirement to have a documented process for selection and retention of preferred providers that are adequately credentialed. Proposed new §3.3706(a)(5) specifies that insurers cannot exclude physicians or providers because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization or because they treat or specialize in such populations. Proposed new §3.3706(c) requires that at a minimum, an insurer's credentialing standards are required to meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC. Under proposed §3.3706(c), an insurer is also required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed.

The Department anticipates that proposed new §3.3706(a)(5) and (c) could result in costs to comply for small and micro-business insurers that are not currently compliant with the proposed requirements. The cost of compliance with proposed new §3.3706(a)(5) and (c) will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for

insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to proposed §3.3706(a)(5) and (c) that would minimize any adverse impact on small or micro businesses. For instance, the Department considered exempting small or micro businesses from all or part of these proposed provisions but concluded that such exemptions would not adequately achieve the purpose of the proposed provisions to ensure that insurers cannot refuse to contract with providers in high risk areas and that insurers contract only with providers who are adequately credentialed and in accordance with a documented process designed for this purpose. The proposed §3.3706(a)(5) prohibition is necessary to ensure that insurers afford all providers a fair, reasonable, and equivalent opportunity to apply to be and to be designated as preferred providers, as required by the Insurance Code §1301.051. The proposed prohibition also reflects the requirement of the Insurance Code §1301.058 that any economic profiling of providers conducted by insurers be adjusted to recognize the characteristics of a particular provider's practice that may account for variations from average costs. Additionally, the proposed §3.3706(a)(5) prohibition ensures that a health insurance policy providing for the use of preferred providers is not unjust as prohibited under the Insurance Code §1701.055(a)(2). Exempting insurers because of their smaller size from all or part of proposed §3.3706(a)(5) and (c) could also result in insureds covered by small and micro-business insurers making plan choices without knowledge that the small or micro-business insurer has chosen to exclude qualified providers for impermissible reasons that do not

relate to the providers' qualifications or the quality of care that they provide or include providers whose credentials have not been verified. Exempting insurers because of their smaller size from all or part of proposed §3.3706(a)(5) and (c) could also result in all medical and health care services and items contained in the package of benefits for which coverage is provided not being accessible or available as required in the Insurance Code §1301.006. For these reasons, the Department, in accordance with the Government Code §2006.002(c-1), has determined that there are no alternative methods of accomplishing the objectives of proposed §3.3706(a)(5) and (c) that will adequately protect the health and economic welfare of all insureds in Texas, including those insured by small or micro-business insurers, while minimizing any adverse economic impact on small or micro businesses.

V. Cost to insurers concerning waiver requirements due to failure to contract in local markets.

Proposed §3.3707(b): Waiver of network adequacy standards due to failure to contract in local markets. Under proposed §3.3707(a), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the insurer may seek a waiver from one or more network adequacy requirements. Proposed new §3.3707(b) requires an insurer seeking a waiver to file the request with the Department and submit a copy to any physician or provider named in the waiver. Proposed new §3.3707(e) requires an insurer seeking a waiver to file the renewal request with the Department annually at the

same time the insurer files the annual network adequacy report required under proposed §3.3709. The Department anticipates that the proposed §3.3707 could result in costs to comply for small and micro-business insurers. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code regarding proposed §3.3707 because small or micro-business insurers are not required by statute or by this proposed rule to request a waiver. Therefore, those small and micro-business insurers that request a waiver do so at their own choice, and as a result, they agree to bear the additional costs required for compliance with this proposal. Nevertheless, the Department considered alternatives that could assist small or micro-business insurers in obtaining waivers, such as allowing small or micro-business insurers to seek waivers through electronic applications, making the size of the insurer an element to be considered in the grant of a waiver, or having waivers granted to smaller insurers be effective for more than one year. However, the Department concluded that such modifications would not adequately achieve the purpose of the proposed section. The purpose of requiring the mailing of waiver requests, rather than electronic filing, is to be consistent with current Chief Clerk procedures and not add additional expense to the state in creating new electronic processes. Permitting small and micro-business

insurers to make electronic filings of waiver requests, while declining to permit large insurers to do so, would impose additional cost to the State at little cost savings to small or micro-business insurers. Section 3.3707 does not place any significant restrictions on the content of a waiver application, and, therefore, the Department is unable to reduce the content requirements for small and micro-business insurers. Section 3.3707 contemplates a process in which waivers are granted only in cases where the local market conditions justify the waiver and that the waiver last only so long as necessary. Insureds purchasing preferred provider benefit plans are entitled to adequate networks of providers within the advertised service area regardless of the size of the insurer, and easing the requirements of obtaining a waiver by making the size of the insurer a factor in the grant of the waiver would potentially harm insureds who might not have the same ability to access care as insureds of large insurers. Additionally, the Department does not anticipate that there will be significant additional expense to insurers in renewing their requests for previously granted waivers, but extending those waiver periods for small or micro-business insurer for longer periods than necessary could result in harm to insureds needing services that have been the subject of a waiver. Additionally, waivers are only necessary within the service area of the insurer. Small and micro-business insurers will be able to limit their service areas under the rule and thus limit the necessity to apply for waivers from the Department. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of §3.3707 while minimizing any adverse impact on small or micro businesses.

VI. Cost to insurers for payment of nonpreferred provider claims; related disclosures and waivers.

Proposed §3.3708: Requirements for reimbursements of nonpreferred provider claims when no preferred provider is reasonably available, requirements concerning methodologies used to determine reimbursement of nonpreferred providers generally, and required disclosures. Proposed §3.3708 generally applies to services provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured. In such a case, the insurer is required to pay the claim at the preferred benefit coinsurance level as required pursuant to the Insurance Code §1301.005(b) and §1301.155(b). Proposed new §3.3708(b)(2) also requires the insurer to credit out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. Proposed new §3.3708(c) more broadly requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria. Proposed new §3.3708(d) requires insurers to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan. Proposed §3.3708(e) imposes a disclosure requirement on insurers that applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as provided in proposed §3.3708(a)(1) – (3). In such cases, the insurer is required to disclose with each explanation of benefits that the insured has the

right to request three categories of reimbursement data in relation to the claim for comparison purposes. Section 3.3708(e) is proposed to apply effective January 1, 2012, and the Department proposes to provide for a six-month waiver process with respect to the disclosure in §3.3708(f).

The Department anticipates that proposed §3.3708 will result in costs to comply for small and micro-business insurers. The cost of compliance with proposed §3.3708 will not vary between large businesses and small or micro businesses. The Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered exempting small or micro-business insurers from all or part of the requirements in §3.3708, but determined that neither a full or partial exemption would be consistent with the objectives of the rule. The requirement in §3.3708(b)(1) that insurers pay out of network claims under the enumerated circumstances at the preferred benefit coinsurance level is identical to the statutory requirements under the Insurance Code §§1301.005(b) and 1301.069 and thus could not be waived for small or micro-business insurers. The requirement in §3.3708(b)(2), that out of pocket amounts expended by consumers be credited to their deductible and out of pocket maximum, is intended to protect insureds who do not voluntarily choose to obtain services from out of network providers by giving the insureds credit for their actual out of pocket expenses in the same manner they would receive such credit if they had received services from a contracted provider. Waiver or modification of this

requirement for small or micro-business insurers could unfairly subject the insureds of these small and micro-business insurers to greater health care expenses. The requirements in proposed §3.3708(c) for standardized methodologies for out of network claim reimbursements will help to ensure that reimbursement rates are based upon relevant, current, and statistically valid data. Accordingly, the potential unexpected balance billing to which insureds are subjected as a result of health care emergencies and inadequate networks may be mitigated, giving both providers and insureds greater confidence that the methodologies underlying reimbursement determinations are appropriate. Furthermore terms used in preferred provider benefit plan documents will have consistent meanings as applied by different insurers, and will provide clear standards to the Department to apply when reviewing the appropriateness of out of network reimbursement methodologies. Wavier or modification of these requirements for small or micro-business insurers could result in such insurers utilizing inappropriate methodologies to the detriment of their insureds and result in insureds and providers of small and micro-insurers encountering significant inconsistencies in payments within the market. The requirement in proposed new §3.3708(d) to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan, is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005. Wavier or modification of the proposed §3.3708(d) requirement for small or micro-business

insurers could result in their insureds having no coverage when services are rendered outside of the service area of a small of micro-business insurer. This could result in substantial financial hardship for insureds of small and micro-business insurers. The disclosure required by §3.3708(e) is necessary to provide important information to insureds faced with the financial consequences of unanticipated balance bills that arise due to the need for emergency care or due to the failure of the insurer to provide an adequate network. The disclosure required by §3.3708(e) will provide insureds the ability to obtain information on request to evaluate the reimbursement made by the insurer and the payment requested by the provider and to determine whether to request mediation as permitted under the Insurance Code §1467.054 for eligible claims or to otherwise contest the billed charge. Waiver or modification of the §3.3708(e) requirement for small or micro-business insurers would unfairly leave insureds of such insurers without information necessary to evaluate balance bills that they receive.

In accordance with the Government Code §2001.001(c-1), the Department has reviewed every provision of §3.3708 and has determined that there are no alternatives to these provisions that would be sufficiently protective of the health and economic welfare of those consumers insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

VII. Cost to insurers for annual network adequacy and access plan reports.

Proposed §3.3709(a) and §3.3709(d): Requirement to file a network adequacy report and local market access plan, if applicable, with the Department annually before April 1 and prior to marketing any plan in a new service area.

Proposed new §3.3709(a) requires an insurer to file a network adequacy report with the Department on or before April 1 of each year and prior to marketing any plan in a new service area. Proposed new §3.3709(d) requires an insurer to submit a local market access plan if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements in §3.3704. Proposed new §3.3709(f)(1)(A) requires insurers to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(1)(A), an insurer must utilize a documented procedure to identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer. Proposed §3.3709(f)(1)(B) requires an insurer to establish and implement documented procedures for use in all service areas for which a local market access plan is submitted to furnish insureds an estimate of the amount the insurer will pay the out-of-network physician or provider prior to their services being rendered. Proposed §3.3709(f)(1)(C) requires an insurer to notify the insured of potential liability for any amounts charged by the physician or provider that are not paid in full by the insurer. Proposed §3.3709(f)(2) requires that insurers utilize a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. Proposed §3.3709(h) requires that insurers file annual network adequacy reports and access plans, if applicable,

electronically to the Department using Microsoft Word or Excel documents. Proposed §3.3709(i) requires that insurers establish an access plan within 30 days of the date on which their network becomes noncompliant with the network adequacy requirements specified in §3.3704.

The Department anticipates that proposed §3.3709 will result in costs to comply for small and micro-business insurers. The cost of compliance with proposed §3.3709 will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered exempting small or micro-business insurers from all or part of the requirements in §3.3709 but determined that neither a full or partial exemption would be consistent with the objectives of the rule. The objectives of proposed §3.3709 are to permit ongoing monitoring of insurer compliance with network adequacy standards by the Department and to ensure that insurers are taking reasonable steps to reduce the potential scope of unanticipated balance bills. If small or micro-business insurers were fully or partially exempted from these requirements, the Department would not be able to adequately monitor their compliance, and their insureds could face greater risk of financial hardship due to balance billing.

In accordance with the Government Code §2001.001(c-1), the Department has reviewed every provision of §3.3709 and has determined that there are no alternatives to these provisions that would be sufficiently protective of the health and economic

welfare of those consumers insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

VIII. Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements

Proposed §3.3713: Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements. Proposed §3.3713 is not effective until the expiration of seven years from the effective date of the section. At that time, insurers are required under §3.3713(a) to initiate an annual reporting requirement that provides to the Department, in accordance with the requirements of §3.3713(b), the following information: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. Effective at the expiration of eight years from the effective date of §3.3713, proposed §3.3713(c) requires insurers to make the information concerning the effects of uncompensated care as reported to the Department publicly available and to provide notice of the availability of such information in each policy, certificate, and outline of coverage. Proposed §3.3713(d) requires that an insurer's contract with a facility contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required under §3.3713. Proposed §3.3713(a) – (d) is necessary to provide information to both the Department and the interested public concerning the relationship of uncompensated care to health care costs incurred by insurers and insureds.

Information concerning the impact of uncompensated care upon health care fees and insurance premium rates will help insureds to educate themselves concerning possible barriers to improved networks of preferred providers and factors influencing health insurance premium rates. Proposed §3.3713(e) – (g) establish a six-month waiver process for the requirements of §3.3713 to provide flexibility to an insurer that has particular circumstances that would justify such delay. These circumstances include (i) undue hardship, including financial or operational hardship; (ii) the geographical area in which the insurer operates; and (iii) total number of insureds covered by the insurer. These requirements could enable small or micro-business insurers to obtain a six-month waiver if they meet the specified requirements for the waiver.

The Department anticipates that proposed §3.3713(a) – (d) will result in costs to comply for small and micro-business insurers. The cost of compliance with the these proposed requirements will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department has considered exempting small or micro-business insurers from all or part of the requirements in §3.3713(a) – (d), but has determined that neither a full or partial exemption would be consistent with the objectives of the rule, which is to provide the Department and the prospective and current insureds of all insurers, regardless of size, information on the impact of uncompensated care on insurance premium rates and network adequacy. A full or partial exemption from the information

submission requirement would prevent the Department from developing a full analysis of the adequacy of the networks of small and micro-business insurers and the basis of their premium rates. It would also prevent prospective and current insureds of small and micro-business insurers from being able to adequately compare coverages and networks offered by different insurers and assess premium rates being charged. The Department has included a six-month waiver process, which will take into consideration issues of undue hardship and the number of insureds impacted, potentially allowing for the consideration of the size of the insurer requesting the waiver.

The Department also considered having more limited requirements for the submission of waiver requests in the case of small or micro-business insurers, but determined that the current submission requirements are not amenable to being limited because they already grant such broad latitude to insurers in justifying the grant of a waiver.

Thus, in accordance with §2006.002(c-1) of the Government Code, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §3.3713(a) – (d) and of protecting the health and economic welfare of Texas insureds while minimizing adverse impacts on small or micro businesses.

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 February 28, 2011, 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 for Regulatory Matters, Life, Health and Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The Commissioner will consider the proposed amendments to §§3.3701 – 3.3706 and new §§3.3707 – 3.3713 in a public hearing under Docket No. 2726 scheduled for February 8, 2011, at 9:30 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered. A separate and additional notice of this public hearing was submitted to the Office of the Secretary of State on January 14, 2011, for publication in the January 28, 2011 issue of the *Texas Register.* The notice specifies the availability of the Department's proposal by means of the following Internet link: http://www.tdi.state.tx.us/alert/agenda.html effective January 14, 2011.

7. STATUTORY AUTHORITY. The amendments and new sections are proposed pursuant to: (i) the Insurance Code §§521.102, 544.002(a)(2), 544.052, 1301.0046,

1301.005, 1301.0055, 1301.006, 1301.007, 1301.051, 1301.058, 1301.069, 1301.155(b), 1301.158(b) and (d), 1301.159, 1301.1591, 1301.161, 1451.053, 1451.054(a), 1451.104(a) and (b), 1456.003(c), 1456.007, 1467.051(a), 1467.053(d), 1467.054(a), 1661.005, 1701.055(a)(2), and 36.001; (ii) the Health and Safety Code §324.101(d); and (iii) the Occupations Code §101.352(c). Section 521.102 requires an insurer to maintain a toll-free number to provide information concerning its policies and to receive complaints from policyholders. Section 544.002(a)(2) prohibits an insurer from charging an individual a rate that differs from the rate charged to other individuals for the same coverage because of the individual's geographic location. Section 544.052 prohibits an insurer from engaging in or permitting unfair discrimination between individuals of the same class and essentially the same hazard, including unfair discrimination in: (i) the amount of premium, policy fees, or rates charged for a policy or contract of insurance; (ii) the benefits payable under a policy or contract of insurance; or (iii) any of the terms or conditions of a policy or contract of insurance. Section 1301.0046 provides that an insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Section 1301.005 requires that: (i) an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area; and (ii) if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of

reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider. Section 1301.0055 requires the Commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. Section 1301.006 requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. Section 1301.051 provides that an insurer: (i) is required to afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers

are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy and comply with the terms established by the insurer for designation as preferred providers; (ii) is prohibited from unreasonably withholding a designation as a preferred provider; (iii) is required to give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation; and (iv) is prohibited from withholding a designation to a podiatrist described by Section 1301.0521. Section 1301.058 requires that: (i) an insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured; and (ii) economic profiles be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs. Section 1301.069 specifies that the provisions of Chapter 1301 relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a nonpreferred provider who furnishes to an insured: (i) care related to an emergency or its attendant episode of care as required by state or federal law; or (ii) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network. Section 1301.155(b) specifies that if an insured cannot reasonably reach a preferred provider,

an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider: (i) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists; (ii) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and (iii) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition. Section 1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(d) requires an insurer to provide to an insured on request information on: (i) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network; (ii) whether proposed health care services are covered by the health insurance policy; (iii) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and (iv) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services. Section 1301.159 requires insurers to provide a current list of preferred

providers at least annually. Section 1301.1591: (i) requires an insurer subject to Chapter 1301 that maintains an Internet site to list on the Internet site the preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan.; (ii) requires that the listing identify those preferred providers who continue to be available to provide services to new patients or clients; (iii) requires the insurer to update such Internet sites at least quarterly; and (iv) authorizes the Commissioner to adopt rules as necessary to implement the section, specifying that the rules may govern the form and content of the information required to be provided. Section 1301.161 prohibits an insurer from engaging in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has: (i) filed a complaint against the insurer or against a preferred provider; or (ii) appealed a decision of the insurer. Section 1451.053 prohibits an accident and health insurance policy from making a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize. Section 1451.054(a) mandates that a provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section. Section 1451.104(a) prohibits an insurer from classifying, differentiating, or discriminating between scheduled services or procedures provided by a health care

practitioner selected under the subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to: (i) the payment schedule or payment provisions of the policy; or (ii) the amount or manner of payment or reimbursement under the policy. Section 1451.104(b) prohibits an insurer from denying payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under the subchapter. Section 1456.003(c) requires a preferred provider benefit plan to clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the plan's provider network and specifies that health care facilities identified under the subsection are required to be identified in a separate and conspicuous manner in any provider network directory or website directory. Section 1456.007 requires a preferred provider benefit plan to, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and to specify any deductibles, copayments, coinsurance, or other amounts for which the enrollee is responsible. The preferred provider benefit plan must advise the enrollee that: (i) the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and (ii) the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage. Section 1467.051(a) specifies 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. Section 1467.053(d) provides that a facility-based physician who makes a disclosure under §1467.053(c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under the subchapter if the amount billed is less than or equal to the maximum amount projected in the disclosure. Section 1467.054(a) authorizes an enrollee to request mandatory mediation under the chapter. Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. Section 1701.055(a)(2) authorizes the Commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section. The Health and Safety Code §324.101(d) requires a facility to provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The facility must advise the consumer that: (i)

the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service; (ii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service; (iii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor; (iv) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or other service depending on the consumer's health benefit plan coverage; and (v) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service. The Occupations Code §101.352(c) mandates that on the request of a patient who is seeking services that are to be provided on an out-of-network basis or who does not have coverage under a government program, health insurance policy, or health maintenance organization evidence of coverage, a physician shall provide an estimate of the charges for any health care services or supplies. A physician must advise the consumer that: (i) the request for an estimate of charges may result in a delay in the scheduling and provision of the services; (ii) the actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services; (iii) the actual charges for the services or supplies may differ from the

amount to be paid by the patient or the patient's third-party payor; and (iv) the patient may be personally liable for payment for the services or supplies depending on the patient's health benefit plan coverage. The Insurance Code §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.

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

Rule	Statute
§3.3701	Insurance Code §§843.002, 1301.001 – 1301.202, 1353.001, 1353.002, 1451.001, 1451.053, 1451.054, and 1451.101 - 1451.127
§3.3702	Insurance Code §§1301.001 – 1301.202, and 4201.002; Health and Safety Code Chapters 241, 243, 244, Title 7, Subtitle C
§3.3703	Insurance Code Chapter 542, Subchapter A; §§1301.001 – 1301.202, 1456.007, and 1661.005; Occupations Code Chapters 551 - 566 and 568 – 569
§3.3704	Insurance Code Chapter 542, Subchapter A; §§544.051 - 544.054; 1251.005, 1251.006, 1301.001 – 1301.202, 1451.001, 1451.053, 1451.054,

	1451.101 – 1451.127, 1701.002 – 1701.005; 1701.051 – 1701.060; 1701.101 – 1701.103, and 1701.151; and Chapter 4201
§3.3705	Insurance Code §§521.102, 1301.001 – 1301.202, 1456.003, 1456.007, 1467.051, 1467.053, 1467.054, and 1701.055; Health and Safety Code §324.101(d); and Occupations Code §101.352(c)
§3.3706	Insurance Code §§1301.001 – 1301.202, and 1701.055
§3.3707	Insurance Code §§1301.001 – 1301.202
§3.3708	Insurance Code §§1301.001 – 1301.202, 1467.054, and 1701.055
§3.3709	Insurance Code §§83.001 – 83.153, and 1301.001 – 1301.202
§3.3710 and §3.3711	Insurance Code §§1301.001 – 1301.202
§3.3712	Insurance Code §§1301.001 – 1301.202, and 1467.051
§3.3713	Insurance Code §§1301.001 – 1301.202

9. TEXT.

§3.3701. Application.

(a) Except as otherwise specified in this subchapter, the [~~The~~] sections of this subchapter apply to any preferred provider benefit plan as specified in this subsection.

(1) This subchapter applies to any preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after June 1, 2011. Any preferred provider benefit plan policy delivered, issued for delivery, or renewed prior to June 1, 2011, is subject to the statutes and provisions of this subchapter in effect at the time the policy was delivered, issued for delivery, or renewed.

(2) The sections of this subchapter do not apply to provisions for dental care benefits in any health insurance policy.

(b) This subchapter is not an interpretation of and has no application to any law requiring licensure to act as a principal or agent in the insurance or related businesses including, but not limited to, health maintenance organizations.

(c) [~~(b)~~] The provisions of this subchapter are [~~shall be~~] subject to the Insurance Code §§1451.001, 1451.053, and 1451.054; Chapter 1301; §§1451.101 - 1451.127; and §1353.001 and §1353.002 [~~Articles 3.70-2(B), 3.70-3C (Preferred Provider Benefit Plans), 3.70-3C (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans), 21.52, and 21.53K~~] as they relate to insurers and the practitioners named therein.

(d) [~~(c)~~] These sections do not create a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action. These sections do not abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available.

(e) [~~(d)~~] If a court of competent jurisdiction holds that any provision [~~terms, sections or subsections~~] of this subchapter or its application to any person or circumstance is [~~are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code or~~] invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable [~~remaining terms, sections, or subsections of this subchapter will continue in effect~~].

§3.3702. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(2) [~~(1)~~] Contract holder--An individual who holds an individual health insurance policy, or an organization which holds a group health insurance policy.

(3) [~~(2)~~] Emergency care--As defined in the Insurance Code §1301.155 [~~Article 3.70-3C §1(1) (Preferred Provider Benefit Plans)~~].

(4) Facility--

(A) an ambulatory surgical center licensed under the Health and Safety Code Chapter 243;

(B) a birthing center licensed under the Health and Safety Code Chapter 244; or

(C) a hospital licensed under the Health and Safety Code Chapter 241.

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

(A) to whom a facility has granted clinical privileges; and

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

(6) General practitioner--A physician providing general medical care and treatment for acute and chronic conditions to patients of all ages rather than focusing on a specific specialty.

(7) [~~(3)~~] Health care provider or provider--As defined in the Insurance Code §1301.001(1) [~~Article 3.70-3C §1(3) (Preferred Provider Benefit Plans)~~].

(8) [~~(4)~~] Health insurance policy--As defined in the Insurance Code §1301.001(2) [~~Article 3.70- 3C §1(2) (Preferred Provider Benefit Plans)~~].

(9) [~~(5)~~] Health maintenance organization [~~Maintenance Organization~~] (HMO)--As defined in the Insurance Code §843.002(14) [~~Article 20A.02(n)~~].

(10) [~~(6)~~] Hospital--As defined in the Insurance Code §1301.001(3), a licensed public or private institution as defined by the Health & Safety Code Chapter 241 or the Health & Safety Code Title 7, Subtitle C [~~Article 3.70-3C §1(4) (Preferred Provider Benefit Plans)~~].

(11) [~~(7)~~] Institutional provider--As defined in the Insurance Code §1301.001(4) [~~Article 3.70-3C §1(5) (Preferred Provider Benefit Plans)~~].

(12) [~~(8)~~] Insurer--As defined in the Insurance Code §1301.001(5) [~~Article 3.70-3C §1(6) (Preferred Provider Benefit Plans)~~].

(13) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(14) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(15) Pediatric practitioner--A physician with appropriate education, training and experience whose practice is limited to providing medical and health care services to children and young adults.

(16) [~~(9)~~] Physician--As defined in the Insurance Code §1301.001(6) [~~Article 3.70-3C §1(8) (Preferred Provider Benefit Plans)~~].

(17) [~~(10)~~] Practitioner--As defined in the Insurance Code §1301.001(7) [~~Article 3.70-3C §1(9) (Preferred Provider Benefit Plans)~~].

(18) [~~(11)~~] Preferred provider--As defined in the Insurance Code §1301.001(8) [~~Article 3.70-3C §1(1) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(19) [~~(12)~~] Preferred provider benefit plan [~~Provider Benefit Plan~~]--As defined in the Insurance Code §1301.001(9) [~~Article 3.70-3C §1(2) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(20) [~~(13)~~] Prospective insured--As defined in the Insurance Code §1301.158(a) [~~Article 3.70-3C §1(11) (Preferred Provider Benefit Plans)~~].

(21) [~~(14)~~] Quality assessment--As defined in the Insurance Code §1301.059(a) [~~Article 3.70-3C §1(12) (Preferred Provider Benefit Plans)~~].

(22) Rural area--

(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;

(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or

(C) any other area designated as rural under rules adopted by the commissioner, notwithstanding subparagraphs (A) and (B) of this paragraph.

(23) [~~(15)~~] Service area--As defined in the Insurance Code §1301.001(10) [~~Article 3.70-3C §1(13) (Preferred Provider Benefit Plans)~~].

(24) Specialist--A physician who, by virtue of completing specialized education and specialized training, or by earning a board certification or fellowship, provides care that is narrow in scope, including care that is limited to one or more organ systems and whose primary practice is not as a general practitioner.

(25) Urgent care--Health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury

is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

(26) [~~(16)~~] Utilization review [~~Review~~]--As defined in the Insurance Code §4201.002(13) [~~Article 21.58A §2(20)~~].

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan is required to [~~must~~] contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract is required to [~~must~~] meet the following requirements:

(1) A contract between a preferred provider and an insurer may [~~shall~~] not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider organizations, or HMOs.

(2) Any term or condition limiting participation on the basis of quality[~~,~~] that is contained in a contract between a preferred provider and an insurer[~~,~~] is required to [~~shall~~] be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain

terms and conditions that [~~which~~] include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider may [~~shall~~] not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition is limited in subparagraphs (A)-(C) of this paragraph:

(A) with respect to physicians or practitioners that are members of a practice group that includes 15 or more physicians or practitioners, the contracting prohibition of this paragraph shall not apply after June 1, 2014;

(B) with respect to physicians or practitioners that are members of a practice group that includes at least 7 and not more than 14 physicians or practitioners, the contracting prohibition of this paragraph shall not apply after June 1, 2016; and

(C) notwithstanding subparagraphs (A) and (B) of this paragraph, with respect to any practice group of physicians or providers that has not previously held staff membership or privileges with a hospital or institutional provider and acquires such membership or privileges, the contracting prohibition of this paragraph applies for the first three years of such membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may [~~shall~~] not require the preferred provider to pay hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may [~~shall~~] not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may [~~shall~~] not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's [~~A~~] contract with [~~between~~] a physician, physician [~~physicians'~~] group, or practitioner [~~and an insurer~~] is required to [~~shall~~] have a mechanism for the resolution of complaints that are initiated by an insured, a physician, physician [~~physicians'~~] group, or practitioner. The mechanism must provide [~~which provides~~] for reasonable due process including, in an advisory role only, a review panel selected as specified [~~by the manner set forth~~] in subsection (b)(2) of §3.3706 of this subchapter [~~title~~] (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may [~~shall~~] not require any health care provider, physician, or physician [~~physicians'~~] group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must [~~shall~~] require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must [~~shall~~] require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims, including the Insurance Code Chapter 1301, Subchapter C [~~Article 3.70-3C §3A (Prompt Payment of Preferred Providers)~~] and §§21.2801 – 21.2820 of this title (relating to Submission of Clean Claims) with respect to payment to the provider for covered services that are rendered to insureds.

(12) A contract between a preferred provider and an insurer must [~~shall~~] require the provider to comply with the Insurance Code §§1301.152 - 1301.154 [~~Article 3.70-3C §4 (Preferred Provider Benefit Plans)~~], which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may [~~shall~~] not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in the Insurance Code §1301.067 [~~Article 3.70-3C §7(c) (Preferred Provider Benefit Plans)~~] about any of the matters set forth therein.

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must [~~shall~~] require the insurer to inform the provider of the insurer's obligation to comply with the Insurance Code §1301.058 [~~Article 3.70-3C §3(h) (Preferred Provider Benefit Plans)~~].

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to [~~shall~~] disclose in the contract all requirements of the Insurance Code §1301.059(b) [~~Article 3.70-3C §3(i) (Preferred Provider Benefit Plans)~~].

(16) A contract between a preferred provider and an insurer may [~~shall~~] not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may [~~shall~~] not prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas

Pharmacy Act, Chapters 551 - 566 and Chapters 568 – 569 of the Occupations Code, [~~Article 4542a-1, Texas Civil Statutes~~] and rules promulgated thereunder.

(18) A contract between a preferred provider and an insurer must [~~shall~~] require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must [~~shall~~] require the insurer to provide assistance to the provider as set forth in the Insurance Code §1301.160(b) [~~Article 3.70-3C §6(e)(2) (Preferred Provider Benefit Plans)~~].

(19) A contract between a preferred provider and an insurer must [~~shall~~] require written notice to the provider upon termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must [~~shall~~] include the provider's right to request a review, as specified [~~set forth~~] in §3.3706(d) [~~§3.3706(c)~~] of this subchapter [~~title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process)~~].

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The

insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including e-mail, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided pursuant to this paragraph are required to [~~must~~] be made in accordance with subparagraph (D) of this paragraph. The insurer is required to [~~shall~~] provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to [~~must~~] include a preferred provider specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to [~~must~~] include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is

being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to [~~must~~] be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to [~~shall~~] clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may [~~shall~~] be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to [~~must~~] supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will [~~shall~~] be effective as to the preferred provider, unless the insurer provides at least 90 calendar days written notice to the preferred provider identifying with specificity the amendment, revision or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is

required to [~~must~~] provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;[~~,~~]

(II) billing activities;[~~,~~]

(III) other business operations;[~~,~~] or

(IV) communications with a governmental agency involved in the regulation of health care or insurance [~~and~~];

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred

provider chooses to terminate the contract, the insurer is required to [~~shall~~] assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to [~~shall~~] include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured, if applicable:

(A) that the physician, provider, or facility to whom the insured is being referred is not a preferred provider; and

(B) that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005 (relating to refunds of overpayments from enrollees).

(26) A contract between an insurer and a facility must require that:

(A) the facility give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer; and

(B) the facility require facility-based physicians providing services at the facility to comply with the requirements specified in clauses (i) and (ii) of this subparagraph.

(i) A provision of the contract must require facility-based physicians to make disclosure to the general public of the typical range of the physician's billed charges for no fewer than those professional services identified in §3.3712 of this subchapter (relating to Facility-Based Physician Disclosure of Certain Billed Charges), represented in that section by CPT codes as published by the American Medical Association.

(ii) A provision of the contract must require facility-based physicians to provide responsive information no more than annually to surveys of physician fees conducted by the department or by an academic institution conducting the survey on behalf of the department.

(b) In addition to all other contract rights, violations of these rules will [~~shall~~] be treated for purposes of complaint and action in accordance with the Insurance Code Chapter 542, Subchapter A [~~Article 21.21-2~~], and the provisions of that subchapter will [~~article shall~~] be utilized insofar as practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of the Insurance Code Chapter 1301 [~~Article 3.70-3C (Preferred Provider Benefit Plans)~~] and this subchapter; or

(2) ensure that the requirements of the Insurance Code Chapter 1301 [~~Article 3.70-3C (Preferred Provider Benefit Plans)~~] and this subchapter are met.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness Requirements. A preferred provider benefit plan is [~~shall~~] not [~~be~~] considered unjust under the Insurance Code §§1701.002 – 1701.005; §§1701.051 – 1701.060; §§1701.101 – 1701.103; and §1701.151 [~~Article 3.42~~], or to unfairly discriminate [~~unfair discrimination~~] under the Insurance Code Chapter 542, Subchapter

A, [~~Articles 21.21-6~~] or §§544.051 - 544.054 [~~21.21-8~~], or to violate §§1451.001, 1451.053, 1451.054 [~~Articles 3.70-2(B)~~] or §§1451.101 – 1451.127 [~~21.52~~] of the Insurance Code provided that:

(1) pursuant to the Insurance Code §§1251.005, 1251.006, 1301.003, 1301.004, 1301.006, 1301.051, 1301.053, 1301.054, 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201, [~~Article 3.70-3C §3 (Preferred Provider Benefit Plans), Article 3.51-6, (3, and Article 3.70-3(A)(9)~~], the [~~no~~] preferred provider benefit plan does not [~~may~~] require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are [~~shall be~~] provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds [~~shall~~] have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds [~~shall~~] have the right to continuity of care as set forth in the Insurance Code §§1301.152 – 1301.154 [~~Article 3.70-3C, §4 (Preferred Provider Benefit Plans)~~];

(5) insureds [~~shall~~] have the right to emergency care services as set forth in the Insurance Code §1301.155 [~~Article 3.70-3C, §5 (Preferred Provider Benefit Plans)~~];

(6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 50 percent [~~30%~~] less than the higher level of coverage. A reasonable difference in deductibles is [~~shall be~~] determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider are not restricted by the insurer;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the basic level of coverage is [~~must be~~] reasonably consistent with such other health insurance policies offered by the insurer that [~~which~~] do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan is [~~shall be~~] taken pursuant to the Insurance Code Chapter 4201 [~~Article 21.58A~~] and Chapter 19, Subchapter R of this title (relating to Utilization Review Agents);

[~~(10) if covered services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. Nothing in this section requires reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience;~~]

(10) [~~(11)~~] a preferred provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider[~~,~~] only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this subchapter [~~title~~] (relating to Nature of Communications with Insureds; Readability, [~~and~~] Mandatory Disclosure Requirements, and Plan Designations); and

(11) [~~(12)~~] both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) Payment of Nonpreferred Providers. Payment by the insurer must [~~shall~~] be made for services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(c) Retaliatory Action Prohibited. An insurer is prohibited from engaging [~~shall not engage~~] in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint against the insurer or a preferred provider or has appealed a decision of the insurer.

(d) Access to Certain Institutional Providers. In addition to the requirements for availability of preferred providers set forth in the Insurance Code §1301.005 [~~Article 3.70-3C §8 (Preferred Provider Benefit Plans)~~], any insurer offering a preferred provider benefit plan is required to [~~shall~~] make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under such plan freedom of choice in the selection

of institutional providers at which they will receive care, unless such a mix proves to be not feasible due to geographic, economic, or other operational factors. An insurer is required to [~~shall~~] give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(e) Network Requirements. Each preferred provider benefit plan is required to include a health care service delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements described in this section. An adequate network is required to:

(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:

(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(B) projected utilization of covered health care services;

(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;

(3) include sufficient numbers and types of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;

(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;

(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;

(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(B) 75 miles for specialty care and specialty hospitals;

(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(10) ensure that routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions;

(11) ensure that preventive health services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and

(B) within three months for an adult.

(f) Network Monitoring and Corrective Action. Insurers are required to monitor compliance with subsection (e) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate.

(g) Service Areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide are required to be defined in terms of one of the following:

(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this subchapter (relating to Geographic Regions);

(2) one or more Texas counties; or

(3) the first three digits of ZIP Codes in Texas.

§3.3705. Nature of Communications with Insureds; Readability, [~~and~~] Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to [~~shall~~] be written in a readable and understandable format that meets the requirements of §3.602 of this chapter [~~title~~] (relating to Plain Language Requirements [~~for Health Benefit Policies~~]).

(b) Disclosure of Terms and Conditions of the Policy. The insurer is required [~~shall~~], upon request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that [~~which~~] allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description is required to [~~must~~] be in a readable and understandable format, by category, and is required to [~~must~~] include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company, the name of the insurance company, and that the insurance contract contains preferred provider benefits;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any prior authorizations, including preauthorization review, concurrent review, post-service review, and postpayment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a

physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients, both of which may be provided electronically with the agreement of the insured provided that information about how to obtain a nonelectronic provider listing free of charge is also provided; [~~and~~]

(13) the service area(s); and [~~area.~~]

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this subchapter (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatrics, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery:

(i) the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that type of provider in the

service area or region and how such access plan may be obtained or viewed, if applicable;

(ii) the percentage of preferred providers that are accepting new patients; and

(iii) the percentage of preferred providers with board certifications in the area of practice, as applicable;

(C) for hospitals:

(i) the number of preferred provider hospitals in the service area or region and the ratio of insureds to hospital beds, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter applies to hospital services in that service area or region and how the access plan may be obtained or viewed;

(ii) the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and

(iii) the average surgical site infection rate at each specific preferred provider hospital in the service area or region.

(c) Filing Required. A copy of the written description required in subsection (b) of this section must [~~shall~~] be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b).of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made

electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following e-mail address: hwcn@tdi.state.tx.us. Nonelectronic filings are required to be submitted to the department at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104.

(d) Promotional Disclosures Required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan are required to [~~shall~~] clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits is required to [~~must~~] be in close proximity to an equally prominent description of basic benefits.

(e) Internet Website Disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds are required to provide:

(1) an Internet-based provider listing for use by current insureds;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of Rights under a Network Plan Required. An insurer is required to include the notice specified in Figure: 28 TAC §3.3705(f) in all policies, certificates, and outlines of coverage in at least 12 point font:

FIGURE 28 TAC §3.3705(f):

Texas Department of Insurance Notice

- *You are entitled to an adequate network of preferred providers. If you believe that the network is inadequate, you may file a complaint with the Department of Insurance. If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network or out-of-network out-of-pocket maximum, as appropriate.*
- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at*

the in-network level of benefits. If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.

- *You have certain rights under state law to obtain advance estimates:*
  - *of the amounts that the providers may bill for projected services, from your out-of-network provider; and*
  - *of the amounts that the insurer may pay for the projected services, from your insurer.*
- *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.state.tx.us/consumer/cpmmediation.html.*

(g) [~~(e)~~] Untrue or Misleading Information Prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

[~~(f) A current list of preferred providers shall be distributed to all prospective insureds, and to all insureds no less than annually, and shall be filed with the department by June 1 of each year.~~]

[~~(g) Unless exempted by statute or rule, the insurer shall provide to each insured a toll free number to be maintained 50 hours per week during regular business hours that the insured can call to obtain a current, up-to-date list of preferred providers.~~]

(h) Disclosure Concerning Access to Preferred Provider Listing. The insurer is required to provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required Updates of Available Provider Listings. The insurer is required to ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months.

(j) Annual Provision of Provider Listing Required in Certain Cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer is required to distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if such alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance Upon Provider Listing in Certain Cases. A claim for services rendered by a nonpreferred provider must be paid at the applicable preferred benefit coinsurance percentage if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional Listing-Specific Disclosure Requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer is required to comply with the requirements in paragraphs (1) – (11) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to:

(A) exercise good faith efforts to accommodate requests from insureds to utilize preferred providers; and

(B) in those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer by or on behalf of facility-based physicians other than neonatologists and pathologists are filed by or on behalf of a physician that is not under contract with the insurer.

(3) In determining whether a hospital meets the specifications in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program.

(6) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(7) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(8) The provider information must be provided in fonts of not less than 10-point type.

(9) The provider information must specifically identify those facilities at which the insurer has no contracts with a type of facility-based provider, specifying the applicable provider type.

(10) The provider information must specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type.

(11) The provider information must specify the date on which the information was provided to the insured.

(m) Annual Policyholder Notice Concerning Use of Access Plan. An insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 of this subchapter is required to provide notice of this fact to each individual and group policyholder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes made available pursuant to subsection (e)(2) of this section.

(n) Disclosure of Substantial Decrease in the Availability of Certain Preferred Providers. An insurer is required to provide notice of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility as specified in this subsection.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination.

(2) Notwithstanding paragraph (1) of this subsection, no notice is required if alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility such that the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease.

(3) An insurer is required to prominently post notice of the termination specified in paragraph (1) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of the termination specified in paragraph (1) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.

(5) In addition to posting notice as specified in paragraph (3) of this subsection, an insurer is required to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures Concerning Reimbursement of Basic Benefit Services. An insurer is required to make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services as specified in this subsection.

(1) An insurer is required to disclose how reimbursements of nonpreferred providers will be determined.

(2) If an insurer reimburses nonpreferred providers based directly or indirectly upon data regarding usual, customary, or reasonable charges by providers, the insurer is required to disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

(3) If an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer is required to:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) Plan Designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers) without reliance upon an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that

does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this subchapter, the insurer is required to disclose that the plan has a "Limited Hospital Care Network:"

(1) on the cover page of any insurance policy, certificate of coverage, or outline of coverage utilizing the network; and

(2) on the cover page of any nonelectronic provider listing describing the network.

(q) Loss of Status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer is required to:

(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all insureds of such change of status at the time of renewal.

§3.3706. Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process.

(a) Access to Designation as a Preferred Provider. Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners,

and institutional providers[~~,~~] if such other health care providers are included by an insurer as preferred providers, that are licensed to treat injuries or illnesses or to provide services covered by the preferred provider benefit plan and that comply with the terms and conditions established by the insurer for designation as preferred providers, are [~~shall be~~] eligible to apply for and must be afforded a fair, reasonable and equitable opportunity to become preferred providers, subject to subsection (b) of this section.

(1) An insurer initially sponsoring a preferred provider benefit plan is required to [~~shall~~] notify all physicians and practitioners in the service area covered by the plan of its intent to offer the plan and of the opportunity to apply to participate.

(2) Subsequently, an insurer is required to [~~shall~~] annually notify all non-contracting physicians and practitioners in the service area covered by the plan of the existence of the plan and the opportunity to apply to participate in the plan.

(3) An insurer is required [~~shall~~], upon request, to make available to any physician or provider information concerning the application process and qualification requirements, including the use of economic profiling by the insurer, used by the insurer to admit a provider to the plan.

(4) All notifications required to be made by an insurer pursuant to this subsection are required to [~~shall~~] be made by publication or distributed in writing to each physician and practitioner in the same manner.

(5) Selection standards used by the insurer in choosing participating preferred providers must not directly or indirectly:

(A) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or

(B) exclude a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(b) Withholding Preferred Provider Designation. An insurer may not unreasonably withhold designation as a preferred provider except [~~Designation as a preferred provider shall not be unreasonably withheld provided~~] that, unless otherwise limited by the Insurance Code or rule promulgated by the department, an insurer may reject an application from a physician or health care provider on the basis that the preferred provider benefit plan has sufficient qualified providers.

(1) An insurer is required to [~~shall~~] provide written notice of denial of any initial application to a physician or health care provider, which includes:

(A) the specific reason(s) for the denial; and

(B) in the case of physicians and practitioners, the right to a review of the denial as set forth in paragraph (2) of this subsection.

(2) An insurer is required to [~~shall~~] provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel.

(A) The advisory review panel is required to [~~shall~~] be composed of not less than three individuals selected by the insurer from the list of physicians or practitioners in the applicable service area contracting with the insurer.

(B) At least one of the three individuals on the advisory review panel is required to [~~shall~~] be a physician or practitioner in the same or similar specialty as the physician or practitioner requesting review unless there is no physician or practitioner in the same or similar specialty contracting with the insured.

(C) The list of physicians or practitioners required by subparagraph (A) of this paragraph is required to [~~shall~~] be provided to the insurer by the physicians or practitioners who contract with the insurer in the applicable service area.

(D) The recommendation of the advisory review panel is required to [~~shall~~] be provided upon request to the affected physician or practitioner.

(E) In the event that the insurer makes a determination that is contrary to the recommendation of the advisory review panel, a written explanation of the insurer's determination is required to [~~shall~~] be provided to the affected physician or practitioner upon request.

(c) Credentialing of Preferred Providers. Insurers are required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. At a minimum, an insurer’s credentialing standards are required to meet the standards promulgated by the NCQA or URAC to the extent that those standards do not conflict with other laws of this state. Insurers shall be presumed to be in compliance with statutory and regulatory

requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, the URAC, or the Accreditation Association for Ambulatory Health Care.

(d) [~~(c)~~] Notice of Termination of a Preferred Provider Contract. Before terminating a contract with a preferred provider, the insurer is required to [~~shall~~] provide written notice of termination, which includes:

(1) the specific reason(s) for the termination; and

(2) in the case of physicians or practitioners, notice of the right to request a review prior to termination that is conducted in the same manner as the review mechanism set forth in subsection (b)(2) of this section and that complies with [~~which includes~~] the timelines set forth in subsections (e) – (h) of this section [~~(d) and (e)~~] for requesting review, except in cases involving:

(A) imminent harm to patient health;

(B) an action by a state medical or other physician licensing board or other government agency which impairs the physician's or practitioner's ability to practice medicine or to provide services; or

(C) fraud or malfeasance.

(e) [~~(d)~~] Review of a Decision to Terminate. To obtain a standard review of an insurer's decision to terminate him or her, a physician or practitioner must [~~shall~~]:

(1) make a written request to the insurer for a review of that decision within 10 [~~ten~~] business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 20 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(f) [~~(3)~~] Completion of the Review Process. The review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, is required to [~~shall~~] be completed and the results provided to the physician or practitioner within 60 calendar days of the insurer's receipt of the request for review.

(g) [~~(e)~~] Expedited Review Process. To obtain an expedited review of an insurer's decision to terminate him or her, a physician or practitioner must [~~shall~~]:

(1) make a written request to the insurer for a review of that decision within five business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 10 [~~ten~~] business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(h) [~~(3)~~] Completion of the Expedited Review Process. The expedited review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, shall be completed and the results provided to the physician or practitioner within 30 calendar days of the insurer's receipt of the request for review.

(i) [~~(f)~~] Confidentiality of Information Concerning [~~information concerning~~] the Insured [~~insured~~].

(1) An insurer is required to [~~shall~~] preserve the confidentiality of individual medical records and personal information used in its termination review process. Personal information of the insured includes [~~shall include~~], at a minimum, the insured's name, address, telephone number, social security number, and financial information.

(2) An insurer may not disclose or publish individual medical records or other confidential information about an insured without the prior written consent of the insured or unless otherwise required by law. An insurer may provide confidential information to the advisory review panel for the sole purpose of performing its advisory review function. Information provided to the advisory review panel is required to [~~shall~~] remain confidential.

(j) [~~(g)~~] Notice to Insureds [~~insureds~~].

(1) If the contract of a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer may [~~shall~~] not notify insureds of the termination until the effective date of the termination or at such time as an

advisory review panel makes a formal recommendation regarding the termination, whichever is later.

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the insurer is required to [~~shall~~] provide assistance to the physician or provider in assuring that the notice requirements are met as required by §3.3703(a)(17) [~~§3.3703(a)(18)~~] of this subchapter [~~title~~] (relating to Contracting Requirements).

(3) If the contract of a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) In accordance with the Insurance Code §1301.0055(3), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets under this subchapter are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the department may excuse the insurer from one or more network adequacy requirements in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers) and may impose reasonable conditions on the grant of such waiver.

(b) An insurer seeking a waiver under subsection (a) of this section is required to file the request with the department at the Office of the Chief Clerk, MC 113-2A, P.O. Box 149104, Austin, TX 78714-9104. The insurer is also required to submit a copy of the request to any provider or physician named in the request for waiver at the same

time that the request is filed with the department. The insurer may use any reasonable means to submit the copy of the request to the provider or physician and is required to maintain proof of such submission.

(c) Any provider or physician may elect to provide a response to an insurer's request for waiver by filing such response within 30 days after the insurer files the request with the department. Such response, if filed, shall be filed at the same address specified in subsection (b) of this section for filing the request for waiver.

(d) If the department grants a waiver under subsection (a) of this section, the department shall post on the department's website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area.

(e) An insurer is required to apply for renewal of a waiver described in subsection (a) of this section annually and at the same time the insurer files the annual network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).

(f) An insurer's receipt of a waiver under this section does not authorize the insurer to designate its plan as having an "Approved Hospital Care Network" (AHCN). The insurer is required to designate such plan as having a "Limited Hospital Care Network" in accordance with the requirements of §3.3705(p) of this subchapter (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations).

§3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver.

(a) An insurer must comply with the requirements of subsections (b) and (e) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

(1) requiring emergency care;

(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to:

(1) pay such claim at the preferred benefit coinsurance level; and

(2) credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary

billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;

(2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(3) is updated no less than once per year;

(4) does not use data that is more than three years old; and

(5) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) An insurer is required to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan shall not be a basis for denial of a claim.

(e) Effective January 1, 2012, when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to include a notice on each explanation of benefits that the insured has the right to request the following information for comparison purposes:

(1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount;

(2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers (such as the usual, customary, and reasonable amount), excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount; and

(3) the amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*) for the service, excluding any cost sharing imposed with respect to the insured.

(f) An insurer may apply for a six-month waiver of the requirements of subsection (e) of this section by complying with the requirements specified in paragraphs (1) – (3) of this subsection.

(1) Waiver applications are required to be:

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

(B) legible;

(C) in typewritten, computer-generated, or printer's proof format; and

(D) signed by an officer of the insurer.

(2) Waiver applications are required to be mailed to the 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.

(3) An application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including:

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

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

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

(D) specification of the insurer's plan to achieve compliance with the requirements of subsection (e) of this section, including identification of actions already taken and those planned to be taken; and

(E) the estimated cost of compliance with subsection (e) of this section and an estimate of the increased cost for compliance at an earlier date.

(g) The waiver application is received when the commissioner has received a waiver application containing all specific facts and circumstances as listed in subsection (f) of this section, including any addendums provided by the insurer.

§3.3709. Annual Network Adequacy Report; Access Plan.

(a) Network Adequacy Report Required. An insurer is required to file a network adequacy report with the department on or before April 1st of each year and prior to marketing any plan in a new service area.

(b) General Content of Report. The report required in subsection (a) of this section must specify:

(1) the trade name of each preferred provider benefit plan in which insureds currently participate;

(2) the applicable service area of each plan; and

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards set forth in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers).

(c) Additional Content Applicable Only to Annual Reports. As a part of the annual report on network adequacy, each insurer is required to provide additional demographic data as specified in paragraphs (1) – (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this subchapter (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer is required to specify in the report that there is no applicable data for that region. The report must include the number of:

(1) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level;

(2) claims for basic benefits that were paid at the preferred benefit coinsurance level;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing;

(5) complaints by insureds relating to the availability of preferred providers; and

(6) complaints by insureds relating to the accuracy of preferred provider listings.

(d) Additional Content Applicable if Inadequate Networks are Utilized. As a part of the annual report on network adequacy, an insurer is required to submit a local market access plan as specified in subsection (e) of this section if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements specified in §3.3704 of this subchapter.

(e) Content of Local Market Access Plan.

(1) A local market access plan required under subsection (d) of this section must specify for each service area that does not meet the network adequacy requirements:

(A) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this subchapter, including a specification of the type of provider that is not sufficiently available;

(B) a map, with key and scale, that identifies the geographic areas within the service area in which such health care services and/or physicians and providers are not available;

(C) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this subchapter;

(D) procedures that the insurer will utilize to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and

(E) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this subchapter (relating to Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver).

(2) The department may request additional information necessary to assess the local market access plan.

(f) Procedures to Supplement Local Market Access Plan. An insurer is required to establish and implement documented procedures as specified in this subsection for use in all service areas for which a local market access plan is submitted as required in subsection (d) of this section.

(1) The insurer must utilize a documented procedure to:

(A) identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer;

(B) furnish to such insureds, prior to such services being rendered, an estimate of the amount the insurer will pay the physician or provider; and

(C) notify the insured that the insured may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.

(2) The insurer must utilize a documented procedure to:

(A) identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and

(B) make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level.

(g) Negotiation Procedure Permitted in Access Plan. A local market access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(h) Filing the Report. The annual report required under this section must be submitted electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following e-mail address: hwcn@tdi.state.tx.us.

(i) Access Plan Required if Network Adequacy Status Changes. If the status of a preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the plan no longer complies with the network adequacy requirements specified in §3.3704 of this subchapter for a specific service area, the insurer is required to establish an access plan within 30 days of the date on which the network becomes non-compliant. Such access plan must contain all of the information specified in subsection (e) of this section and must be made available to the department upon request.

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions pursuant to the authority of the commissioner in the Insurance Code Chapter 83 to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and/or

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty pursuant to the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

§3.3711. Geographic Regions. The 11 Texas geographic regions that an insurer is permitted to use for purposes of defining a smaller than statewide service area as described in §3.3705(d)(1) of this subchapter (relating to Nature of Communications

with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations) are as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, comprised of the following ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054, 79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110, 79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, comprised of the following ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464, 76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227, 79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;

(3) Region 3--Metroplex, including Fort Worth and Dallas, comprised of the following ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062,

75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138, 75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180, 75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211, 75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001,

76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108, 76109, 76110, 76111, 76112, 76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;

(4) Region 4--Northeast Texas, including Tyler, comprised of the following ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450,

75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637, 75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651, 75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;

(5) Region 5--Southeast Texas, including Beaumont, comprised of the following ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969,

75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664, 77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;

(6) Region 6--Gulf Coast, including Houston and Huntsville, comprised of the following ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255,

77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304, 77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365, 77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583, 77584, 77586, 77587, 77588,

77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;

(7) Region 7--Central Texas, including Austin and Waco, comprised of the following ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539, 76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606,

78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615, 78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721, 78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;

(8) Region 8--South Central Texas, including San Antonio, comprised of the following ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029,

78039, 78050, 78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219, 78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291, 78292, 78293, 78294, 78295, 78296, 78297, 78298, 78299, 78604, 78614, 78618, 78623, 78624, 78629, 78631, 78632, 78638, 78658, 78670, 78671, 78675, 78677, 78801, 78802, 78827, 78828, 78829, 78830, 78832, 78833, 78834, 78836, 78837, 78838, 78839, 78840, 78841, 78842, 78843, 78847, 78850, 78852, 78853, 78860, 78861, 78870, 78871, 78872, 78873, 78877, 78879, 78880, 78881, 78883, 78884, 78885, 78886, and 78959;

(9) Region 9--West Texas, including Midland, Odessa, and San Angelo comprised of the following ZIP Coded areas: 76820, 76825, 76836, 76837, 76841, 76842, 76848, 76849, 76852, 76854, 76855, 76856, 76858, 76859, 76862, 76866, 76869, 76872, 76874, 76886, 76887, 76901, 76902, 76903, 76904, 76905, 76906,

76908, 76909, 76930, 76932, 76933, 76934, 76935, 76936, 76937, 76939, 76940, 76941, 76943, 76945, 76949, 76950, 76951, 76953, 76955, 76957, 76958, 78851, 79331, 79342, 79359, 79360, 79377, 79511, 79701, 79702, 79703, 79704, 79705, 79706, 79707, 79708, 79710, 79711, 79712, 79713, 79714, 79718, 79719, 79720, 79721, 79730, 79731, 79733, 79735, 79738, 79739, 79740, 79741, 79742, 79743, 79744, 79745, 79748, 79749, 79752, 79754, 79755, 79756, 79758, 79759, 79760, 79761, 79762, 79763, 79764, 79765, 79766, 79768, 79769, 79770, 79772, 79776, 79777, 79778, 79780, 79781, 79782, 79783, 79785, 79786, 79788, 79789, and 79848;

(10) Region 10--Far West Texas, including El Paso, comprised of the following ZIP Coded areas: 79734, 79821, 79830, 79831, 79832, 79834, 79835, 79836, 79837, 79838, 79839, 79842, 79843, 79845, 79846, 79847, 79849, 79851, 79852, 79853, 79854, 79855, 79901, 79902, 79903, 79904, 79905, 79906, 79907, 79908, 79910, 79911, 79912, 79913, 79914, 79915, 79916, 79917, 79918, 79920, 79922, 79923, 79924, 79925, 79926, 79927, 79928, 79929, 79930, 79931, 79932, 79934, 79935, 79936, 79937, 79938, 79940, 79941, 79942, 79943, 79944, 79945, 79946, 79947, 79948, 79949, 79950, 79951, 79952, 79953, 79954, 79955, 79958, 79960, 79961, 79968, 79976, 79978, 79980, 79990, 79995, 79996, 79997, 79998, 79999, 88510, 88511, 88512, 88513, 88514, 88515, 88516, 88517, 88518, 88519, 88520, 88521, 88523, 88524, 88525, 88526, 88527, 88528, 88529, 88530, 88531, 88532, 88533, 88534, 88535, 88536, 88538, 88539, 88540, 88541, 88542, 88543, 88544, 88545, 88546, 88547, 88548, 88549, 88550, 88553, 88554, 88555, 88556, 88557, 88558, 88559, 88560, 88561, 88562, 88563, 88565, 88566, 88567, 88568, 88569,

88570, 88571, 88572, 88573, 88574, 88575, 88576, 88577, 88578, 88579, 88580, 88581, 88582, 88583, 88584, 88585, 88586, 88587, 88588, 88589, 88590, and 88595; and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, comprised of the following ZIP Coded areas: 77950, 77990, 78007, 78022, 78040, 78041, 78042, 78043, 78044, 78045, 78046, 78049, 78060, 78067, 78071, 78072, 78075, 78076, 78102, 78104, 78125, 78142, 78145, 78146, 78162, 78330, 78332, 78333, 78335, 78336, 78338, 78339, 78340, 78341, 78342, 78343, 78344, 78347, 78349, 78350, 78351, 78352, 78353, 78355, 78357, 78358, 78359, 78360, 78361, 78362, 78363, 78364, 78368, 78369, 78370, 78371, 78372, 78373, 78374, 78375, 78376, 78377, 78379, 78380, 78381, 78382, 78383, 78384, 78385, 78387, 78389, 78390, 78391, 78393, 78401, 78402, 78403, 78404, 78405, 78406, 78407, 78408, 78409, 78410, 78411, 78412, 78413, 78414, 78415, 78416, 78417, 78418, 78419, 78426, 78427, 78460, 78461, 78463, 78465, 78466, 78467, 78468, 78469, 78470, 78471, 78472, 78473, 78474, 78475, 78476, 78477, 78478, 78480, 78501, 78502, 78503, 78504, 78505, 78516, 78520, 78521, 78522, 78523, 78526, 78535, 78536, 78537, 78538, 78539, 78540, 78541, 78543, 78545, 78547, 78548, 78549, 78550, 78551, 78552, 78553, 78557, 78558, 78559, 78560, 78561, 78562, 78563, 78564, 78565, 78566, 78567, 78568, 78569, 78570, 78572, 78573, 78574, 78575, 78576, 78577, 78578, 78579, 78580, 78582, 78583, 78584, 78585, 78586, 78588, 78589, 78590, 78591, 78592, 78593, 78594, 78595, 78596, 78597, 78598, and 78599.

§3.3712. Facility-Based Physician Disclosure of Certain Billed Charges. The billed charges for professional services that an insurer must require to be publicly disclosed pursuant to §3.3703(a)(26)(B)(i) of this subchapter (relating to Contracting Requirements) are as follows:

(1) General Professional Services – CPT Codes 58140, 58150, 58180, 58260, 58550, 58552, 59025, 59400, 59510, 90657, 90658, 90669, 90700, 90707, 90713, 90716, 90718, 90744, 90746, 90806, 92004, 92014, 93000, 93307, 93307*26, 93510, 93510*26, 95004, 95117, 95165, 96372, 96413, 97140, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99391, 99392, 99393, 99394, 99395, 99396, 99397;

(2) Pathology - CPT Codes 80048, 80053, 80061, 81000, 81025, 82270, 82947, 82962, 84153, 84443, 85018, 85025, 85610, 87491, 87880, 88142, 88304, 88304*26, 88305, 88305*26, 88307, 88307*26, 88309, 88309*26, 88312, 88331, 88331*26, 88342, 88342*26;

(3) Anesthesiology - CPT Codes 00142, 00160, 00300, 00320, 00400, 00630, 00670, 00740, 00790, 00810, 00840, 00944, 01400, 01402, 01480, 01630, 01810, 01961, 01967, 01992;

(4) Radiology - CPT Codes G0202, G0202*26, G0204, G0204*26, G0206, G0206*26, 70450, 70450*26, 70460, 70460*26, 70470, 70470*26, 70486, 70486*26, 70487, 70487*26, 70488, 70488*26, 70498, 70498*26, 70543, 70543*26, 70544, 70544*26, 70549, 70549*26, 70551, 70551*26, 70552, 70552*26, 70553,

70553*26, 71010, 71010*26, 71020, 71020*26, 71250, 71250*26, 71260, 71260*26, 71270, 71270*26, 71275, 71275*26, 72131, 72131*26, 72132, 72132*26, 72133, 72133*26, 72141, 72141*26, 72146, 72146*26, 72148, 72148*26, 72156, 72156*26, 72157, 72157*26, 72158, 72158*26, 72191, 72191*26, 72192, 72192*26, 72193, 72193*26, 72195, 72195*26, 72197, 72197*26, 73090, 73090*26, 73120, 73120*26, 73130, 73130*26, 73206, 73206*26, 73218, 73218*26, 73220, 73220*26, 73221, 73221*26, 73222, 73222*26, 73223, 73223*26, 73510, 73510*26, 73520, 73520*26, 73550, 73550*26, 73560, 73560*26, 73564, 73564*26, 73565, 73565*26, 73600, 73600*26, 73610, 73610*26, 73620, 73620*26, 73630, 73630*26, 73700, 73701, 73701*26, 73702, 73702*26, 73706, 73706*26, 73718, 73718*26, 73720, 73720*26, 73721, 73721*26, 73723, 73723*26, 74000, 74000*26, 74022, 74022*26, 74150, 74150*26, 74160, 74160*26, 74170, 74170*26, 74175, 74175*26, 74181, 74181*26, 74183, 74183*26, 74241, 74241*26, 76645, 76645*26, 76700, 76700*26, 76801, 76801*26, 76805, 76805*26, 76817, 76817*26, 76830, 76830*26, 76856, 76856*26, 77051, 77051*26, 77052, 77052*26, 77055, 77055*26, 77056, 77056*26, 77057, 77057*26, 77078, 77078*26, 77080, 77080*26, 77081, 77081*26, 77082, 77082*26, 77418, 77427, 78814, 78814*26, 78815, 78815*26, 78816, 78816*26;

(5) Neonatology Critical Care/Newborn Care - CPT Codes 99460, 99461, 99462, 99463, 99464, 99465, 99468, 99469, 99478, 99479, 99480; and

(6) Professional Services (Outpatient) - CPT Codes 19102, 19103, 19120, 29824, 29826, 29827, 29877, 29879, 29880, 29881, 29888, 31255, 36561,

42820, 43234, 43235, 43239, 45378, 45380, 45384, 45385, 47000, 49505, 52332, 58558, 58563, 58661, 58662, 62311, 64721, 66984, 69436.

§3.3713. Submission and Disclosure of Information Concerning the Effects of Uncompensated Care; Waiver.

(a) Effective seven years from the effective date of this section, an insurer is required to submit to the department on the first business day of each July the following information concerning the effects of uncompensated care:

(1) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and

(2) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility.

(b) The information concerning the effects of uncompensated care are required to be submitted to the department electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following e-mail address: lhlmail@tdi.state.tx.us.

(c) Effective eight years from effective date of this section, an insurer is required to make the information concerning the effects of uncompensated care as reported to the department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage.

(d) An insurer's contract with a facility must contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required by this section.

(e) An insurer may apply for a six-month waiver from some or all of the requirements of this section by complying with paragraphs (1) – (3) of this subsection.

(1) Waiver applications are required to be:

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

(B) legible;

(C) in typewritten, computer-generated, or printer's proof format; and

(D) signed by an officer of the insurer.

(2) Waiver applications are required to 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.

(3) An application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including:

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

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

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

(D) specification of the insurer's plan to achieve compliance with the requirements of subsections (a) – (d) of this section, including identification of actions already taken and those planned to be taken; and

(E) the estimated cost of compliance with subsections (a) – (d) of this section and an estimate of the increased cost for compliance at an earlier date.

(f) The waiver application is received when the commissioner has received a waiver application containing all specific facts and circumstances as listed in subsection (e) of this section, including any addendums provided by the insurer.

(g) The commissioner may impose reasonable conditions upon the grant of a waiver under this section.