## SUBCHAPTER KK. HEALTH CARE REIMBURSEMENT RATE INFORMATION

## 28 TAC §§21.4501 - 21.4507

**INTRODUCTION:** The Texas Department of Insurance proposes amendments to 28 TAC §§21.4501-21.4507, concerning the collection and submission of aggregate health care reimbursement rate information by health benefit plan issuers. The proposed amendments to §§21.4501-21.4507 are necessary because data collected under the current rules do not produce a consistent and accurate representation of average market prices for health care services.

**EXPLANATION:** Insurance Code Chapter 38, Subchapter H requires TDI to collect health benefit plan reimbursement rate information in a uniform format and to disseminate the combined rates derived from this data by geographical regions in the state. This statute applies to issuers of preferred provider benefit plans, health maintenance organization (HMO) plans, and specified governmental employee plans under Insurance Code Chapters 1551, 1575, 1579, and 1601.

TDI adopted rules on January 9, 2011, implementing Insurance Code Chapter 38, Subchapter H. TDI publishes the data collected under the rules in a Reimbursement Rate Guide (guide) on TDI's website. The purpose of the guide is to help consumers estimate costs in advance of planned procedures and mitigate balance billing, but TDI has found that much of the data submitted by carriers under the current rules may not accurately reflect costs that consumers are likely to face. In collaboration with the University of Texas School of Public Health, TDI has worked to improve the quality and relevance of data provided to consumers through the Reimbursement Rate Guide.

Current data is orientated around single medical billing codes, but the full cost of a procedure may include multiple claims, each including multiple lines of billing codes. The proposed methodology will present more accurate procedure costs by using key target codes. For any claim that includes a target code, the issuer will provide the full cost of the claim, inclusive of the target code and other services provided.

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

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

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

In selecting procedures for purposes of the proposed data collection, TDI considered several factors. First, TDI considered services that are widely used and provide consumers with ability to plan in advance of receiving a service. TDI surveyed existing price transparency websites for the services included. TDI prioritized services, such as imaging, for which the price may vary significantly based on the place of service. TDI also considered consumers’ need for data on fair market prices for services for which they may be balance billed, such as pathology or emergency care.

*Proposed Amendments*. In addition to the substantive amendments, throughout the rule text TDI corrects typographical, grammatical, and punctuation errors; makes changes to conform rule text to current TDI drafting style; and nonsubstantively simplifies and clarifies certain provisions.

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

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

§21.4502. Applicability. Proposed amendment to §21.4502 deletes the word "group" and inserts "applicable" before health benefit plan to conform to proposed amendments at §21.4503(3). Proposed amendments add new paragraph (e) permitting an applicable health benefit plan issuer to include data concerning reimbursement rates for self-insured health benefit plans administered by the issuer. Proposed amendments add new paragraph (f) exempting an applicable health benefit plan issuer with fewer than 20,000 covered lives in comprehensive health coverage as reported on Part 1 of the National Association of Insurance Commissioners Supplemental Health Care Exhibit as of the end of the applicable reporting period from reporting requirements under §21.4506 as provided in Insurance Code §38.353(e). Proposed amendments add new paragraphs (g)(1) and (g)(2) indicating that under Insurance Code §38.353(e), the subchapter does not apply to a Medicare supplemental policy as defined in §1882(g)(1), Social Security Act (42 U.S.C. §1395ss) or a Medicare Advantage plan offered under a contract with the federal Centers for Medicare and Medicaid Services.

§21.4503. Definitions. Proposed amendments to §21.4503 add new definitions and update current definitions, and delete definitions no longer relevant to the proposed rule. The proposed amendment to §21.4503(1) replaces current text with proposed new text defining "allowed amount" as an amount that the applicable health benefit plan issuer allows as reimbursement for a health care service or group of services, including reimbursement amounts for which a patient is responsible due to deductibles, copayments, or coinsurance.

The proposed amendment to §21.4503(2) replaces current text with proposed new text defining "ambulatory surgical center" as a facility licensed under Health and Safety Code Chapter 243.

The proposed amendment to §21.4503(3) changes "group health benefit plan" previously defined at §21.4503(1) to "applicable health benefit plan" and updates current text to include an exclusive provider benefit plan consistent with Insurance Code §1301.0042.

The proposed amendment to §21.4503(4) replaces current text with proposed new text defining "billed amount" as the amount charged for medical care or health care services on a claim submitted by a provider.

The proposed amendment to §21.4503(5) replaces current text with proposed new text defining "facility claims" as any claim for health care services provided by a facility as defined in §3.3702 of this title.

Proposed new §21.4503(6) adds "freestanding emergency medical care facility" and defines it as a facility, structurally separate and distinct from a hospital, that receives an individual and provides emergency care, as defined in Insurance Code §1301.155.

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

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

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

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

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

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

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

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

Proposed new §21.4503(15) adds "primary plan" and defines it as it is defined in 28 TAC §3.3503(18).

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

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

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

Proposed new §21.4503(19) adds "TDI" defined as Texas Department of Insurance.

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

§21.4504. Geographic Regions. The proposed amendment replaces existing text with new text, requiring issuers to report data collected under this subchapter according to the three-digit ZIP code in which the health care service was provided. TDI also notes in proposed text that publication of health care reimbursement rate information derived from the data may be aggregated across broader geographic regions if necessary to ensure, consistent with Insurance Code §38.357, that the published information does not reveal the name of any health care provider or health benefit plan issuer.

§21.4505. Requirement to Collect Data. The proposed amendments to §21.4505(a) removes the word "group" preceding "health benefit plan" and inserts the word "applicable" to conform to proposed

amendments at §21.4503(3), adds the requirement to collect the data annually, and deletes text referring to Form LHL616 to conform to proposed amendments to §21.4507.

The proposed amendment to §21.4505(b) replaces current text with new text requiring that data elements and medical services specified under proposed amendments to §21.4507(b) and (c) must be collected with respect to medical billing codes specified by TDI. The current set of medical billing codes will be available to issuers in a Microsoft Excel template on TDI's website and will be updated not more often than annually to account for any changes in standard medical practice and medical billing codes related to the services specified in proposed amendment to §21.4507(c).

The proposed amendment to §21.4505(c) deletes subsection (c) related to an exemption based on number of covered lives to conform to proposed amendment §21.4502(f).

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

The proposed amendment to §21.4506(b) replaces current text with proposed new text requiring the data be filed electronically as a Microsoft Excel form and emailed to TDI, or uploaded by secure File Transfer Protocol.

The proposed amendment to §21.4506(c) replaces current text with new text alerting issuers that they may use a Microsoft Excel template available on TDI's website to meet the requirements of proposed §§21.4501 - 21.4507.

The proposed amendment to §21.4506(d) and the proposed amendment to §21.4506(e) delete subsections (d) and (f), both relating to procedures for accessing the report form and acceptance of the End User Agreement to conform to proposed amendments to §21.4507.

The proposed amendment to §21.4506 (e) deletes subsection (e) related to an exemption based on number of covered lives to conform to proposed amendments to §21.4502(f).

§21.4507. Data Required. Proposed amendments change the title of the section from "Report Form" to

"Data Required" to more accurately describe the section. The proposed amendment to §21.4507 deletes §21.4507(1)-(3) to conform with proposed new §21.4507(a)-(d).

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

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

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

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

Proposed new §21.4507(c)(1) relates to inpatient procedures and requires issuers to report the data separately for facility claims and professional claims. Proposed new §21.4507(c)(1)(A)-(C) describes the data to report and proposed new §21.4507(c)(1)(C)(i)-(xi) lists the services to include.

Proposed new §21.4507(c)(2) relates to outpatient procedures and requires issuers to report facility claims and professional claims separately. Proposed new §21.4507(c)(2)(A)-(C) describe the data to report for outpatient procedures and proposed new §21.4507(c)(2)(C)(i)-(xiii) lists the services to

include.

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

Proposed new §21.4507(c)(4) relates to imaging services and requires issuers to report the data separately for facility claims and professional claims. Proposed new §21.4507(c)(4)(A)-(C) describe the data to report for imaging services and proposed new §21.4507(c)(4)(C)(i)-(xxvi) lists the services to include.

Proposed new §21.4507(c)(5)relates to pathology services and requires issuers to report the data only for professional claims for which the place of service is an independent lab. Proposed new §21.4507(c)(5)(A)-(B) describes the data to report and proposed new §21.4507(c)(5)(B)(i)-(x) lists the services to include.

Proposed new §21.4507(c)(6) relates to office visits and requires issuers report data only for professional claims for which the place of service is an office or rural health clinic. Proposed new §21.4507(c)(6)(A)-(C) describes the data to report for office visits, and proposed new §21.4507(c)(6)(B)(i)-(xii) lists the types of office visits to include.

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

**FISCAL NOTE.** Rachel Bowden, program specialist, Regulatory Initiatives Office, has determined that, for each year of the first five years the proposed amendments are in effect, there may be measurable fiscal impact to state and local governments as a result of administration of this proposal. The cost analysis in the Public Benefit and Cost Note part of this proposal is applicable to these local and state governments.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

**PUBLIC BENEFIT AND COST NOTE.** Ms. Bowden has determined that for each year of the first five years the proposed amendments are in effect, there are public benefits anticipated as a result of the enforcement and administration of the rule, and there will also be potential costs for persons required to comply with the proposal. TDI drafted the proposed rules to maximize public benefits consistent with the intent of Insurance Code Chapter 38, Subchapter H, while mitigating costs.

Anticipated Public Benefit. One anticipated public benefit will be the implementation of an improved data collection methodology that will collect data for the full cost of a claim for certain in-network and out-of-network, and inpatient and outpatient, treatment events. Inpatient treatment events include cesarean section delivery; vaginal delivery; hysterectomy; hip replacement; knee replacement; back surgery - laminectomy; coronary artery bypass grafting; inguinal hernia repair, unilateral; inguinal hernia repair, bilateral; laparoscopic cholecystectomy; and appendectomy. Outpatient treatment events include: tonsillectomy; adenoidectomy; tonsillectomy and adenoidectomy; inguinal hernia repair, unilateral; inguinal hernia repair, bilateral; laparoscopic cholecystectomy; appendectomy; myringotomy; colonoscopy; upper GI endoscopy; upper and lower GI endoscopy; bunion repair; ACL repair; rotator cuff repair; cardiac catheterization, left; cardiac catheterization, right; cardiac catheterization, left and right; and percutaneous transluminal coronary angioplasty.

A second anticipated public benefit will be the collection of professional claims data for emergency services for which the place of services is an emergency room or outpatient hospital. Emergency services are: emergency room visit, self-limited or minor problem; emergency room visit, low to moderately severe problem; emergency room visit, moderately severe problem; emergency room visit, problem of high severity; and emergency room visit, problem with significant threat to life or function.

A third anticipated public benefit will be improved transparency concerning health care reimbursement rate information. Specifically, TDI will publish the data in a Reimbursement Rate Guide on its website that consumers can use to estimate costs in advance of planned procedures and mitigate balance billing.

Anticipated Costs.

*Persons required to comply with the proposal*. Under Insurance Code §38.353(a), the persons required to comply with the proposal are issuers of a health benefit plan, including an insurance company; a group hospital service corporation; a fraternal benefit society; a stipulated premium company; a reciprocal or interinsurance exchange; and an HMO.

In accordance with Insurance Code §38.353(b), several governmental employee plans must comply with the data submission requirements. These plans are: a basic coverage plan under Insurance Code Chapter 1551; a basic plan under Insurance Code Chapter 1575; a primary care coverage plan under Insurance Code Chapter 1579; and a basic coverage plan under Insurance Code Chapter 1601. Further, under Insurance Code §38.353(c), small employer health benefit plans under Insurance Code Chapter 1501 are required to comply with the data submission requirements except as provided in subsection (d) of §38.353. Under Insurance Code §38.353(d), the data submission requirements do not apply to standard health benefit plans (also known as "consumer choice" plans) provided under Insurance Code Chapter 1507; children's health benefit plans provided under Insurance Code Chapter 1502; health care benefits provided under a workers' compensation insurance policy; Medicaid managed care programs operated under Government Code Chapter 533; Medicaid programs operated under Human Resources Code Chapter 32; or the state child health plan operated under Health and Safety Code Chapters 62 or 63.

Some health benefit plan issuers may report information and data on behalf of certain governmental employee plans. Each governmental employee plan must either independently submit the data required by the proposed amendments or must authorize and require the entity administering the governmental employee plan to submit the information and data on its behalf. A governmental employee plan may determine that the health benefit plan with which it contracts should provide the requested information, and so will delegate that authority to report. Based on reporting on behalf of governmental employee plans in other data collections unrelated to this proposal, TDI anticipates that these delegations are more probable than not. The proposal, therefore, affords some flexibility to health benefit plan issuers that administer governmental employee plans.

The estimated cost for reporting for a governmental employee plan should be comparable to the cost incurred by a health benefit plan issuer. To the extent that a health benefit plan issuer submits

information on behalf of a governmental employee plan in addition to the issuer's own data, the cost to a governmental employee plan may be reduced. Health benefit plan issuers submitting the requested information and data on behalf of other entities, in addition to submitting the information and data for themselves, may incur some additional costs. These costs may be mitigated to the extent that the issuer maintains aggregate claims data for the governmental employee plans and data for the issuer's own health benefit plans.

*Proposed Amendments Resulting in Potential Costs*. The cost to persons required to comply with the proposed amendments results from requirements concerning the collection and preparation of health care reimbursement data as specified in proposed amendments to §§21.4505, 21.4506 and 21.4507; and the submission of the data as specified in proposed amendments to §§21.4505, 21.4506 and 21.4507.

*Cost Components*. The probable cost components associated with the compliance requirements in proposed amendments to §§21.4505, 21.4506, and 21.4507 include personnel costs associated with programming information systems, and personnel costs associated with reviewing the data.

TDI identified no new technology or software costs associated with the proposed amendments, as the technology or software needed to comply with the proposed amendments is the same as the technology or software needed to comply with the current rule. For an analysis of those costs, see the September 10, 2010, issue of the *Texas Register* (35 TexReg 8286).

*Cost of personnel associated with programming information systems*. TDI anticipates that health benefit plan issuers will undertake information system programming in order to collect information as required by proposed amendments to §§21.4505 and 21.4507. The proposed amendment to §21.4505(a) requires health benefit plan issuers to annually collect data for in-network and out-of-network claims by three-digit ZIP code for several categories of medical and health care services in accordance with proposed amendments to §21.4507. The type of data requested for specified treatment events in proposed amendments to §21.4507 include claims data for inpatient procedures, including facility claims and professional claims; outpatient procedures, including facility claims and professional claims;

imaging services, including facility claims and professional claims; professional claims for pathology services; and professional claims for office visits.

Proposed amendments to §21.4507(b) require health benefit plan issuers to collect the requested data with respect to medical billing codes specified by TDI. The medical billing codes are standard code sets used to bill for specific medical services, including the HCPCS and DRG systems established by CMS, the CPT code set maintained by the American Medical Association, and the ICD code sets developed by the World Health Organization.

In addition to programming to collect the required data and information, TDI anticipates that health benefit plan issuers will perform programming necessary to automate the collection of the data to the extent possible. Total programming costs will vary depending on the number of hours required, the skill level of the programmer or programmers, the complexity of the health benefit plan issuer's information systems, and whether contract programmers will be involved. Each issuer has the information needed to estimate its individual costs for this programming. However, based on information submitted by issuers who tested the revised methodology, TDI estimates that the initial year of data collection will require between 90 and 240 hours of programming and quality assurance time, while reports submitted in subsequent years will require between 45 and 90 hours of programming and quality assurance time. The latest State Occupational Employment and Wage Estimates for Texas published by the U.S. Department of Labor (DOL, May 2014) at http://www.bls.gov/oes/current/oes_tx.htm, indicates that the mean hourly wage for a computer programmer in Texas is $38.85. Based on information TDI has previously obtained from insurers, hourly wage rates for outside contract programmers are estimated to range upwards of $200 per hour. The actual number, types, and cost of personnel will be determined by the health benefit plan issuer's existing information systems and staffing. Further, issuers with less sophisticated data systems may incur greater costs than those issuers with more sophisticated data infrastructure.

*Cost of personnel associated with review of data*. TDI estimates that a member of the health benefit plan issuer's management staff can review and approve the prepared information in two to four hours. The salary for this employee is estimated at the mean salary rate of $55.04 per hour, as set forth for management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2014) at http://www.bls.gov/oes/current/oes_tx.htm.

*Stakeholder Feedback on Costs*. TDI requested cost information by public comment during the posting of the informal draft of the rule text and from issuers who chose to test the new methodology in response to this year's rate reimbursement guide data call. TDI received input from three issuers who tested the revised methodology, with the amount of time to complete the data collection ranging from 60 to 168 hours of time for programming development and quality assurance. TDI used this information to estimate the time to complete the initial year of data collection under this proposal. The full scope of data to be collected under the proposal is larger than the scope of test data submitted by issuers. However, the test included 82 percent of the query designs that will be required under the full scope of the rule.

*Exempt Issuers and Optional Additional Data Inclusion*. Under Insurance Code §38.353(e), the commissioner by rule may exclude a type of health benefit plan from the requirements of Chapter 38, Subchapter H, if the commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of Subchapter H. The current rules provide an exemption for private market preferred provider benefit plans operating under Insurance Code Chapter 1301 and private market HMOs operating under Insurance Code Chapter 843 that do not exceed 10,000 covered lives as of December 31 for the year preceding the submission of the data. Proposed amendment §21.4502(f) increases the threshold from 10,000 to 20,000 covered lives. The proposed amendment also removes the requirement previously at §21.4505(c) that health benefit plan issuers asserting this exemption collect enrollment data and submit to TDI an exemption statement. As a result, issuers who qualify for the exemption under the proposed amendments will no longer incur any costs to comply.

Self-insured health benefit plans are not subject to the data submission requirements of Insurance Code Chapter 38, Subchapter H. However, proposed new §21.4502(e) permits an applicable health benefit plan issuer to electively include data concerning reimbursement rates for self-insured health benefit plans. This proposed provision enables health benefit plan issuers who offer self-insured health benefit plans to avoid the possible expense of separating out claims data for those types of plans if that claims data is otherwise aggregated with the data that is required to be submitted.

**ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.**

Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses, and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. 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.

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. Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in Government Code §2006.002(b)-(d) for small businesses.

*Economic Impact Statement*. As required by Government Code §2006.002(c), TDI has determined that the proposed amendment to §21.4505 and §21.4507 may have an adverse economic effect on HMOs and preferred provider benefit plan issuers that qualify as small or micro businesses under Government Code §2006.001(1) and (2) and are required to comply with these proposed rules. The adverse economic impact will result from the necessary costs for health benefit plan issuers that, in compliance with this proposal, are collecting and preparing health care reimbursement data as specified in proposed §21.4507, and submitting the data as specified in proposed §21.4505 and proposed §21.4507. These costs are discussed in the Public Benefit/Cost Note part of this proposal. As also discussed in the Public Benefit/Cost Note part of this proposal, the cost components associated with these compliance requirements include personnel costs associated with programming information systems for compliance with the requirements in proposed §21.4505 and §21.4507, and personnel costs associated with reviewing the data in compliance with the requirements in proposed §21.4506 and §21.4507.

The current rules incorporate regulatory provisions designed to reduce potential economic impact for all health benefit plans, including small and micro businesses (see rule proposal in the

September 10, 2010, issue of the *Texas Register* (35 TexReg 8286)). The proposed amendments to §21.4502(e) and 21.4502(f) expand on theses regulatory provisions.

TDI is aware that some health benefit plan issuers maintain aggregated claim data, and that it may be costlier for these issuers to segregate claim data than to include it. Proposed amendment §21.4502(e) permits an applicable health benefit plan issuer to electively include the data concerning reimbursement rates for self-insured plans it administers in its submission of data for purposes of administrative convenience. TDI anticipates that proposed §21.4502(e) may reduce the economic impact of this proposal for applicable health benefit plan issuers that issue self-insured plans, including small and micro businesses.

Section 21.4502(f) increases the number of covered lives in the exemption from 10,000 to 20,000 lives, and grants the exemption without requiring the issuer file a report with TDI. TDI anticipates that the increase in the exemption based on enrollment may reduce the economic impact of this proposal for small and micro businesses. The exemption in proposed amendment §21.4502(f) applies to private-market preferred provider benefit plans operating under Insurance Code Chapter 1301 and private-market HMOs operating under Insurance Code Chapter 843, as applicable for each line of business. This exemption from data collection and reporting requirements is available to all health benefit plan issuers that qualify, including qualifying issuers that are small or micro businesses. While the exemption is not directly contingent on the qualification of the health benefit plan issuers as a small or micro business under Government Code §2006.001, TDI anticipates that small and micro business issuers are more likely to qualify for the exemption than are larger issuers.

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

As previously discussed in this Economic Impact Statement section, TDI has considered and incorporated into this proposal regulatory provisions that will minimize adverse economic impact on all

health benefit plan issuers, including small and micro businesses. Nevertheless, TDI considered three additional regulatory alternatives as required by Government Code §2006.002(c)(2). These three include: (i) total exemption of small or micro business health benefit plan issuers from data collection and reporting requirements instead of an exemption from data collection and reporting requirements on the basis of reduced enrollment in the proposal; (ii) exemption of small or micro business health benefit plan issuers solely on the basis of their meeting the criteria of a small or micro business under Government Code §2006.001; and (iii) reduced frequency requirement for the provision of collection and submission of health care reimbursement data by small or micro business health benefit plan issuers, such as every other year. For the following reasons, TDI rejected each of these alternatives as not being sufficiently consistent with the purpose of the statute or sufficiently protective of the economic welfare of the state, including small and micro businesses.

*Total Exemption of Small or Micro Businesses from Data Collection and Reporting Requirements*. TDI has determined that exempting small and micro business health benefit plan issuers from all data collection and reporting requirements could compromise the accuracy and reliability of the claims data. Health care rate reimbursement data from a small or micro business issuer with a large number of covered lives, and therefore likely a more significant quantity of claims, has a greater potential to affect the overall aggregation of data that will be published for purposes of comparison.

As previously explained in this Economic Impact Statement, TDI has instead elected in proposed amendment §21.4502(f) to exempt an applicable health benefit plan with fewer than 20,000 covered lives in comprehensive health coverage from data collection and reporting. Although the exemption from data collection and reporting under this proposal is permitted on the basis of reduced enrollment rather than the health benefit plan issuer meeting the criteria to qualify as a small or micro business under Government Code §2006.001, TDI anticipates that small and micro business issuers will likely qualify for the proposed exemption. However, under the proposal, should the qualifying small or micro business issuer provide coverage to a greater number of persons than 20,000 as provided in proposed amendment §21.4502(f), and thus have a greater likelihood of affecting the aggregated data, the small or micro business issuer will not qualify for the exemption. TDI has determined that a total or an unqualified exemption for all small or micro business issuers would not be sufficiently protective of the quality and reliability of the data. As a result, the impaired data would not be consistent with the intent

of the statute to improve the ability of patients to make appropriate and cost effective health care decisions. Further, impaired data would reduce the ability of employers, including small and micro businesses, to accurately compare health care reimbursement data in selecting health benefit plans. As such, TDI has determined that this total exemption regulatory alternative is not sufficiently protective of the economic welfare of the state nor sufficiently consistent with the purpose of Insurance Code Chapter 38, Subchapter H, as enacted in SB 1731 (80th Legislature), to provide greater accuracy and transparency of health care costs for consumers.

*Exemption of Small or Micro Businesses Solely on the Basis of Meeting the Criteria of a Small or Micro Business*. Reducing the data collection and reporting requirements for health benefit plan issuers solely on the basis of their meeting the criteria of a small or micro business under Government Code §2006.001 could adversely affect the accuracy and reliability of the claims data. For example, it is possible that a small or micro business issuer could provide coverage to a sufficient number of persons--greater than the 20,000-person requirement in the proposed §21.4502(f) exemption--that a significant quantity of claims are generated. Absent that data, the available data (for purposes of comparison by both employers and consumers) could be less accurate and, therefore, less reliable.

So TDI has instead proposed §21.4502(f) to exempt those with less than 20,000 covered lives from data collection and reporting, regardless of whether the issuer meets the criteria to qualify as a small or micro business. Although under this proposal the exemption from data collection and reporting is permitted on the basis of reduced enrollment rather than whether the issuer meets the criteria to qualify as a small or micro business, TDI anticipates that issuers that meet the criteria as a small or micro business will likely qualify for the exemption in proposed §21.4502(f). Should the qualifying small or micro business issuer provide coverage to a number of persons in excess of 20,000 covered lives and thus have a greater likelihood of affecting the aggregated data, under the proposal the small or micro business issuer will not qualify for the exemption. As a result, the small and micro business issuers' claim data will be included in the collected data along with those issuers that do not meet the criteria as a small or micro business under Government Code §2006.001. TDI has determined that this regulatory alternative is not sufficiently protective of the economic welfare of the state or sufficiently consistent with the purpose of Insurance Code Chapter 38, Subchapter H, to provide greater accuracy and transparency of health care costs for consumers.

*Reduced Frequency Requirement for Small or Micro Businesses to Collect and Submit Data*. Permitting small or micro business health benefit plan issuers to submit health care reimbursement data on a reduced frequency basis could similarly impair the quality and reliability of the data. Health care costs have been consistently rising in recent years, and this trend increases the importance of collecting data on an annual basis.

Because small or micro businesses are likely to be subject to the proposed amendment §21.4502(f) exemption based on not exceeding the 20,000 covered lives requirement, the small or micro businesses that would be subject to the reduced frequency reporting requirement would likely have claims data sufficient to affect the aggregate data for the region or regions in which the small or micro business operates. TDI has determined that absent that data, the quality of data available for purposes of comparison by both employers and patients would be less reliable during the periods when the reduced frequency reporting prevented submission of data. As a result, this regulatory alternative would not be consistent with the intent of the statute to improve the ability of consumers to make appropriate and cost effective health care decisions. TDI has determined that this regulatory alternative is not sufficiently protective of the economic welfare of the state or sufficiently consistent with the purpose of Insurance Code Chapter 38, Subchapter H, to provide greater accuracy and transparency of health care costs for consumers.

For these reasons, TDI has determined, in accordance with the Government Code §2006.002(c-1), that there are no regulatory alternatives to the proposed requirements in §§21.4501-21.4507 that will sufficiently protect the health, safety, environmental, and economic welfare of the state in a manner consistent with the objective and intent of Insurance Code Chapter 38, Subchapter H, as enacted by SB 1731 (80th Legislature).

**TAKINGS IMPACT ASSESSMENT.** TDI has determined that no private real property interests are affected by this proposal. This proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

**REQUEST FOR PUBLIC COMMENT.** TDI invites comments on the proposed rules. If you wish to comment on this proposal, your comments must be postmarked no later than 5 p.m., Central time, on December 21, 2015. Please send comments by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or by email to chiefclerk@tdi.texas.gov. Please simultaneously submit an additional copy of the comments by mail to Rachel Bowden, Regulatory Initiatives, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or by email to lhlcomments@tdi.texas.gov.

A request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

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

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

Section 38.352 provides that in Subchapter H, health benefit plan means a preferred provider benefit plan as defined by §1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by §843.002. Section 1301.001 provides at paragraph (9) that preferred provider benefit plan means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider. Section 1301.001 provides at paragraph (2) that health insurance policy means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness. Section 843.002(9) provides that evidence of coverage means any certificate, agreement, or contract, including a blended contract, that is issued to an enrollee, states the coverage to which the enrollee is entitled.

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

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

Section 38.355(a) requires each health benefit plan issuer to submit aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by TDI, in the form and manner and at the time required by TDI.

Section 38.355(b) requires that TDI by rule establish a standardized format for the submission of the data submitted under the section to permit comparison of health care reimbursement rates. The subsection also requires TDI, to the extent feasible, to develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates.

Section 38.355(c) requires TDI to specify the period for which reimbursement rates must be filed.

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

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

**CROSS REFERENCE TO STATUTE.** The following statutes are affected by this proposal: Insurance Code Chapter 38, Subchapter H; and Chapters 843, 1301, 1501, 1507, 1551, 1575, 1579, and 1601.

**Text**

**CHAPTER 21 SUBCHAPTER KK.**

**HEALTH CARE REIMBURSEMENT RATE INFORMATION**

**§21.4501. Purpose**

The purpose of this subchapter is to:

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

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

(3) facilitate TDI's publication [~~the department's provision~~] of aggregate health care reimbursement rate information derived from the data collected under this subchapter [~~to the Department of State Health Services for publication~~.]

**§21.4502. Applicability**

(a) This subchapter applies to the issuer of an applicable [~~a group~~] health benefit plan as defined in §21.4503 of this subchapter and [~~(relating to Definitions), including,~~] as provided by [~~the~~] Insurance Code §38.353(a):

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; and

(6) a health maintenance organization (HMO).

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

(1) a basic coverage plan under [~~the~~] Insurance Code Chapter 1551;

(2) a basic plan under [~~the~~] Insurance Code Chapter 1575;

(3) a primary care coverage plan under [~~the~~] Insurance Code Chapter 1579; and

(4) basic coverage under [~~the~~] Insurance Code Chapter 1601.

(c) Under[~~Pursuant to the~~] Insurance Code §38.353(d), this subchapter does not apply to:

(1) standard health benefit plans provided under [~~the~~] Insurance Code Chapter 1507;

(2) children's health benefit plans provided under [~~the~~] Insurance Code Chapter 1502;

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

(4) Medicaid managed care programs operated under [~~the~~] Government Code Chapter 533;

(5) Medicaid programs operated under [~~the~~] Human Resources Code Chapter 32; or

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

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

(e) An applicable health benefit plan issuer is not prohibited from electively including data concerning reimbursement rates for self-insured health benefit plans administered by the issuer.

(f) An applicable health benefit plan issuer with fewer than 20,000 covered lives in comprehensive health coverage as reported on Part 1 of the National Association of Insurance Commissioners Supplemental Health Care Exhibit as of the end of the applicable reporting period is not

required to submit a report under §21.4506.

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

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

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

**§21.4503. Definitions**

The following words and terms when used in this subchapter [~~shall~~] have the following meanings unless the context clearly indicates otherwise.

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

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

(3)[~~(1) Group health benefit plan~~] Applicable Health Benefit Plan--As specified in [~~the~~] Insurance Code §38.352, a preferred provider benefit plan as defined by [~~the~~] Insurance Code §1301.001, including an exclusive provider benefit plan consistent with Insurance Code §1301.0042, or an evidence of coverage for a health care plan that provides basic health care services as defined by [~~the~~] Insurance Code §843.002. The term does not include an HMO [~~a health maintenance organization~~] plan providing routine dental or vision services as a single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan.

(4) Billed Amount--The amount charged for medical care or health care services on a

claim submitted by a provider.

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

(6) Freestanding emergency medical care facility--A facility, structurally separate and distinct from a hospital, that receives an individual and provides emergency care, as defined by Insurance Code §1301.155.

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

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

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

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

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

(12) Out-of-Network Claims--Claims filed with an applicable health benefit plan for medical or health care treatment, services, or supplies furnished by a provider that is not an in-network

provider or preferred provider under the plan. Claims paid on an out-of-network basis are considered out-of-network regardless of whether the provider is reimbursed based on an agreed on rate.

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

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

(15) Primary Plan--As defined in §3.3503(17) of this title.

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

[~~(2) Institutional provider--An institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers, and residential treatment centers.~~]

[~~(3) Physician--Any individual licensed to practice medicine in this state and, with regard to a health maintenance organization, as defined in the Insurance Code §843.002(22).~~]

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

(18)[~~(5)~~] Reporting period--The 12[~~six~~]-month interval of time for which a plan or health benefit plan issuer must submit data each year, beginning each January 1 and ending the following

December 31[~~June 30~~].

(19) TDI--Texas Department of Insurance.

**§21.4504. Geographic Regions**

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

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[~~(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.~~]

**§21.4505. Requirement to Collect Data**

(a) Each applicable [~~group~~] health benefit plan issuer and plan specified in §21.4502(a) and (b) of this subchapter [~~(relating to Applicability) is required to~~] must annually collect the data specified under [~~in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) that is adopted by reference in~~] §21.4507 of this subchapter [~~(relating to Report Form)~~] and [~~is required to~~] prepare and file data as provided [~~in accordance with the requirements~~] in §21.4506 of this subchapter [~~(relating to Submission of Report)~~].

(b) Data elements and medical services specified under §21.4507(b) and (c) of this subchapter must be collected with respect to medical billing codes specified by TDI. The current set of medical billing codes will be available to issuers in a Microsoft Excel template on TDI's website at

www.tdi.texas.gov/health/reimbursement.html. If there are changes in standard medical practice or medical billing codes that necessitate changing the identified billing codes for the services specified in §21.4507(c) of this subchapter, the billing codes on TDI's website will be updated and affected carriers notified, but in no event will these updates occur more often than annually or less than six months before the May 1st reporting deadline. [~~The six-month reporting period for the data requested in Form No. LHL616 (Health Care Claims Reimbursement Rate Report), including the claims and reimbursement rate data, is January 1 to June 30 of the applicable reporting year. The enrollment data required in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) for private market plans and governmental employee plans is for the total number of lives covered under the plans as of both December 31 of the year prior to the applicable reporting period and June 30 of the applicable reporting year.~~]

[~~(c) Notwithstanding subsection (a) of this section, a health benefit plan issuer that is exempt from filing a full reimbursement report pursuant to §21.4506(e) of this subchapter is not required to collect the full data indicated in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) and is required to instead collect enrollment data as necessary to comply with the applicable instructions specified in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) to support an exemption.~~]

**§21.4506. Submission of Report**

(a) Not later than May [~~September~~] 1 of each year, each plan and health benefit plan issuer identified in §21.4502(a) and (b) of this subchapter, or the plan or issuer's authorized agent, [~~(relating to Applicability) is required to~~] must submit to TDI[~~the department~~] the data required under [~~in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) that is adopted by reference in~~] §21.4507 of this subchapter [~~(relating to Report Form)~~].

[~~(b) Notwithstanding the requirements of subsection (a) of this section, the first reporting date for the submission of data required by this subchapter is 60 days from effective date of rule for data regarding claims payments from January 1, 2010, to June 30, 2010.~~]

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

[~~(1) accessing a link designated on the department's website, http://www.tdi.state.tx.us/forms/form10accident.html, to obtain Form No. LHL616 (Health Care Claims Reimbursement Rate Report);~~]

[~~(2) completing the report in accordance with the form's instructions; and~~]

[~~(3) emailing the completed report to the department at ReimbursementRates@tdi.state.tx.us.~~]

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

[~~(d) To access the report form, the user must indicate acceptance of the End User Agreement concerning use of Current Procedural Terminology. Acceptance is indicated by clicking the button labeled "Accept." The content of the End User Agreement is provided in Figure: 28 TAC §21.4506(f) of this subchapter.~~]

[~~(e) Notwithstanding subsections (a) - (d) of this section, a group health benefit plan issuer as specified in §21.4502(a) of this subchapter may submit to the department an exemption statement and the data required in Section B of Form No. LHL616 (Health Care Claims Reimbursement Rate Report) to support an exemption in place of the full report described in subsections (a) - (d) of this section. The group health benefit plan issuer asserting an exemption shall certify that the group health benefit plan~~

~~issuer is exempt from the reporting requirement applicable to its health benefit plans for one of the following reasons:~~]

[~~(1) the total number of all covered lives in private market preferred provider benefit plans operating under the Insurance Code Chapter 1301 and offered by the health benefit plan issuer in Texas does not exceed 10,000 persons as of December 31 of the year preceding the report; or~~]

[~~(2) the total number of all covered lives in the private market health maintenance organization plans operating under the Insurance Code Chapter 843 and offered by the health benefit plan issuer does not exceed 10,000 persons as of December 31 of the year preceding the report.~~]

[~~(f) The content of the End User Agreement is as follows:~~]

[~~Figure: 28 TAC §21.4506(f)~~]

**§21.4507. Data Required [~~Report Form~~]**

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

(1) reporting period;

(2) company or plan name;

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

(4) TDI company number;

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

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

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

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

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

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

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

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

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

(5) total amount billed;

(6) total amount allowed;

(7) mean amount billed;

(8) mean amount allowed;

(9) median amount billed;

(10) median amount allowed;

(11) maximum amount billed;

(12) maximum amount allowed;

(13) minimum amount billed;

(14) minimum amount allowed;

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

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

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

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

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

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

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

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

(C) Inpatient procedure claims data must be reported for the full cost of any claim, or the full cost of any discharge for facility claims, for the following services, using the medical billing codes specified by TDI consistent with §21.4705(b) of this subchapter:

(i) cesarean section delivery;

(ii) vaginal delivery;

(iii) hysterectomy;

(iv) hip replacement;

(v) knee replacement;

(vi) back surgery - laminectomy;

(vii) coronary artery bypass grafting;

(viii) inguinal hernia repair, unilateral;

(ix) inguinal hernia repair, bilateral;

(x) laparoscopic cholecystectomy; and

(xi) appendectomy.

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

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

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

(C) Data on outpatient procedure facility claims must be reported for the full cost of any claim for the following services, using the medical billing codes specified by TDI, consistent with §21.4705(b) of this subchapter:

(i) tonsillectomy;

(ii) adenoidectomy;

(iii) tonsillectomy and adenoidectomy;

(iv) inguinal hernia repair, unilateral;

(v) inguinal hernia repair, bilateral;

(vi) laparoscopic cholecystectomy;

(vii) appendectomy;

(viii) myringotomy;

(ix) colonoscopy;

(x) upper GI endoscopy;

(xi) upper and lower GI endoscopy;

(xii) bunion repair;

(xiii) ACL repair;

(xiv) rotator cuff repair;

(xv) cardiac catheterization, left;

(xvi) cardiac catheterization, right;

(xvii) cardiac catheterization, left and right; and

(xviii) percutaneous transluminal coronary angioplasty.

(3) Emergency Services. Data on emergency room visits must be reported only for professional claims for which the place of service is an emergency room or outpatient hospital. An emergency room includes both a hospital emergency room and a freestanding emergency medical care facility. Data must be reported at the claim line level for the following types of emergency room visits, using the medical billing codes specified by TDI, consistent with §21.4705(b) of this subchapter:

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

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

(C) emergency department visit, moderately severe problem;

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

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

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

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

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

(i) outpatient hospital;

(ii) office; and

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

(C) Data must be reported at the claim-line level for the following imaging services, using the medical billing codes specified by TDI, consistent with §21.4705(b) of this subchapter:

(i) CT abdomen and pelvis;

(ii) CT scan abdomen;

(iii) CT scan pelvis;

(iv) CT scan head/brain;

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

(vi) CT scan soft tissue neck;

(vii) CT scan chest;

(viii) CT scan lumbar lower spine;

(ix) CT scan lower extremity;

(x) MRI brain;

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

(xii) MRI angiography head;

(xiii) MRI neck spine;

(xiv) MRI spine;

(xv) MRI lumbar spine;

(xvi) MRI lower limb;

(xvii) MRI upper limb, other than joint;

(xviii) MRI lower limb with joint;

(xix) MRI upper limb joint;

(xx) MRI abdomen;

(xxi) MRI one breast;

(xxii) MRI both breasts;

(xxiii) MRI pelvis;

(xxiv) mammogram, analog;

(xxv) mammogram with CAD; and

(xxvi) mammogram, digital.

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

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

(B) Data must be reported for the following pathology services, using the medical billing codes consistent with §21.4705(b) of this subchapter:

(i) organ or disease panels;

(ii)evocative suppression testing;

(iii) urinalysis;

(iv) chemistry;

(v) hematology-coagulation;

(vi) immunology;

(vii) microbiology;

(viii) anatomic pathology;

(ix) screening cytopathology; and

(x) complete blood count.

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

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

(B) Data must be reported for the following types of office visits, using the medical billing codes consistent with §21.4705(b) of this subchapter:

(i) office or other outpatient visit with a new patient;

(ii) office or other outpatient visit with an established patient;

(iii) office consultation;

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

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

(vi) annual gynecological exam, new patient;

(vii) annual gynecological exam, established patient;

(viii) screening pelvic and breast exam;

(ix) screening pap smear; and

(x) cytopathology for pap smear.

(C) Data must be reported for well-woman exams so that all costs associated with a claim are reported with respect to the medical billing consistent with §21.4705(b) of this subchapter.

(d) Data submission requirements. In reporting data required under this section, issuers must:

(1) report data elements according to medical billing codes specified by §21.4705(b) of this subchapter;

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

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

(4) filter claims data to include only:

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

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

(C) claims for insureds in commercial fully insured plans or self-funded employer group plans;

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

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

~~[Form No. LHL616 (Health Care Claims Reimbursement Rate Report) is adopted by reference. The form:]~~

~~[(1) contains instructions for completion of the report and requires submission of information and data concerning group health benefit plan issuer identification and enrollment information;]~~

~~[(2) requires the submission of both contracted and out-of-network claim information for general professional services; pathology services; anesthesiology services; radiology services; neonatology services; outpatient professional and institutional provider services; and inpatient institutional provider services; and]~~

~~[(3) is available at http://www.tdi.state.tx.us/forms/form10accident.html.]~~

**CERTIFICATION.** This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on October 28, 2015.

Sara Waitt
General Counsel
Texas Department of Insurance