SUBCHAPTER DD. Eligibility Statements

28 TAC §§21.3801 - 21.3808

1. INTRODUCTION. The Texas Department of Insurance proposes new Subchapter DD, §§21.3801 - 21.3808, concerning eligibility statements. These new sections are necessary to implement the provisions of Senate Bill (SB) 1149 (79th Regular Legislative Session), requiring carriers to provide certain eligibility information to contracted physicians and providers (hereinafter collectively referred to as "providers"). Consistent with SB 1149, the department consulted with the Technical Advisory Committee on Claims Processing (TACCP) in a meeting held June 30, 2005, and solicited comments prior to initiating the rulemaking process. The proposed amendments create a new Subchapter DD relating to eligibility statements. Proposed §21.3801 defines the scope of the subchapter and provides that, consistent with SB 1149, the provisions of Insurance Code §1274.002 and this subchapter do not apply to Medicaid and Children's Health Insurance Program (CHIP) plans. Insurance Code §1274.005 allows the Commissioner of Insurance, in consultation with the Commissioner of the Health and Human Services Commission, to determine whether certain provisions of §1274.002 will cause a negative fiscal impact to the state with respect to providing benefits or services under the Medicaid and CHIP plans and, if so, to waive application of those provisions. Based upon a request from the Commissioner of the Health and Human Services Commission, proposed §21.3801 states that the statute and rules do not apply to Medicaid and CHIP plans. Proposed §21.3802

provides definitions for terms used within the subchapter. Proposed §21.3803 sets forth the requirement that carriers provide written notice to providers of the acceptable method(s) for requesting eligibility statements. The written notice is required to be delivered to providers that enter into or renew contracts with a health benefit plan issuer on or after January 31, 2006. The notice may be included in existing materials, such as a provider manual or other provider communication, which may be available on a website or in other electronic format. If an issuer chooses to make the eligibility statement process available to all participating providers and not limit the availability of the process to only those providers that enter into or renew a contract on or after January 31, 2006, the issuer may provide the notice to all participating providers. Proposed §21.3804 identifies the information required in a request for an eligibility statement. As a result of the consultation process with the TACCP, the department is aware that existing processes that closely mirror the requirements of SB 1149 require the inclusion of an identification number or other information in the provider's initial request. Consistent with the statutory framework, the proposed rules require health benefit plan issuers to maintain a system that is able to provide eligibility statements in response to the three items of information required for a request. If a health benefit plan issuer is unable to locate an enrollee using the three pieces of information provided in the request, the health benefit plan issuer may request additional information. However, a health benefit plan issuer may not require that the provider include any additional information as part of an initial request for an eligibility statement. The ability to request additional information may not be used as a substitute for compliance with the

requirement to provide eligibility statements in response to the three items of information required in a request. The department anticipates that requests for additional information should rarely be necessary if the health benefit plan issuer is compliant with the requirements of proposed §21.3805(a).

Additionally, if the provider is seeking information concerning whether the service to be performed is a covered benefit, the provider must include a description of the specific type or category of service. Consistent with the requirement that a health benefit plan issuer provide benefit information related to the type or category of service, the provider need not include such detailed information as procedure codes or a specific description of the service. If a provider would like confirmation of whether a particular service will be covered under the terms of the policy, the provider may request a verification under §19.1724 of this title. Under that process, the provider will include an increased level of detail regarding the proposed services and the response will include a more definite answer as to the coverage terms of the policy. Consistent with this concept, §21.3807 specifies that an eligibility statement is not a verification under §19.1724 of this title.

Proposed §21.3805 details the required content of an eligibility statement and the requirement that the health benefit plan issuer provide an eligibility statement in such a manner as to give a provider access to the information at the time of the enrollee’s visit. An eligibility statement provided under this proposed section is not required to be in writing and may be delivered telephonically, electronically, or by internet website portal consistent with the procedures detailed by the health benefit plan issuer pursuant to

§21.3803. If the provider includes in the request information concerning the proposed services, the health benefit plan issuer must respond with information concerning whether that type or category of service is a covered benefit under the policy. Because the eligibility statement process is designed to quickly provide information to a provider so that a patient's eligibility status is known at the time of the visit, a health benefit plan issuer is required to provide more general coverage information regarding the type or category of service and not to issue a guarantee that a particular service is covered. A provider that wishes to receive a guarantee that a claim resulting from a proposed service will be paid should utilize the existing verification process that is designed for that purpose.

Proposed §21.3806 provides that a health benefit plan issuer may refuse to provide all or a portion of an eligibility statement if applicable privacy laws prevent disclosure. Proposed §21.3806 also requires the health benefit plan issuer to describe the reason(s) for refusing to provide the eligibility information. Within three days, the health benefit plan issuer must also provide a written explanation of the reason(s) and identify the applicable law(s) that prevent disclosure. The health benefit plan issuer may provide this information via e-mail, facsimile or other electronic means. The department believes it is important that the information be provided in written form because it ensures that the provider has the opportunity to evaluate the factual and legal basis for the health benefit plan issuer's refusal to provide the information and, if appropriate, respond to the identified privacy concerns. Proposed §21.3808 provides for the severability of the subchapter.

The department will consider the adoption of the proposed new sections in a public hearing under Docket No. 2619 scheduled for September 7, 2005, at 10:00 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street in Austin, Texas.

2. FISCAL NOTE. Kimberly Stokes, Senior Associate Commissioner for Life, Health and Licensing, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Stokes has determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of the proposed sections will be the establishment of a clear process by which providers may make requests for eligibility information and health benefit plan issuers may respond to such requests. Implementation should result in greater availability to providers of current information relating to enrollee demographics, enrollment and eligibility status, benefits, and financial responsibility. Except as provided in this discussion, any cost to persons required to comply with these sections for each year of the first five years the proposed sections will be in effect is the result of the enactment of SB 1149 and not the result of the adoption, enforcement, or administration of the sections. The probable economic cost to persons required to comply with the sections

is as follows. The requirement that health benefit plan issuers provide written notice of methods for eligibility statement requests set forth in §21.3803 may impose an additional cost not required by the statute. This requirement is necessary to enable providers to request eligibility statements efficiently by providing a clear understanding of each health benefit plan issuer's process for receiving and responding to eligibility requests. The proposal does not require health benefit plan issuers to deliver the notice by any particular means, and they may reduce or avoid costs by including the notice in existing materials, such as a provider manual or other provider communication, which may be available on a website or in other electronic format. Notices that are delivered electronically, whether included with other materials or sent separately, should not result in additional cost. For printed notices, a health benefit plan issuer should not incur additional cost if the notice will fit on an existing page of a provider manual or other similar materials. If a health benefit plan issuer decides to print the notice and it does not fit on an existing page, the health benefit plan issuer will be subject to the cost of one additional printed sheet of paper, which the department estimates will cost between one and four cents per page. If a health benefit plan issuer intends to distribute a separate printed notice to participating providers, it will incur the cost of paper plus the cost of delivery to all participating providers, which should not exceed 40 cents per provider. The costs associated with delivery of the notice may include postage or expenses related to facsimile transmission. The total cost to a health benefit plan issuer will depend on the number of notices it needs to print and distribute and the method it uses for distribution. Except to the extent that the size of a health benefit plan issuer

may impact the number of providers with which the issuer may contract, and thus the number of notices that it must provide, the cost of the notices should not vary between health benefit plan issuers that are large, small, or micro businesses. The department believes it would be neither legal nor feasible to exempt small or micro businesses from this part of the proposed rule, or to establish separate compliance standards, since to do so would unfairly deprive providers that have contracted with small or micro businesses of information critical to the eligibility statement process.

The requirement that health benefit plan issuers provide a written explanation of the inability to provide an eligibility statement due to privacy laws will impose an additional cost not required by the statute. This requirement is necessary to ensure that a provider has the opportunity to evaluate the factual and legal basis for the health benefit plan issuer's refusal to provide an eligibility statement and, if appropriate, respond to the identified privacy concerns. A health benefit plan issuer may deliver the written explanation via e-mail, facsimile transmission, U.S. mail, or other electronic means. No matter which method the issuer employs, the requirement that an issuer identify a privacy law that prevents disclosure is not purely a function of the rule. SB 1149 states that health benefit plan issuers may only provide information to providers authorized under state and federal law to receive personally identifiable information, and privacy laws prevent unauthorized disclosure of such information. In order to comply with these requirements, health benefit plan issuers must be able to determine whether a requesting provider is authorized under state and federal law to receive the information. Therefore, the only cost related to the requirement that a health benefit

plan issuer provide an explanation for its inability to provide an eligibility statement is related to reducing the explanation to written form and transmitting it to the provider. As with the notice for methods of eligibility statement requests, an issuer may combine this notice with other transmissions, such as the eligibility statement for another enrollee. If the issuer transmits the notice separately, costs will depend on the method used. As indicated herein, the department estimates the cost of one printed sheet of paper at between one and four cents. If a health benefit plan issuer intends to provide the explanation to providers via U.S. mail or facsimile, it will incur the cost of paper plus the cost of delivery, which should not exceed 40 cents per explanation. The costs associated with delivery of the notice may include postage or expenses related to facsimile transmission. If a health benefit plan issuer transmits the information via e-mail, the health benefit plan issuer should not incur any additional cost for transmission. For existing electronic systems designed to provide eligibility information to providers, such as web portals, some programming costs may be necessary to enable the system to produce a written explanation of the applicable privacy issue that prevents disclosure. According to May 2004 data from the U.S. Bureau of Labor Statistics, the mean hourly rate for a computer programmer in the insurance business is $33.92. The amount of time necessary to implement system changes will vary greatly based upon the complexity of the system and current capabilities of the system. If an issuer has an existing system to provide eligibility information to providers, the system should include a function that will enable the health benefit plan issuer to evaluate whether privacy laws prevent disclosure of information, which is not a part of the cost that results from

this proposal. Any capabilities that an existing system has to evaluate and identify privacy considerations will mitigate any cost this proposal imposes.

The cost to a health benefit plan issuer is not dependent upon the size of the health benefit plan issuer, but rather is dependent upon the number of persons to whom the health benefit plan issuer provides health coverage and the number of providers with whom the health benefit plan issuer contracts. Both small and micro businesses and the largest businesses affected by these sections would incur the same cost per notice. The cost per hour of labor for any required computer system changes would not vary between the smallest and largest businesses. Therefore, it is the department's position that the adoption of these proposed sections will have no adverse economic effect on small or micro businesses. Regardless of the fiscal effect, it is neither legal nor feasible to waive or modify the requirements of this rule for small or micro businesses because the proposed amendments are either required by statute or would potentially result in certain providers not receiving necessary information regarding the effect of privacy laws on the provider’s request based solely on the size of the health benefit plan issuer.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 6, 2005, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the

comment must be simultaneously submitted to Kimberly Stokes, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

5. STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 1274 and §36.001. Chapter 1274 requires health benefit plan issuers to provide specific eligibility information to participating providers upon request. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

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

Rule	Statute
§§21.3801 – 21.3808	Insurance Code §§1274.001 – 1274.005

7. TEXT.

§21.3801. Scope and Applicability. This subchapter applies to a health benefit plan issuer that enters into or renews a contract with a participating provider on or after January 31, 2006. The provisions of Insurance Code §1274.002 and this subchapter are not applicable to Medicaid and Children's Health Insurance Program (CHIP) plans provided by a health benefit plan issuer to persons enrolled in the medical assistance

program established under Chapter 32, Human Resources Code, or the child health plan established under Chapter 62, Health and Safety Code.

§21.3802. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Enrollee--An individual who is eligible for coverage under a health benefit plan, including a covered dependent.

(2) Health benefit plan--A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides only dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation insurance coverage or similar insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(3) Health benefit plan issuer--Any entity that issues a health benefit plan, including:

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

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

(C) an insurance company;

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

(E) a fraternal benefit society operating under Insurance Code Chapter 885; or

(F) a stipulated premium company operating under Insurance Code Chapter 884.

(4) Health care provider--

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist or dentist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

(5) Participating provider--

(A) a physician or health care provider who contracts with a health benefit plan issuer to provide medical care or health care to enrollees in a health benefit plan; or

(B) a physician or health care provider who accepts and treats a patient on a referral from a physician or provider described by subparagraph (A) of this paragraph.

(6) Physician--

(A) an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) a nonprofit health corporation certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by §§61.003, 61.501, or 74.601, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another entity wholly owned by physicians.

(7) Primary enrollee--The individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility under the health benefit plan.

§21.3803. Method for Requesting Eligibility Statements.

(a) Beginning January 31, 2006, a health benefit plan issuer shall, in writing, communicate to each participating provider that enters into or renews a contract with the health benefit plan issuer, the method or methods by which the provider may request an eligibility statement. The health benefit plan issuer may communicate the method or methods a provider may use to request an eligibility statement in existing materials, such as a provider manual, so long as the information is clearly identified and properly captioned with an underlined or bold-faced, or otherwise conspicuous heading.

(b) A health benefit plan issuer may accept a request for an eligibility statement by:

(1) telephone;

(2) internet website portal; or

(3) other electronic means.

§21.3804. Requests for Eligibility Statements.

(a) A participating provider may, prior to providing services to an enrollee, request an eligibility statement using a method designated by the health benefit plan issuer.

(b) A request under subsection (a) of this section must include:

(1) the enrollee's full name;

(2) the enrollee's relationship to the primary enrollee; and

(3) the enrollee's birth date.

(c) If the participating provider is seeking information concerning the enrollee's benefits under §21.3805(b)(2)(B) of this subchapter (relating to Requirement to Provide Eligibility Statements), the request must also include a description of the specific type or category of service.

§21.3805. Requirement to Provide Eligibility Statements.

(a) A health benefit plan issuer shall maintain a system to enable it to provide eligibility statements to participating providers using the information provided under §21.3804(b) and (c) of this subchapter (relating to Requests for Eligibility Statements). On receipt of a request for an eligibility statement that complies with §21.3804 of this subchapter, a health benefit plan issuer must provide an eligibility statement to the participating provider allowing the provider access to the information at the time of the enrollee's visit.

(b) If the health benefit plan issuer is unable to provide an eligibility statement, the health benefit plan issuer shall notify the participating provider and may request additional information to assist the health benefit plan issuer in providing an eligibility statement. A health benefit plan issuer may not use a request for additional information to satisfy the requirement that the issuer maintain a system to provide eligibility statements using the information described in §21.3804(b) and (c) of this subchapter.

(c) An eligibility statement provided under this section shall include information that will enable the participating provider to determine at the time of the request:

(1) the enrollee’s identification and eligibility under the health benefit plan, including:

(A) the enrollee's identification number assigned by the health benefit plan issuer;

(B) the name of the enrollee and all covered dependents, if necessary to provide services to the patient;

(C) the birth date of the enrollee and the birth dates of all covered dependents, if necessary to provide services to the patient;

(D) the gender of the enrollee and the gender of each covered dependent, if necessary to provide services to the patient; and

(E) the current enrollment and eligibility status of the enrollee under the health benefit plan;

(2) the enrollee's benefits, including:

(A) excluded benefits or limitations, both group and individual; and

(B) if the participating provider included the information required by §21.3804(c) of this subchapter, whether the specific type or category of service is a benefit under the policy; and

(3) the enrollee's financial information, including:

(A) copayment requirements, if any; and

(B) the unmet amount of the enrollee's deductible or enrollee financial responsibility.

(d) The information required to be provided under this section is limited to information in the possession of and maintained by the health benefit plan issuer in the ordinary course of business at the time of a request for an eligibility statement.

(e) A health benefit plan issuer may not directly or indirectly charge a participating provider for an eligibility statement.

§21.3806. Privacy Issues. A health benefit plan issuer may refuse to provide all or part of an eligibility statement if applicable state or federal law prevents the disclosure of an enrollee's or dependent's personally identifiable information to the requesting participating provider. A health benefit plan issuer that refuses to provide all or part of an eligibility statement shall provide a response to the request for an eligibility statement indicating the reason(s) for refusing to provide the information. Within three days of refusing to provide an eligibility statement under this section, a health benefit plan issuer shall provide a written response indicating the reason(s) for refusing to provide the information and describing the particular state or federal law provision(s) that prevent the disclosure.

§21.3807. Effect of Eligibility Statement. An eligibility statement provided under this subchapter is not a verification under §19.1724 of this title (relating to Verification).

§21.3808. Severability. If a court of competent jurisdiction holds that any provision of this subchapter is inconsistent with any statutes of this state, is unconstitutional, or is

invalid for any reason, the remaining provisions of this subchapter shall remain in full effect.

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

Issued at Austin, Texas, on _____, 2005.

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