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INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 TAC §§21.4902, 21.5002, 21.5003, and 21.5040, concerning the independent dispute resolution (IDR) process, and new §§21.5060, 21.5070, and 21.5071, concerning submission requirements for certain entities. Amendments to §§21.4902, 21.5002, 21.5003, and 21.5040, and new §21.5060 implement House Bill 1592, 88th Legislature, 2023. Amendments to §21.5040, and new §21.5070 and §21.5071 implement Senate Bill 2476, 88th Legislature, 2023. Amendments to §21.5040 implement House Bill 3924, 87th Legislature, 2021.

EXPLANATION. Amendments to §§21.4902, 21.5002, 21.5003, and 21.5040, and new §21.5060 are necessary to implement HB 1592 and Insurance Code Chapter 1275. Insurance Code §1275.002 as amended by HB 1592 permits a plan sponsor of a self-insured or self-funded plan established by an employer under the Employee Retirement

Income Security Act of 1974 (ERISA) (29 USC §1001 et seq.) to opt in to the Texas IDR process under Insurance Code Chapter 1467 by electing to apply Insurance Code Chapter 1275 to the plan during the relevant plan year. Insurance Code Chapter 1275 creates similar requirements for out-of-network billing that already exist for HMOs and preferred provider benefit plans, as well as for health benefit plans administered by the Employees Retirement Systems of Texas and Teacher Retirement System of Texas plans under Insurance Code Chapters 1551, 1575, and 1579.

The amendments to §§21.4902, 21.5002, and 21.5003 clarify that a plan sponsor may elect to apply Insurance Code Chapter 1275 to its self-insured or self-funded plan. Under Insurance Code §1275.004, Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies.

The amendments to §21.5040 require health benefit plans offered by nonprofit agricultural organizations and ERISA plans to include additional information in the explanation of benefits provided to physicians or providers. Proposed additional information includes a disclaimer that the plan opted in to the Texas IDR process for the relevant plan year and that claims after the effective date must proceed through the Texas IDR process. Amendments to §21.5040 also require health benefit plans offered by nonprofit agricultural organizations and ERISA plans to display "TXIDR" on the ID card issued to enrollees. The proposed ID card requirement will apply to plans delivered, issued for delivery, and renewed on or after 90 days of the effective date of the section. Additional amendments to this section are discussed below as they relate to the implementation of SB 2476.

The proposal also adds new Division 7 and new §21.5060 to prescribe the form and manner of identifying information that plan sponsors must include to make an election for the relevant plan year under Insurance Code §1275.002. The identifying information must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov.

Amendments to §21.5040 and new §21.5070 and §21.5071 are necessary to implement SB 2476. This bill authorizes political subdivisions to submit rates for emergency medical services (EMS) to TDI for use in payment by health benefit plans. SB 2476 requires health benefit plans to cover ground emergency medical services at (1) the rates submitted to TDI by a political subdivision; or (2) if no rates have been submitted, the lesser of either the EMS provider's billed charge or 325% of the current Medicare rate.

Additional amendments to §21.5040 require the explanation of benefits to include transport as added by SB 2476 and clarify that the right to pursue mediation or arbitration applies only to out-of-network claims subject to Insurance Code Chapter 1467.

The proposal also adds new Division 8, consisting of new §21.5070 and §21.5071, to prescribe the form and manner that political subdivisions must use if they wish to submit rates to TDI for use in EMS billing, and the EMS payment standards that apply for an applicable health benefit plan issuer or administrator. The rate submission must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov.

New §21.5070 and §21.5071 propose a quarterly rate publication schedule. The publication schedule states when TDI will update rates on the publicly available database. The publication schedule will not affect the ability of a political subdivision to submit rates to TDI at any time until the final submission deadline of September 1, 2024. However, for a rate to be reflected in the updated rate publication, a political subdivision must submit a rate by the submission deadline.

A rate submitted after the submission date will be reflected in the rate publication the following quarter. Health benefit plans must apply the rates, as reflected in the published rate database, to claims on or after the implementation dates proposed in new Division 8. A table of the proposed quarterly deadlines for submission, publication, and implementation is included as Figure: 28 TAC §21.5070(h).

The proposal permits a political subdivision to submit EMS rates until the final submission deadline of September 1, 2024. The final submission deadline reflects the drafting of SB 2476, which requires health benefit plans to increase the submitted rates once in a calendar year. Figure: 28 TAC §21.5071(d)(2) provides illustrative examples of which final published rates apply to claims for emergency medical services provided on or after September 1, 2024, depending on the health benefit plan renewal date.

New Division 8 also proposes December 15, 2023, as the first deadline by which political subdivisions must submit rates to be used in the first quarter. Rates submitted to TDI on or before December 15, 2023, will apply to claims made on or after January 1, 2024. TDI anticipates publishing the submitted rates no later than January 1, 2024. Health benefit plans must apply rates to those claims beginning January 1, 2024.

The publication and implementation deadline for the first quarter are identical and will require health benefit plans to quickly update software and internal databases to reflect the published rates. SB 2476 applies to emergency medical services provided on or after January 1, 2024, and requires TDI to establish the publicly accessible database by January 1, 2024.

SB 2476 requires health benefit plans to make the payment using the submitted rate, if applicable, and the bill provides 30 or 45 days for payment of the claim, depending on whether the claim is electronic or not. This will provide health benefit plans with some lead time to update internal systems. TDI recognizes the challenges of quickly implementing the published rates but seeks to comply with the statutory deadlines in SB 2476.

The proposed amended and new sections are described in the following paragraphs.

Section 21.4902. An amendment clarifies that the section provides definitions for use in Subchapter OO. The amendments to §21.4902 clarify that an administrator as defined in Insurance Code §1467.001 may also include an administrator of a self-insured or self-funded plan under Insurance Code Chapter 1275 when election by a plan sponsor has occurred. The amendments expand the definition of "health benefit plan" to include a self-insured or self-funded plan for which the plan sponsor has elected to apply Insurance Code Chapter 1275. The amendments also add a definition of "ERISA" to reflect agency drafting style and plain language preferences.

The proposal adds "Insurance Code" to a citation, adds "an administrator of" to a definition of "administrator" for consistency in §21.4902(1), renumbers paragraphs to reflect the expansion of definitions, and amends punctuation and grammar throughout.

Section 21.5002. This section describes the scope of Subchapter PP. The amendments to §21.5002 expand the applicability of Subchapter PP to a self-insured or self-funded plan if election by the plan sponsor is submitted according to the requirements in proposed new §21.5060. The proposal also amends punctuation and grammar to reflect the addition of new paragraph (4) and adds "Insurance Code" to an incomplete citation.

Section 21.5003. This section provides definitions for use in Subchapter PP. The amendments to §21.5003 clarify that an administrator as defined in Insurance Code §1467.001 may also include an administrator of a self-insured or self-funded plan under Insurance Code Chapter 1275 when election by a plan sponsor has occurred. The amendments expand the definition of "health benefit plan" to include a self-insured or self-funded plan for which the plan sponsor has elected to apply Insurance Code Chapter 1275. The amendments also add a definition of ERISA to reflect agency drafting style and plain language preferences.

The proposal adds "Insurance Code" to a citation, adds "an administrator of" to a definition in "administrator" for consistency in §21.5003(1), renumbers paragraphs to reflect the expansion of definitions, and amends punctuation and grammar throughout.

Section 21.5040. This section provides the contents required in an explanation of benefits (EOB) provided to an enrollee, physician, and provider. The amendments to §21.5040 clarify that the EOB provided to both enrollees and physicians or providers must include transport as added by SB 2476. The amendments also clarify that the notice explaining that a physician or provider may request mediation or arbitration for a payment dispute should be included only for a claim that is subject to mediation or arbitration under Insurance Code Chapter 1467.

The amendments also add new subsection (b) and subsection (c). Section 21.5040(b) includes additional requirements for EOBs provided by certain health benefit plans. Section 21.5040(c) adds information that must be included in the ID card provided to enrollees. Because the addition of subsections (b) and (c) is proposed, the existing rule text is designated as subsection (a). Proposed new requirements in §21.5040(b) and (c) apply only to a health benefit plan offered by a nonprofit agricultural organization or a self-funded or self-insured plan under ERISA where a plan sponsor has elected to apply Insurance Code Chapter 1275.

Proposed new §21.5040(b)(1) requires a health benefit plan offered by a nonprofit agricultural organization under Insurance Code Chapter 1682 to include in the EOB to physicians and providers instructions to identify the plan type as "Ag Plan" when requesting mediation or arbitration. Similarly, new §21.5040(b)(2) proposes that health benefit plans offered by ERISA plans that have opted in to the Texas IDR process under Insurance Code Chapter 1275 must include in the EOB a statement about the opt-in, the effective date of the opt-in, a prohibition of using the federal IDR process, and instructions

to physicians and providers to identify the plan type as "ERISA Opt-In" when requesting mediation or arbitration.

Proposed new §21.5040(c) requires a health benefit plan offered by a nonprofit agricultural organization or self-insured or self-funded ERISA plan to include the letters "TXIDR" on the ID cards issued to enrollees. This requirement applies to a plan that is delivered, issued for delivery, or renewed on or after 90 days of the effective date of the section.

The proposal also amends the titles of Division 5 and §21.5040 to expand the scope to include the ID card requirements.

Section 21.5060. The proposal adds new §21.5060 to new Division 7. Section 21.5060 provides submission requirements for a plan sponsor that elects to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan for the relevant plan year. Proposed submission requirements include:

- the name and contact information of both the plan sponsor and, if applicable, the administrator;
- the health benefit plan year start and end date;
- the requested effective date of the election, which must be at least 30 days after the date the identifying information is submitted;
- the group number of the health benefit plan; and
- the number of enrollees covered under the health benefit plan.

Identifying information must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov. TDI proposes this requirement to ensure a plan sponsor is able to successfully opt in to the Texas IDR process and IDR claims submitted by physicians or providers are correctly matched to the ERISA plan.

The proposal clarifies that a plan sponsor must renew election each plan year, update identifying information as proposed in the section, and make the election 30 days before the date the relevant plan year begins. The proposal also clarifies that once a plan sponsor opts in to the Texas IDR process for the relevant plan year, the plan sponsor may not opt out until the end of the relevant plan year.

Section 21.5070. The proposal adds new §21.5070 to new Division 8. Section 21.5070 provides the form and manner for a political subdivision to submit rates for emergency medical services. Political subdivisions that choose to submit rates to TDI must comply with the data submission requirements, including providing certain identifying information and submitting rate information using the method provided on TDI's website at www.tdi.texas.gov.

Proposed identifying information includes:

- the political subdivision's name and contact information;
- the National Provider Identification number of each EMS provider that is subject to the rates set by the political subdivision, if known;
- each ZIP code subject to the rates set, controlled, or regulated by the political subdivision; and
- applicable billing codes, code types, and dollar amounts for each health care service, supply, or transport rate that is set, controlled, or regulated by the political subdivision.

A claim submitted by an EMS provider or its designee must include the ZIP code in which the health care service, supply, or transport originated. A political subdivision or EMS provider subject to the rule may not issue a bill that exceeds the amount of the rate set, controlled, or regulated by the political subdivision.

Political subdivisions that choose to submit rates to TDI must comply with the proposed submission schedule in §21.5070(e). The first proposed submission deadline is December 15, 2023, effective for claims submitted on or after January 1, 2024. The submission deadline is the date that the rate must be submitted in order to be published by TDI for the following quarter.

Political subdivisions may submit updated rates at any time on or before the final deadline of September 1, 2024, but the updated rates will be published according to the publication schedule in §21.5070(e) and will be effective for claims according to the implementation schedule in §21.5071(c). These proposed schedules are illustrated in Figure: 28 TAC §21.5070(h).

Political subdivisions are not required to submit rates under SB 2476. However, if a political subdivision chooses not to submit rates by the submission deadline for a given quarter and has no published rates for a particular health care service, supply, or transport, then the health benefit plan must determine the applicable rate according to the formulas in SB 2476 and implemented in §21.5071(b). A political subdivision may also remove a submitted rate according to the submission and publication schedule in §21.5070(e) and require health benefit plans to determine rates according to the formulas.

Section 21.5071. The proposal adds new §21.5071 to new Division 8. Section 21.5071 clarifies that certain health benefit plans must pay EMS provider claims under SB 2476. Health benefit plan issuers and administrators must pay EMS provider claims at the rate submitted by a political subdivision or, if no rate has been submitted under proposed §21.5070, according to the formulas in SB 2476 and implemented in §21.5071(b).

Health benefit plan issuers and administrators must apply published rates by the proposed implementation schedule in §21.5071(c). For claims submitted on or after January 1, 2024, health benefit plans must apply the rate published on TDI's website. Health benefit plan issuers and administrators must update rates each quarter to reflect

newly published rates, consistent with the implementation deadlines. These proposed schedules are illustrated in Figure: 28 TAC §21.5070(h).

SB 2476 uses the term "Medicare Inflation Index." TDI interprets the term to mean the Medicare Economic Index, a measure of inflation faced by physicians with respect to their practice costs and general wage levels that is updated on an annual basis. The Medicare Economic Index is available on the CMS website at www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata.

The proposal clarifies that a health benefit plan issuer or administrator must adjust a payment required by SB 2476 and implemented in §21.5071(d) by the lesser of either the Medicare Economic Index or 10% of the provider's previous calendar year rates. Proposed Figure: 28 TAC §21.5071(d)(2) provides examples of which published rates health benefit plans must use when adjusting a payment under SB 2476, depending on the renewal date of the health benefit plan.

The proposal defines "plan year" as a plan that starts on or after September 1, 2024, and "calendar year rate" as the most recently published rate available before the first day of the new plan year.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives, has determined that during each year of the first five years the proposed new and amended sections are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the proposed new and amended sections, other than those imposed by statute. Ms. Bowden made this determination because the proposed new and amended sections do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new and amended sections. The

rule applies to political subdivisions that choose to submit rates to TDI, but political subdivisions are not required to participate. Any measurable fiscal impact on a political subdivision that voluntarily submits rates to TDI are a result of those imposed by statute.

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

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new and amended sections are in effect, Ms. Bowden expects that administering them will have the public benefit of ensuring that TDI's rules conform with Insurance Code Chapters 1275 and 1467, and §§38.006, 1271.008, 1271.159, 1275.003, 1275.054, 1301.010, 1301.166, 1551.015, 1551.231, 1575.009, 1575.174, 1579.009, and 1579.112.

Ms. Bowden expects that the proposed new and amended sections that implement HB 1592 will not increase the cost of compliance with Insurance Code Chapter 1275 because the sections as proposed do not impose requirements beyond those in statute. Insurance Code §1275.002 permits a plan sponsor to elect to apply Insurance Code Chapter 1275 to self-insured or self-funded plans. Plan sponsors may submit identifying information to TDI for election under Insurance Code §1275.002, but plan sponsors are not required to opt in to the Texas Out-of-Network Independent Dispute Resolution process in Insurance Code Chapter 1467. Those plans may instead continue to use the Federal No Surprises Act Independent Dispute Resolution process for disputes. As a result, the cost associated with submitting identifying information to opt in to the Texas IDR process does not result from the enforcement or administration of the proposed sections.

Ms. Bowden expects that the proposed new and amended sections that implement SB 2476 will not increase the cost of compliance with Insurance Code §§38.006, 1271.008, 1271.159, 1275.003, 1275.054, 1301.010, 1301.166, 1551.015, 1551.231, 1575.009, 1575.174, 1579.009, and 1579.112 because they do not impose requirements beyond

those in statute. Political subdivisions may submit EMS rates to TDI but are not required to submit rates under Insurance Code §38.006. Health benefit plan issuers and administrators are required by statute to cover certain EMS-related claims according to SB 2476. As a result, the cost associated with submitting rates or payment of EMS claims does not result from enforcement or administration of the proposed sections.

Ms. Bowden expects that the amendments to §21.5040 may result in an administrative cost to health benefit plan issuers and administrators who are subject to Insurance Code §1275.003. Amendments to §21.5040(b) and (c) apply only to:

- a health benefit plan offered by a nonprofit agricultural organization; or
- a self-funded or self-insured plan under ERISA when the plan sponsor opts in to the Texas IDR process through HB 1592.

Amendments to §21.5040(b) require these plans to include additional information in the explanation of benefits (EOB) on how a physician or provider should identify the plan type in the request for mediation or arbitration. A self-insured or self-funded plan under ERISA must also include in the EOB a statement that notifies the physician or provider that the plan sponsor opted in to the Texas IDR process and the effective date that the opt in begins to apply to claims under the ERISA plan.

Amendments to §21.5040(c) require these plans to add the signifier "TXIDR" to the ID card provided to enrollees. The ID card requirement will apply to these plans when the plan is delivered, issued for delivery, or renewed starting on or after 90 days of the effective date of the section. If the plan has been delivered, issued for delivery, or renewed before the effective date of the section or before the 90-day deadline triggered by the effective date, the plan must provide updated ID cards to enrollees at the time of plan renewal.

Ms. Bowden anticipates that health benefit plans offered by nonprofit agricultural organizations and self-insured or self-funded plans under ERISA may need to update programming or software to update the EOB and enrollee ID card, but that updates to the software will occur when updates to the EOB and ID cards are routinely made. Ms. Bowden estimates that updating software may require between zero and four hours of computer programming staff time. Staff costs may vary depending on the skill level required, the number of staff required, and the geographic location where work is done. The 2021 median hourly wage for this position in Texas was $37.16 as reported by the Texas Wages and Employment Projections database, which is developed and maintained by the Texas Workforce Commission and located at www.texaswages.com/WDAWages. Information on median wages in other states may be obtained directly from the federal Bureau of Labor Statistics website at www.bls.gov/oes/current/oes_nat.htm.

Ms. Bowden expects that the proposed amendments to §21.5040(b) and (c) will have the benefit of reducing enrollee and physician or provider confusion about which IDR process applies to claims arising under a health benefit plan offered by a nonprofit agricultural organization or a self-insured or self-funded plan under ERISA. Because there will be less confusion about which IDR process applies to those claims, Ms. Bowden anticipates those health benefit plans will have less cost in responding to ineligible IDR claims.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the amendments to §21.5040 may impose a cost on health benefit plan issuers or administrators that are subject to Insurance Code §1275.003, specifically health benefit plans offered by self-insured or self-funded plans under ERISA when the plan sponsor elects to apply Insurance Code Chapter 1275.

HB 1592 authorizes a plan sponsor of a self-insured or self-funded plan under ERISA to elect to apply Insurance Code Chapter 1275 to the plan for the relevant plan year. TDI is unable to estimate how many plan sponsors may make this election or how many plan sponsors that make the election will meet the definition of a small or micro business under Government Code §2006.001, because employers sponsoring a self-insured or self-funded plan are not limited to any particular industry. The rule will not apply to a plan sponsor that does not elect to apply Insurance Code Chapter 1275.

The primary purpose of the amendments to §21.5040 is to lessen enrollee, physician, and provider confusion about which IDR process applies to claims arising under the health benefit plan offered by self-funded or self-insured ERISA plans that opt in.

TDI considered the following alternatives to minimize any adverse effect on small and micro businesses while accomplishing the proposal's objectives:

(1) not proposing the explanation of benefits (EOB) or ID card requirements in §21.5040(b) and (c);

(2) proposing a different requirement for small and micro businesses required to comply with §21.5040; and

(3) extending the small and micro business deadline for compliance in §21.5040.

Not proposing the EOB or ID card requirements in §21.5040(b) and (c). As previously noted, the primary purpose of this amendment is to lessen confusion about which IDR process applies to claims that arise under the health benefit plan offered by self-insured or self-funded ERISA plans that opt in. Excluding the EOB or enrollee ID card requirements from the scope of the proposal would result in confusion about the eligibility of those claims.

HB 1592 authorizes self-insured and self-funded plans to elect to apply the Texas IDR process to claims that would otherwise only proceed through the federal IDR process under the No Surprises Act. Requiring self-funded and self-insured ERISA plans to signify that the Texas IDR process applies to claims arising under the plan may lessen the number of physicians or providers who submit ineligible claims to the federal IDR process. Failure to submit claims to the applicable IDR process may result in untimely requests. For these reasons, TDI has rejected this option.

Proposing a different requirement for small and micro businesses required to comply with §21.5040. TDI believes that proposing different standards based on the size of a business would not provide a better option. This requirement is proposed in order to lessen confusion about applicable IDR processes. Proposing separate standards based on employer size would likely cause further confusion. If the EOB or ID card requirements are based on employer size, only some of the ERISA plans that opt in would be required to comply, and physicians and providers might assume that plans with EOBs and enrollee ID cards that do not contain Texas IDR information have not opted in and are subject to the federal IDR process. For these reasons, TDI has rejected this option.

Extending the small and micro business deadline for compliance under §21.5040. TDI believes that the EOB and enrollee ID card requirement should apply consistently to all self-funded or self-insured ERISA plans that opt in to the Texas IDR process to promote clarity and consistency for providers, physicians, and enrollees. Extending the deadline by which small and micro businesses must provide the EOB and enrollee ID card does not meaningfully change the effect on small or micro businesses because the software updates will still exist. For these reasons, TDI has rejected this option.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined this proposal, as it relates to implementing HB 1592 and SB 2476, does not impose a cost on regulated persons. However, even if the proposal did impose a cost on regulated persons, the proposed new and amended sections are necessary to implement legislation.

The proposed amendments to §21.5040(b) and (c) may impose a cost on health benefit plans offered by nonprofit agricultural organizations and self-insured or self-funded plans under ERISA where the plan sponsor opts in to the Texas IDR process. However, even if the cost to these plans is not offset by updating the explanation of benefits and ID cards during the regular course of business, Insurance Code §1467.003(b), exempts a rule adopted under Insurance Code Chapter 1467 from Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new and amended sections are in effect, the proposed rule:

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will create a new regulation;
- will expand an existing regulation;
- will increase the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on October 2, 2023. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2840 at 2:00 p.m., central time, on September 26, 2023, in Room 2.029 of the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701.

Subchapter OO. Disclosures by Out-of-Network Providers
28 TAC §21.4902

STATUTORY AUTHORITY. TDI proposes amendments to §21.4902 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes a plan sponsor to elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

Insurance Code §36.001 provides that the commissioner may 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. Section 21.4902 implements Insurance Code §1275.002 and §1275.004, and HB 1592.

TEXT.

§21.4902. Definitions.

Words and terms defined in Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, have the same meaning when used in this subchapter unless the context clearly indicates otherwise, and the following words and terms have the following meanings when used in this subchapter unless the context clearly indicates otherwise.

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, and an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing

Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, offering a health benefit plan.

(2) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

(3) [(2)] Health benefit plan--A plan that provides coverage under:

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

(B) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; [or]

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682; or [.]

(D) a self-insured or self-funded plan established by an employer under ERISA (29 USC §1001 et seq.) for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 1. General Provisions
28 TAC §21.5002 and §21.5003

STATUTORY AUTHORITY. TDI proposes amendments to §21.5002 and §21.5003 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes a plan sponsor to elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for

the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

Insurance Code §36.001 provides that the commissioner may 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. Section 21.5002 and §21.5003 implement Insurance Code §1275.002 and HB 1592.

TEXT.

§21.5002. Scope.

(a) This subchapter applies to a qualified mediation claim or qualified arbitration claim filed under health benefit plan coverage:

(1) issued by an insurer as a preferred provider benefit plan under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, including an exclusive provider benefit plan;

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform

Group Health Coverage; or 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations; [~~or~~]

(3) offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations; or [~~.~~]

(4) offered by a self-insured or self-funded plan established by an employer under ERISA if the plan sponsor submitted election according to §21.5060 of this title (relating to Election Submission Requirements).

(b) This subchapter does not apply to a claim for health benefits that is not a covered claim under the terms of the health benefit plan coverage.

(c) Except as provided in §21.5050 of this title (relating to Submission of Information), this subchapter applies to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2020. A claim for health care or medical services or supplies provided before January 1, 2020, is governed by the rules in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose. This subchapter applies to a claim filed for emergency care or health care or medical services or supplies by the administrator of a health benefit plan under Insurance Code Chapter 1682.

§21.5003. Definitions.

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

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, and an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing

Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, offering a health benefit plan.

(2) Arbitration--Has the meaning assigned by Insurance Code §1467.001.

(3) Claim--A request to a health benefit plan for payment for health benefits under the terms of the health benefit plan's coverage, including emergency care, or a health care or medical service or supply, or any combination of emergency care and health care or medical services and supplies, provided that the care, services, or supplies:

(A) are furnished for a single date of service; or

(B) if furnished for more than one date of service, are provided as a continuing or related course of treatment over a period of time for a specific medical problem or condition, or in response to the same initial patient complaint.

(4) Diagnostic imaging provider--Has the meaning assigned by Insurance Code §1467.001.

(5) Diagnostic imaging service--Has the meaning assigned by Insurance Code §1467.001.

(6) Emergency care--Has the meaning assigned by Insurance Code §1301.155, concerning Emergency Care.

(7) Emergency care provider--Has the meaning assigned by Insurance Code §1467.001.

(8) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

(9) [~~(8)~~] Enrollee--Has the meaning assigned by Insurance Code §1467.001.

(10) [~~(9)~~] Facility--Has the meaning assigned by Health and Safety Code §324.001, concerning Definitions.

(11) [~~(10)~~] Health benefit plan--A plan that provides coverage under:

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

(B) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; [~~or~~]

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682; or [~~.~~]

(D) a self-insured or self-funded plan established by an employer under ERISA for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

(12) [~~(11)~~] Facility-based provider--Has the meaning assigned by Insurance Code §1467.001.

(13) [~~(12)~~] Insurer--A life, health, and accident insurance company; health insurance company; or other company operating under: Insurance Code Chapters 841, concerning Life, Health, or Accident Insurance Companies; 842, concerning Group Hospital Service Corporations; 884, concerning Stipulated Premium Insurance Companies; 885, concerning Fraternal Benefit Societies; 982, concerning Foreign and Alien Insurance Companies; or 1501, concerning Health Insurance Portability and Availability Act, that is authorized to issue, deliver, or issue for delivery in this state a preferred provider benefit plan, including an exclusive provider benefit plan, under Insurance Code Chapter 1301.

(14) [~~(13)~~] Mediation--Has the meaning assigned by Insurance Code §1467.001.

(15) [~~(14)~~] Mediator--Has the meaning assigned by Insurance Code §1467.001.

(16) [~~(15)~~] Out-of-network claim--A claim for payment for medical or health care services or supplies or both furnished by an out-of-network provider or a non-network provider.

(17) [~~(16)~~] Out-of-network provider--Has the meaning assigned by Insurance Code §1467.001.

(18) [~~(17)~~] Party--Has the meaning assigned by Insurance Code §1467.001.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 5. Explanation of Benefits and Enrollee ID Card Requirements
28 TAC §21.5040

STATUTORY AUTHORITY. TDI proposes amendments to §21.5040 under Insurance Code §§1275.004, 1301.007, 1467.003, and 36.001.

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1301.007 authorizes the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

Insurance Code §36.001 provides that the commissioner may 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. Section 21.5040 implements Insurance Code Chapters 1467 and 1682; §§1271.008, 1275.003, 1301.010, 1551.015, 1575.009, and 1579.009; House Bills 3924 and 1592; and Senate Bills 1264 and 2476.

TEXT.

§21.5040. Required Explanation of Benefits and Enrollee Identification Card Information.

(a) General requirements for explanation of benefits. A health benefit plan issuer or administrator subject to Insurance Code §1271.008, concerning Balance Billing Prohibition Notice; §1275.003, concerning Balance Billing Prohibition Notice; §1301.010, concerning Balance Billing Prohibition Notice; §1551.015, concerning Balance Billing Prohibition Notice; §1575.009, concerning Balance Billing Prohibition Notice; or §1579.009, concerning Balance Billing Prohibition Notice, must provide written notice in accordance with this section in an explanation of benefits in connection with a health care or medical service or supply or transport provided by a non-network provider or an out-of-network provider:

(1) to the enrollee and physician or provider, which must include:

(A) a statement of the billing prohibition, as applicable; and

(B) the total amount the physician or provider may bill the enrollee under the health benefit plan and an itemization of in-network copayments, coinsurance, deductibles, and other amounts included in that total; and

(2) to the physician or provider, for a claim that is subject to mediation or arbitration under Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, a conspicuous statement in not less than 10-point boldface type that is substantially similar to the following: "If you disagree with the payment amount, you can request mediation or arbitration. To learn more and submit a request, go to

www.tdi.texas.gov. After you submit a complete request, you must notify {HEALTH BENEFIT PLAN ISSUER OR ADMINISTRATOR NAME} at {EMAIL}."

(b) Specific requirements for explanation of benefits provided by health benefit plans subject to Insurance Code Chapter 1275. In addition to the requirements in subsection (a) of this section, the following requirements apply.

(1) For a health benefit plan offered by a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, the notice to a physician or provider for a claim must also include the following instruction that is substantially similar to the following: "The request for mediation or arbitration must identify the plan type as 'Ag Plan.'"

(2) For a self-insured or self-funded plan under ERISA where the plan sponsor has elected to apply Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-Of-Network Claim Dispute Resolution for Certain Plans, to the plan for the relevant plan year, the notice to a physician or provider for a claim must also include a statement that is substantially similar to the following: "The plan sponsor of {THE HEALTH BENEFIT PLAN NAME} has opted in to the Texas Independent Dispute Resolution Process under Insurance Code Chapter 1275 for this plan year. Beginning on {EFFECTIVE DATE OF ELECTION}, a claim arising under this health benefit plan must proceed through the Texas process and may not proceed through the Federal No Surprises Act Independent Dispute Resolution Process. The request for mediation or arbitration must identify the plan type as 'ERISA Opt-In.'"

(c) Requirements for ID cards issued to enrollees of health benefit plans subject to Insurance Code Chapter 1275. For a plan that is delivered, issued for delivery, or renewed on or after 90 days of the effective date of this section, a health benefit plan issuer or administrator that is subject to Insurance Code §1275.003 must include the letters TXIDR on the ID card issued to enrollees.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 7. Submission Requirements for Election by ERISA Plans
28 TAC §21.5060

STATUTORY AUTHORITY. TDI proposes new §21.5060 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes the commissioner to prescribe the form and manner in which a plan sponsor may elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

Insurance Code §36.001 provides that the commissioner may 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. Section 21.5060 implements Insurance Code §1275.002 and HB 1592.

TEXT.

§21.5060. Election Submission Requirements.

(a) A plan sponsor of a self-insured or self-funded plan may elect to participate in out-of-network claim dispute resolution under Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, by providing identifying information to the Texas Department of Insurance as specified on the department's website at www.tdi.texas.gov, including:

(1) the name and contact information of the plan sponsor;

(2) the name and contact information of the administrator of the health benefit plan, if applicable;

(3) the health benefit plan year start and end date;

(4) the requested effective date, which must be at least 30 days after the date the identifying information is submitted;

(5) the group number of the health benefit plan; and

(6) the number of enrollees covered under the health benefit plan.

(b) Election under subsection (a) of this section applies only to the relevant plan year. A plan sponsor must elect to participate in out-of-network claim dispute resolution each plan year and must provide or update identifying information required by this section. A plan sponsor that elects to apply Insurance Code Chapter 1275 to a plan for the relevant plan year may not opt out until the end of that relevant plan year.

(c) A plan sponsor or its authorized representative may provide the identifying information required by this section.

Subchapter PP. Out-of-Network Claim Dispute Resolution

Division 8. Emergency Medical Service Rate Submission and Payment Requirements

28 TAC §21.5070 and §21.5071

STATUTORY AUTHORITY. TDI proposes new §21.5070 and §21.5071 under Insurance Code §§38.006, 1301.007, and 36.001.

Insurance Code §38.006 authorizes the commissioner to prescribe the form and manner by which political subdivisions may submit rates for ground ambulance services.

Insurance Code §1301.007 directs the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

Insurance Code §36.001 provides that the commissioner may 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. Section 21.5070 and §21.5071 implement Insurance Code §§38.006, 1271.159, 1275.054, 1301.166, 1551.231, 1575.174, and 1579.112, and SB 2476.

TEXT.

§21.5070. Rate Database for Emergency Medical Services Providers.

(a) Consistent with Insurance Code §38.006, concerning Emergency Medical Services Provider Balance Billing Rate Database, this section applies to:

(1) a political subdivision that sets, controls, or regulates a rate charged for a health care service, supply, or transport provided by an emergency medical services (EMS) provider, other than an air ambulance; and

(2) an EMS provider or its designee that provides a health care service, supply, or transport on behalf of a political subdivision that sets, controls, or regulates a rate.

(b) A political subdivision or EMS provider subject to this section may not issue a bill for a health care service, supply, or transport that exceeds the amount of the rate set, controlled, or regulated by the political subdivision.

(c) A political subdivision that chooses to submit data to the Texas Department of Insurance (TDI) under this section must submit data using the data submission method available at www.tdi.texas.gov and must include at a minimum:

(1) the political subdivision's name and contact information;

(2) if known, the National Provider Identification (NPI) number of each EMS provider that provides a health care service, supply, or transport that is subject to rates set, controlled, or regulated by the political subdivision;

(3) each ZIP code that is subject to the rates set, controlled, or regulated by the political subdivision; and

(4) the applicable billing code, code type, and dollar amount for each health care service, supply, or transport rate that is set, controlled, or regulated by the political subdivision.

(d) A political subdivision may submit rates at any time on or before the final submission deadline of September 1, 2024, but a rate must be published to be used in payments to EMS providers under §21.5071 of this title (relating to Payments to Emergency Medical Services Providers).

(e) TDI will publish data reported by a political subdivision according to the following schedule:

(1) data submitted on or before December 15, 2023, will be published by January 1, 2024.

(2) data submitted on or before March 1, 2024, will be published by March 15, 2024.

(3) data submitted on or before June 1, 2024, will be published by June 15, 2024.

(4) data submitted on or before September 1, 2024, will be published by September 15, 2024.

(f) A political subdivision is not required to submit new or updated data each quarter. Data submitted for an earlier quarter will continue to be published in subsequent quarters unless the political subdivision updates or deletes the rate data. Data that is updated or deleted will be published for use in payments to EMS providers under §21.5071 of this title according to the schedule specified in subsection (e) of this section.

(g) A claim submitted by an EMS provider or its designee for a health care service, supply, or transport provided on behalf of a political subdivision must include the ZIP code in which the health care service, supply, or transport originated.

(h) A table illustrating the dates by which a political subdivision must submit rates, TDI will publish rate data, and published rates will begin to apply to claims is contained in Figure: 28 TAC §21.5070(h).

Figure: 28 TAC §21.5070(h)

Submission deadline for political subdivisions	**TDI publication date**	**Claim submission dates to which the rates apply***
December 15, 2023	January 1, 2024	January 1 - March 31, 2024
March 1, 2024	March 15, 2024	April 1 - June 30, 2024
June 1, 2024	June 15, 2024	July 1 - September 30, 2024
September 1, 2024	September 15, 2024	October 1, 2024 - August 31, 2025

* Claim submission dates to which the rates apply are subject to adjustment for a new plan year, consistent with 28 TAC §21.5071(d).

§21.5071. Payments to Emergency Medical Services Providers.

(a) This section applies to a health benefit plan issuer or administrator that is subject to one of the following statutes:

(1) Insurance Code §1271.159, concerning Non-Network Emergency Medical Services Provider;

(2) Insurance Code §1275.054, concerning Out-of-Network Emergency Medical Services Provider Payments;

(3) Insurance Code §1301.166, concerning Out-of-Network Emergency Medical Services Provider;

(4) Insurance Code §1551.231, concerning Out-of-Network Emergency Medical Services Provider Payments;

(5) Insurance Code §1575.174, concerning Out-of-Network Emergency Medical Services Provider Payments; or

(6) Insurance Code §1579.112, concerning Out-of-Network Emergency Medical Services Provider Payments.

(b) For a covered health care or medical service, supply, or transport that is provided to an enrollee by an out-of-network emergency medical services (EMS) provider, a health benefit plan issuer or administrator must pay:

(1) for a service or transport that originated in a political subdivision that sets, controls, or regulates the rate, the rate for that political subdivision that is published in the EMS provider rate database established by the department consistent with the time frames addressed in subsection (c) of this section and adjusted as required in subsection (d) of this section; or

(2) if there is not a rate published in the EMS provider rate database for the political subdivision in which the service or transport originated, consistent with the time frames addressed in subsection (c) of this section, the lesser of:

(A) the provider's billed charge; or

(B) 325% of the current Medicare rate, including any applicable extenders or modifiers.

(c) Except as provided in subsection (d) of this section, for a claim for emergency medical services that is provided on or after January 1, 2024, a health benefit plan issuer or administrator must make a payment consistent with subsection (b) of this section, using rate data published in the department's EMS provider rate database according to the following schedule.

(1) For a claim submitted before April 1, 2024, the applicable rate is based on data published in the department's EMS provider rate database as of January 1, 2024.

(2) For a claim submitted on or after April 1, 2024, and before July 1, 2024, the applicable rate is based on data published in the department's EMS provider rate database as of March 15, 2024.

(3) For a claim submitted on or after July 1, 2024, and before October 1, 2024, the applicable rate is based on data published in the department's EMS provider rate database as of June 15, 2024.

(4) For a claim submitted on or after October 1, 2024, the applicable rate is based on data published in the department's EMS provider rate database as of September 15, 2024.

(d) The health benefit plan issuer or administrator must adjust a payment required under subsection (b)(1) of this section each plan year by increasing the payment by the lesser of the Medicare Economic Index rate or 10% of the provider's previous calendar year rates.

(1) For purposes of this subsection, the following terms are defined as follows.

(A) Plan year--a plan that starts on or after September 1, 2024.

(B) Calendar year rate--the most recently published rate available before the first day of the new plan year.

(2) Figure: 28 TAC §21.5071(d)(2) provides examples illustrating how a health benefit plan should apply published rates to a plan year under this subsection.

Figure: 28 TAC §21.5071(d)(2)

Examples:

Example 1. A plan renews on September 1, 2024. The previous calendar year rate is the most recently published rate available on August 31, 2024. The applicable rate is contained in the data published by June 15, 2024, for use with claims submitted July 1 - September 30, 2024. For claims incurred on or after September 1, 2024, the applicable rate must be adjusted by the lesser of the Medicare Economic Index rate or 10% of the provider's previous calendar year rates—that is, the rates published by June 15, 2024.

Example 2. A plan renews on October 1, 2024. The previous calendar year rate is the most recently published rate available on September 30, 2024. The applicable rate is contained in the data published by September 15, 2024, for use with claims submitted October 1, 2024 - August 31, 2025. For claims incurred on or after October 1, 2024, the applicable rate must be adjusted by the lesser of the Medicare Economic Index rate or 10% of the provider's previous calendar year rates—that is, the rates published by September 15, 2024.

Example 3. A plan is newly issued, effective January 1, 2025. The previous calendar year rate is the most recently published rate available on December 31, 2024. The applicable

rate is contained in the data published by September 15, 2024, for use with claims submitted October 1, 2024 - August 31, 2025. For claims incurred on or after January 1, 2025, the applicable rate must be adjusted by the lesser of the Medicare Economic Index rate or 10% of the provider's previous calendar year rates—that is, the rates published by September 15, 2024.

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 in Austin, Texas, on August 21, 2023.

DocuSigned by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance