SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
28 TAC §§21.5001 – 21.5031

INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 TAC Chapter 21, Subchapter PP, §§21.5001 – 21.5031, relating to Out-of-Network Claim Dispute Resolution. The amendments are necessary because of changes made to Insurance Code Chapter 1467 by Senate Bill 507, 85th Legislature, Regular Session (2017).

EXPLANATION. SB 507 amended Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution) and, as a result, the department must make conforming changes to 28 TAC Chapter 21, Subchapter PP.

As amended, Chapter 1467 provides for mediation of certain claims for services provided to enrollees of preferred provider benefit plans issued under Insurance Code Chapter 1301, and to enrollees of health benefit plans—other than health maintenance organization plans—provided under Insurance Code Chapters 1551 (the Texas Employees Group Benefits Act), 1575 (the Texas Public School Employees Group Benefits Program), and 1579 (the Texas School Employees Uniform Group Health Coverage).

Chapter 1467 also expands the types of covered providers and authorizes an enrollee to request mediation of an out-of-network health benefit claim if the claim is for emergency care or health care or medical service or supply provided by a facility-based provider in a facility that is a covered plan's preferred provider or that has a contract with the plan's administrator, for services provided on or after January 1, 2018. Amending §§21.5001 – 21.5031 is necessary to include these changes and adopt a new mediation request form.

A description of changes to specific sections follows.

DIVISION 1

Section 21.5001. The proposal makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5002. The proposal conforms §21.5002 to amendments made by SB 507, which expand the scope of mediation to cover claims made for emergency care or health care or medical

services or supplies provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator, provided on or after January 1, 2018, and to apply to health benefit plans under Insurance Code Chapters 1575 (concerning Texas Public School Employees Group Benefits Program) and 1579 (concerning Texas School Employees Uniform Group Health Coverage). The proposal removes the phrase "provided the claim is filed on or after November 1, 2010," from the section because the time limitation is no longer required, since there should be no claims still pending that were filed before that date. The proposal adds a savings clause for claims for health care or medical services or supplies provided before January 1, 2018, consistent with Section 18 of SB 507. The proposal also corrects a reference and makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5003. The proposal conforms the definitions in §21.5003 to amendments made by SB 507. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

DIVISION 2

Section 21.5010. The proposal conforms §21.5010 to amendments made by SB 507 that expand the scope of mediation. The proposal also removes the limitations and applicable dates to conform to amended §21.5002 and the savings clause added there. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5011. The proposal conforms §21.5011 to amendments made by SB 507 that expand the scope of mediation. The proposal adds a requirement to provide financial information about claims to aid the department and the parties in assessing and resolving issues for mediation. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5012. The proposal conforms §21.5012 to amendments made by SB 507 that expand the scope of mediation. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5013. The proposal makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

DIVISION 3

The proposal amends the name of the division to reflect amendments by SB 507, which require notices to be sent by facility-based providers, emergency care providers, insurers, as well as plan administrators.

Section 21.5020. The proposal amends §21.5020 to comply with new Insurance Code §1467.0511, as added by SB 507, and the notice it now requires in bills and explanations of benefits. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

DIVISION 4

Section 21.5030. The proposal conforms §21.5030 to amendments made by SB 507 that expand the scope of mediation. The proposal also makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 21.5031. The proposal makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Patricia Brewer, team lead for the Life and Health Regulatory Initiatives Team, has determined that during each year of the first five years that the proposed amendments are in effect, there will be no fiscal impact on state or local governments as a result of enforcing or administering the sections, other than that imposed by the statute. Ms. Brewer does not anticipate any measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Brewer expects that administering the proposed sections will have the public benefits of: (i) ensuring that the department's rules comply with Insurance Code Chapter 1467; (ii) adopting a revised mediation request form that will incorporate an authorization to disclose protected health information; (iii) clarifying changes made to Insurance Code Chapter 1467 by SB 507 for affected plans,

administrators, and enrollees; and (iv) possibly reducing balance billing of patients for some out-of-network services.

Ms. Brewer expects that the proposed amendments will not increase the cost of compliance with Insurance Code Chapter 1467 because they do not impose requirements beyond those in the statute.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that these proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities, because to the extent they contain requirements, they simply implement statutory requirements or contain minor revisions to existing forms. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does not impose a cost on regulated persons.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. 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. The department welcomes public comment on this proposal. Submit any written comments on the proposal no later than 5 p.m., Central time, on November 13, 2017. The department requires two copies of your comments. Send one copy to chiefclerk@tdi.texas.gov, or to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Send the other copy to LHLComments@tdi.texas.gov or to Patricia Brewer, Regulatory Initiatives, Life and Health Lines Office, Regulatory Policy Division, MC 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. To request a public hearing on the proposal, submit a request before the end of the comment period to chiefclerk@tdi.texas.gov, or to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104,

Austin, Texas 78714-9104. If a hearing is held, written comments and public testimony presented at the hearing will be considered.

SUBCHAPTER PP.
DIVISION 1

28 TAC §§21.5001, 21.5002, and 21.5003

STATUTORY AUTHORITY. The department proposes amendments to §§21.5001 - 21.5003 under Section 18 of SB 507, 85th Legislature, Regular Session (2017), and Insurance Code §§1467.001, 1467.002, 1467.003, 1467.051, 1467.0511, 1467.054, and 36.001.

Section 18 of SB 507 provides that changes in law made by the bill apply to claims for health care or medical services or supplies provided on or after January 1, 2018, and includes a savings clause for claims for health care or medical services or supplies provided before that date.

Section 1467.001 contains definitions for Chapter 1467.

Section 1467.002 sets out the applicability of the chapter.

Section 1467.003 requires the commissioner, the Texas Medical Board, any other appropriate regulatory agency, and the chief administrative law judge to adopt rules as necessary to implement their respective powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.0511 provides for notices to enrollees of the mediation process by facility-based providers, emergency care providers, insurers, and administrators, and encourages them to provide information if contacted by enrollees about bills that may be eligible for mediation under Chapter 1467.

Section 1467.054 sets out the procedure for requesting mediation and preliminary procedures for that mediation, and it provides that a request for mandatory mediation must be provided to the department on a form prescribed by the commissioner.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the department's powers and duties under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5001 implement Insurance Code Chapter 1467. The proposed amendments to 28 TAC §21.5002 implement Section 18 of SB 507, 85th Legislature, Regular Session (2017), and Insurance Code §1467.001 and §1467.051. The proposed amendments to 28 TAC §21.5003 implement Section 18 of SB 507, 85th Legislature, Regular Session (2017), and Insurance Code §§1467.001, 1467.002, and 1467.051.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 1. GENERAL PROVISIONS

§21.5001. Purpose.

As authorized by Insurance Code §1467.003 (concerning Rules), the purpose of this subchapter is to:

(1) prescribe the process for requesting, [~~and~~] initiating, and conducting preliminary procedures for the mandatory mediation of claims as authorized in Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution); and

(2) facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under Insurance Code Chapter 1467.

§21.5002. Scope.

(a) This subchapter applies to a qualified 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), provided the claim is filed on or after November 1, 2010; or

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapters [~~Chapter~~] 1551 (concerning Texas Employees Group Benefits Act), 1575 (concerning Texas Public School Employees Group Benefits Program), or 1579 (concerning Texas School Employees Uniform Group Health Coverage), provided the claim is for emergency care or health care or medical services or supplies provided by a facility-based

provider in a facility that is a preferred provider or that has a contract with the administrator, provided on or after January 1, 2018 [~~filed on or after November 1, 2010~~].

(b) This subchapter does not apply to a claim for health benefits, including emergency care or health care or medical services or supplies [~~medical and health care services or supplies or both~~], that is not a covered claim under the terms of the health benefit plan coverage.

(c) This subchapter applies only to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2018. A claim for health care or medical services or supplies provided before January 1, 2018, 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.

§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--An administering firm or a claims administrator for a health benefit plan, other than a health maintenance organization (HMO) plan, providing coverage under Insurance Code Chapters [~~Chapter~~] 1551, (concerning Texas Employees Group Benefits Act), 1575 (concerning Texas Public School Employees Group Benefits Program), or 1579 (concerning Texas School Employees Uniform Group Health Coverage).

(2) Chief administrative law judge--The chief administrative law judge of the State Office of Administrative Hearings.

(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[~~medical and health care services or supplies or both~~], provided that the care, services, or supplies[~~ or both~~]:

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

(5) Emergency care provider--A physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(6)[~~(4)~~] Enrollee--An individual who is eligible to receive benefits through a preferred provider benefit plan or a health benefit plan under Insurance Code Chapters 1551, 1575, or 1579.

(7) Facility--Has the meaning assigned by Health and Safety Code §324.001 (concerning Definitions).

(8)[~~(5)~~] Health benefit plan--A plan that provides coverage under:

(A) a preferred provider benefit plan offered by an insurer under Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans); or

(B) a plan, other than an HMO plan, under Insurance Code Chapters [~~Chapter~~] 1551, 1575, or 1579.

(9) Facility-based provider--A physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(10) Health care practitioner--An individual who is licensed to provide health care services.

[~~(6) Hospital-based physician -- A radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon if the assistant surgeon's services are provided on or after September 1, 2015:~~]

[~~(A) to whom the hospital has granted clinical privileges; and~~]

[~~(B) who provides services to patients of the hospital under those clinical privileges.~~]

(11)[~~(7)~~] 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 under Insurance Code Chapter 1301.

(12)[~~(8)~~] Mediation--A process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan, or the administrator, and a facility-based provider or emergency care provider [~~hospital-based physician~~] or the provider's [~~physician's~~] representative to settle a qualified claim of an enrollee.

(13)[~~(9)~~] Mediator--An impartial person who is appointed to conduct mediation under Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution).

(14)[~~(10)~~] Out-of-network claim--A claim for payment for medical or health care services or supplies or both furnished by a facility-based provider or emergency care provider [~~hospital-based physician~~] that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator.

(15)[~~(11)~~] Preferred provider--A facility, facility-based provider, or emergency care provider [~~hospital or hospital-based physician~~] that contracts on a preferred-benefit basis with an insurer issuing a preferred provider benefit plan under Insurance Code Chapter 1301 to provide medical care or health care to enrollees covered by a health insurance policy.

DIVISION 2

28 TAC §§21.5010 – 21.5013

STATUTORY AUTHORITY. The department proposes amendments to §§21.5010 – 21.5013 under Insurance Code §§1467.001, 1467.002, 1467.003, 1467.051, 1467.0511, 1467.054, and 36.001.

Section 1467.001 contains definitions for Chapter 1467.

Section 1467.002 sets out the applicability of the chapter.

Section 1467.003 requires the commissioner, the Texas Medical Board, the chief administrative law judge, and any other appropriate regulatory agency to adopt rules as necessary to implement their respective powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.0511 provides for notices to enrollees of the mediation process by facility-based providers, emergency care providers, insurers, and administrators, and encourages them to provide

information if contacted by enrollees about bills that may be eligible for mediation under Chapter 1467.

Section 1467.054 sets out the procedure for requesting mediation and preliminary procedures for that mediation, and it provides that a request for mandatory mediation must be provided to the department on a form prescribed by the commissioner.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the department's powers and duties under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5010 implement Insurance Code §1467.001 and §1467.051. The proposed amendments to 28 TAC §21.5011 and §21.5012 implement Insurance Code §1467.051 and §1467.054. The proposed amendments to 28 TAC §21.5013 implement Insurance Code §1467.003 and §1467.054.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 2. MEDIATION PROCESS

§21.5010. Qualified Claim Criteria.

(a) Required criteria. An enrollee may request mandatory mediation of an out-of-network claim under §21.5011 of this title (relating to Mediation Request Form and Procedure) if the claim complies with the criteria specified in this subsection. An out-of-network claim that complies with those criteria is referred to as a "qualified claim" in this subchapter.

(1) The out-of-network claim must be for:

(A) emergency care; or

(B) a health care or medical service [~~services~~] or supply [~~supplies, or both~~], provided by a facility-based provider [~~a hospital-based physician~~] in a facility [~~hospital~~] that is a preferred provider with the insurer or that has a contract with the administrator.

(2) [~~For services provided before September 1, 2015, the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $1,000.~~]

The [~~(3) For services provided on or after September 1, 2015, the~~] aggregate amount for which the enrollee is responsible to the facility-based provider or emergency care provider [~~hospital-based physician~~] for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $500.

(b) Submission of multiple claim forms. The use of more than one form in the submission of a claim, as defined in §21.5003[~~(3)~~] of this title (relating to Definitions), does not prevent eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible claims.

(1) An out-of-network claim is not eligible for mandatory mediation under this subchapter if:

(A) the facility-based provider [~~hospital-based physician~~] has provided a complete disclosure to an enrollee under Insurance Code §1467.051(c) (concerning Availability of Mandatory Mediation; Exception), and this subsection before providing the medical service or supply or both and has obtained the enrollee's written acknowledgment of that disclosure; and

(B) the amount billed by the facility-based provider [~~hospital-based physician~~] is less than or equal to the maximum amount specified in the disclosure.

(2) A complete disclosure under paragraph (1) of this subsection must:

(A) explain that the facility-based provider [~~hospital-based physician~~] does not have, as applicable, either a contract with the enrollee's health benefit plan as a preferred provider or a contract with the administrator of the plan, other than an HMO plan, provided under Insurance Code Chapters [~~Chapter~~] 1551 (concerning Texas Employees Group Benefits Act), 1575 (concerning Texas Public School Employees Group Benefits Program), or 1579 (concerning Texas School Employees Uniform Group Health Coverage);

(B) disclose projected amounts for which the enrollee may be responsible; and

(C) disclose the circumstances under which the enrollee would be responsible for those amounts.

(d) Qualification continues. A claim that meets the criteria to be [~~for~~] a qualified claim after claim adjudication by the insurer or administrator does not lose that status by virtue of the aggregate

amount for which the enrollee is responsible being reduced below the thresholds set out in this section without the consent of the enrollee.

§21.5011. Mediation Request Form and Procedure.

(a) Mediation request form. The commissioner adopts by reference Form No. CP029 (Health Insurance Mediation Request Form), which is available at www.tdi.texas.gov/consumer/cpmmediation.html. Form No. CP029 (Health Insurance Mediation Request Form) requires information necessary for the department to properly identify the qualified claim, including:

(1) the name and contact information, including a telephone number, of the enrollee requesting mediation;

(2) a brief description of the qualified claim to be mediated, including the amount sought from the enrollee, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee;

(3) the name and contact information, including a telephone number, of the requesting enrollee's counsel, if the enrollee retains counsel;

(4) the name of the facility-based provider or emergency care provider [~~hospital-based physician~~];

(5) the name of the insurer or administrator;

(6) the name and address of the facility [~~hospital~~] where services were rendered; and

(7) an authorization allowing the department to disclose the enrollee's protected health information or other confidential information to the facility-based provider or emergency care provider [~~hospital-based physician and the hospital-based physician's representative~~], the enrollee's health benefit plan's insurer or administrator, the benefit plan's representative or representatives, the insurer or administrator's representative or representatives, the appointed mediator, and the State Office of Administrative Hearings.

(b) Submission of request. An enrollee may submit a request for mediation by completing and submitting Form No. CP029 (Health Insurance Mediation Request Form) as provided in [~~paragraphs (1) - (4) of~~] this subsection. The request may be submitted:

(1) by mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(2) by fax to 512-490-1007;

(3) by email to ConsumerProtection@tdi.texas.gov; or

(4) online, when the department makes Form No. CP029 (Health Insurance Mediation Request Form) available to be completed and submitted online.

(c) Assistance. Assistance with submitting a request for mediation is available at the department's toll-free telephone number, [~~1-~~]800-252-3439.

§21.5012. Informal Settlement Teleconference.

An insurer or administrator subject to mandatory mediation requested by an enrollee under this subchapter [~~§21.5011 of this title (relating to Mediation Request Form and Procedure)~~] must use best efforts to coordinate the informal settlement teleconference required by Insurance Code §1467.054 (concerning Request and Preliminary Procedures for Mandatory Mediation) by:

(1) arranging a date and time when the insurer or administrator; the enrollee or the enrollee's representative, if the enrollee or the enrollee's representative[~~,~~] chooses to participate; and the facility-based provider or emergency care provider [~~hospital-based physician~~] or the facility-based provider's or emergency care provider's [~~hospital-based physician's~~] representative can participate in the informal settlement teleconference, which must occur not later than the 30th day after the date on which the enrollee submitted a request for mediation; and

(2) providing a toll-free telephone number for participation in the informal settlement teleconference.

§21.5013. Mediation Participation.

(a) An insurer or administrator subject to mediation under this subchapter must participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge under [~~in accordance with~~] Insurance Code §1467.003 (concerning Rules).

(b) Under Insurance Code §1467.101 (concerning Bad Faith), conduct that constitutes bad faith mediation includes failing to:

(1) participate in the mediation;

(2) provide information that the mediator believes is necessary to facilitate an agreement; or

(3) designate a representative participating in the mediation with full authority to enter into any mediated agreement.

DIVISION 3

28 TAC §21.5020

STATUTORY AUTHORITY. The department proposes amendments to §21.5020 under Insurance Code §§1467.003, 1467.051, 1467.0511, and 36.001.

Section 1467.003 requires the commissioner, the Texas Medical Board, any other appropriate regulatory agency, and the chief administrative law judge to adopt rules as necessary to implement their respective powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.0511 provides for notice and information to be sent to enrollees by facility-based providers, emergency care providers, insurers, and administrators, and encourages them to provide certain information to enrollees.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the department's powers and duties under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5020 implement Insurance Code §1467.051 and §1467.0511 and SB 507, 85th Legislature, Regular Session (2017), which amends Insurance Code Chapter 1467.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 3. [~~PLAN ADMINISTRATOR'S~~] REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION

§21.5020. Required Notice of Claims Dispute Resolution.

(a) A bill sent to an enrollee by a facility-based provider or emergency care provider or an explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for mediation under Insurance Code Chapter 1467 must contain, in not less than 10-point boldface type, a conspicuous, plain-language explanation of the mediation process available under this chapter, including information on how to request mediation and a statement that is substantially similar to the following:

"You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov/consumer/cpmmediation.html or by calling 800-252-3439."

(b) If an enrollee contacts an insurer, administrator, or facility-based provider or emergency care provider about a bill that may be eligible for mediation under this chapter, the insurer, administrator, or facility-based provider or emergency care provider is encouraged to:

(1) inform the enrollee about mediation under this chapter; and

(2) provide the enrollee with the department's toll-free telephone number and web address.

[~~An administrator of a plan under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act), must include a notice of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim for services, supplies, or both, furnished in a hospital that has a contract with the administrator.~~]

DIVISION 4

28 TAC §21.5030 and §21.5031

STATUTORY AUTHORITY. The department proposes admentments to §21.5030 and §21.5031 under Insurance Code §§1467.003, 1467.051, 1467.0511, 1467.054, and 36.001.

Section 1467.003 requires the commissioner, the Texas Medical Board, any other appropriate regulatory agency, and the chief administrative law judge to adopt rules as necessary to implement their respective powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.0511 provides for notices to enrollees of the mediation process by facility-based providers, emergency care providers, insurers, and administrators, and encourages them to provide

information if contacted by enrollees about bills that may be eligible for mediation under Chapter 1467.

Section 1467.054 sets out the procedure for requesting mediation and preliminary procedures for that mediation, and it provides that a request for mandatory mediation must be provided to the department on a form prescribed by the commissioner.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the department's powers and duties under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5030 and §21.5031 implement Insurance Code §1467.051 and §1467.054. The proposed amendments to 28 TAC implement Insurance Code §1467.051 and §1467.054.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 4. COMPLAINT RESOLUTION AND OUTREACH

§21.5030. Complaint Resolution.

(a) Written complaint.

(1) An individual may submit a written complaint to the department regarding a qualified claim or a mediation [~~that has been~~] requested under §21.5010 of this title (relating to Qualified Claim Criteria). A recommended form for filing a complaint under this subsection is available online at www.tdi.texas.gov/consumer/cpmmediation.html. The complaint may be submitted by:

(A) mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(B) fax to 512-490-1007;

(C) email to ConsumerProtection@tdi.texas.gov; or

(D) online submission.

(2) Assistance with filing a complaint is available at the department's toll-free telephone number, [~~1-~~] 800-252-3439.

(b) Complaint form. The recommended form for filing a complaint under subsection (a) of this section requests information concerning the complaint, including:

(1) whether the complaint is within the scope of Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution);

(2) whether emergency care, health care, or a medical service have [~~medical care has~~] been delayed or have [~~has~~] not been given;

(3) whether the health care, medical service, or supply, or a combination of health care, medical service, or supply, [~~thereof~~] that is the subject of the complaint was for emergency care; and

(4) specific information about the qualified claim, including:

(A) the name, type, and specialty of the facility-based provider or emergency care provider [~~hospital-based physician~~];

(B) the type of service performed or supplies provided;

(C) the city and county where the service was performed; and

(D) the dollar amount of the disputed claim.

(c) Department processing [~~Processing~~]. The department will maintain procedures to ensure that a written complaint made under this section is not dismissed without appropriate consideration, including:

(1) review of all of the information submitted in the written complaint;

(2) contact with the parties that are the subject of the complaint;

(3) review of the responses received from the subjects of the complaint to determine if and what further action is required, as appropriate; and

(4) notification to the enrollee of the mediation process, as described in Insurance Code Chapter 1467, Subchapter B (concerning Mandatory Mediation).

§21.5031. Department Outreach.

In addition to the notice provided to consumers regarding the availability of mandatory mediation described in §21.5030 [~~(c)~~] of this title (relating to Complaint Resolution), the department will provide outreach as required by Insurance Code §1467.151(a)(2) (concerning Consumer Protection; Rules), by making information concerning the availability of this mandatory mediation process available:

(1) on the department's website; and

(2) in consumer publications.

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

Issued at Austin, Texas, on September 28, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance