SUBCHAPTER Z

28 TAC §§21.3401 - 21.3409

INTRODUCTION. The Texas Department of Insurance proposes amending 28 TAC §§21.3401 - 21.3409 concerning data collecting and reporting relating to mandated health benefits and mandated offers of coverage. Insurance Code Chapter 38, Subchapter F requires certain accident and health insurers and HMOs to submit data to TDI on mandated health benefits and mandated offers of coverage as designated by the commissioner. Insurance Code §38.252 directs the commissioner to adopt rules on the collection of information on mandated benefits and mandated offers of coverage. Sections 21.3401 - 21.3409 implement Insurance Code §38.252.

EXPLANATION. Amending 28 TAC §§21.3401 - 21.3409 is necessary because the list of mandated benefits and offers, and the types of information for which the rule requires data submission, has not been updated since the rule was adopted in 2002. Over time, it has become clear that the data collection process has not yielded consistent and accurate information. The amendments will require data on mandates that the agency believes are now useful and will improve the accuracy and standardization of the data collected. The amendments will also revise the reporting period to match the calendar year.

Section 21.3401 states the purpose of the rule and identifies the entities to which the rule applies. Amending §21.3401 is necessary because of changes in the healthcare market and in the state's health insurance laws since the rule was initially adopted. The proposed amendments would require reporting entities to report information separately for small group and large group coverages that meet the threshold of $10 million in reported direct premiums earned. Entities will continue to report data on individual plans separately, but the proposed reporting threshold for these plans has increased from $2 million to $10 million in reported direct premiums earned.

Section 21.3402 defines certain words and terms used in Subchapter Z. Amending §21.3402 is necessary to: clarify that TDI requires information on claims incurred and premiums earned; enable the reporting of additional and more uniform data that will be more useful to TDI and to the legislature; remove items that will no longer be reported; and to revise the reporting period to match the calendar year.

Section 21.3403 directs reporting entities to collect and report the information required by the rule. The proposed amendments to this section conform the proposal to TDI's current writing style and improve the rule's clarity.

Section 21.3404 establishes the rule's reporting periods and due dates. The proposed amendments to this section allow reporting entities, after a conversion period, to report data one calendar year at a time, and to require the data be reported on June 1 of the following year.

Section 21.3405 lists certain exceptions to reporting requirements, and requires reporting entities to provide justification for excluding otherwise required information. The proposed amendments to this section conform the proposal to TDI's current writing style and improve the rule's clarity.

Section 21.3406 identifies the mandated benefits and mandated offers for which data must be reported. Under the proposed amendments, reporting entities will report data separately for small and large group plans, rather than continue aggregating data for small and large group plans. Instead of listing the mandates in separate subsections, based on whether they are applicable to group or to individual health plans, the mandates are in separate subsections, based on whether they are mandated benefits or mandated offers. The mandates are now listed in both subsections in the order of their Insurance Code section numbers, because the Insurance Code was recodified since the original rule was issued. Subsection (b) lists the mandated benefits for which data must be reported. It includes five new mandated benefits and retains 14 existing mandated benefits. The proposed rule deletes mandated benefits for which data collection is not feasible. Subsection (c) lists the mandated offers for which data must be reported. It includes one new mandated offer and retains two existing mandated offers.

Section 21.3407 currently requires that a reporting entity submit its report using the Mandated Benefits and Mandated Offers Reporting Form found on TDI's website. It also requires the reporting entity to use medical billing codes to identify applicable claims for each mandated benefit and mandated offer of coverage. The proposed amended rule requires the report to show, for all plans on which it is reporting, the total direct premiums earned instead of the total premiums written; the total claims incurred instead of the total claims paid; and the total member months. There are also similar proposed changes

to the information to be reported for the mandated benefits and mandated offers. For example, the proposed data requirements include the number of individual claims incurred instead of the number of claims paid; and the total number of member months instead of the number of certificates, policies, or lives covered. The proposed rule no longer requires the reporting entity to report administrative costs.

Section 21.3408 provides notice of possible penalties for noncompliance with the rule. The proposed amendments to this section conform the proposal to TDI's current writing style and improve the rule's clarity.

Section 21.3409 provides for the severability of a section of the rule found invalid by a court of law. The proposed amendments to this section conform the proposal to TDI's current writing style and improve the rule's clarity.

The proposed amendments also include other nonsubstantive editorial and formatting changes to conform the proposal to TDI's current writing style and improve the rule's clarity.

TDI received comments at a stakeholder meeting on November 2, 2016, and considered those comments when drafting this proposal.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Kimberly Rhodes, research specialist, Life and Health Actuarial Office, has determined that for each year of the first five years the proposed amendments will be in effect, there will be no fiscal impact to state or local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

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

Anticipated Public Benefits. Anticipated benefits will be improved integrity and utility of the data collected and reported by the issuers. External stakeholders, particularly legislators, rely on this information to assess the cost of mandated benefits and mandated offers. Proposed changes that will result in these benefits include eliminating mandates and data elements on which it is difficult to collect data, and shifting the reporting year to coincide with the calendar year.

Anticipated Costs. TDI anticipates that health insurers and HMOs required to report will incur costs associated with revising and testing data queries in response to changes in the mandated benefits and mandated offers for which they must report data, and the data elements they are required to report. TDI has identified four categories of labor reasonably necessary to perform the tasks: operations manager, computer programmer, compliance officer, and administrative support. The Texas Workforce Commission publishes the Texas Statewide median hourly wage online at www.texaswages.com and as follows:

(1) an operations manager earns approximately $50.46 per hour,

(2) a computer programmer earns approximately $38.21 per hour,

(3) a compliance officer earns approximately $33.93 per hour, and

(4) an administrative assistant earns approximately $17.90 per hour.

Because the costs to make the necessary revisions to comply with the proposal will vary from issuer to issuer, each issuer is in the best position to determine their actual costs. An issuer may calculate the total cost of labor for each category by multiplying the number of estimated hours for revising and testing the data queries by the median hourly wage for each category of labor.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. TDI has determined that the proposed rule amendments will not have an adverse economic effect on small or micro-business issuers. The amendments will expand a current exemption for issuers with low direct premium amounts, but will not explicitly exempt small or micro-businesses. Therefore, in accordance with Government Code §2006.002(c), TDI is not required to prepare an economic impact statement or a regulatory flexibility analysis with respect to the amendments in the proposed rule.

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 and, therefore, does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. Submit any written comments on the proposal no later than 5 p.m., Central time, on May 1, 2017. TDI 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 Kimberly.Rhodes@tdi.texas.gov, or to Kimberly Rhodes, Research Specialist, Life and Health Actuarial Office/Data Services Team, Mail Code MC 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

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

STATUTORY AUTHORITY. TDI proposes §§21.3401 - 21.3409 under Insurance Code §38.252, and Insurance Code §36.001. Insurance Code §38.252 directs the commissioner to require a health benefit plan issuer to collect and report cost and utilization data for mandated benefits and mandated offers designated by the commissioner; it requires the commissioner to adopt rules specifying which issuers must report data based on dollar amounts of premiums collected in Texas; specifying the data to be collected; the dates of the reporting period and the report's submission; the detail and form of the report; and any other reasonable requirements necessary to determine the impact of those mandated benefits and mandated offers of coverage. 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. Sections 21.3401 - 21.3409 implement Insurance Code §38.252, enacted as amended by HB 2636, 80th Legislature, Regular Session (2007).

TEXT.

SUBCHAPTER Z. DATA COLLECTING AND REPORTING RELATING TO MANDATED HEALTH BENEFITS AND MANDATED OFFERS OF COVERAGE

§21.3401. Purpose and Scope.

(a) Purpose of subchapter. The purpose of this subchapter is to require certain health benefit plan issuers to collect and report to the commissioner data on [~~data regarding~~] certain mandated health benefits and mandated offers of coverage [~~to the commissioner~~].

(b) Scope of subchapter. This subchapter applies to a health benefit plan issuer that is subject to Insurance Code §38.251 (concerning Applicability), and that reports on its submission to the National Association of Insurance Commissioners (NAIC), for the year for which it is reporting data, a total of $10 million or more in direct premiums earned in Texas for individual comprehensive health coverage, small group comprehensive health coverage, or large group comprehensive health coverage.[~~:~~]

[~~(1) a health benefit plan issuer that reports in its most recently filed annual statement a total of $10 million or more in direct premiums earned in the state of Texas for group accident and health insurance policies;~~]

[~~(2) a health benefit plan issuer that reports in its most recently filed annual statement a total of $2 million or more in direct premiums earned in the state of Texas for individual accident and health insurance policies;~~]

[~~(3) a health benefit plan issuer that is a basic service health maintenance organization and reports in its most recently filed annual statement a total of $10 million or more in direct commercial premiums earned in the state of Texas;~~]

[~~(4) a licensed third party administrator that performs claims payment services for any health benefit plan issuer that meets the requirements of paragraphs (1) - (3) of this subsection.~~]

(c) This subchapter does not apply to a governmental plan as defined by 29 U.S.C. § 1002(32).

§21.3402. Definitions. The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings [~~meaning~~] unless the context clearly indicates otherwise:

(1) Claims incurred--Paid claims plus amounts held in reserve for claims that have been incurred but have not yet been paid. [~~Administrative costs--A reasonable estimate of all costs directly associated with each mandate other than the claim amounts. Administrative costs should not include any start-up costs unless those costs were incurred during the reporting year.~~]

(2) Direct premium--The amount of health premiums earned for comprehensive health coverage as reported on an issuer's submission to the NAIC for the year for which it is reporting data. [~~Average annual premium attributable to each mandate--A reasonable estimate of the average annual premium cost per individual policy or group certificate for each mandate based on the health benefit plan issuer's actual experience for the reporting year. If average costs across policies or certificates cannot be determined, the average annual premium must be based on an estimate of the health benefit plan issuer's most commonly issued standard individual or group policy.~~]

(3) Health benefit plan--A health benefit plan regulated under Insurance Code Title 8 (concerning Health Insurance and Other Health Coverages), Subtitles A (concerning Health Coverage in General), B (concerning Group Health Coverage), C (concerning Managed Care), D (concerning Provider Plans), and G (concerning Health Coverage Availability). [~~Direct premium--Premium earned by a health benefit plan issuer in return for coverage, but not including premium received for providing reinsurance.~~]

(4) Mandated benefit--A health benefit listed in §21.3406(b) of this title (relating to Mandates for Which Data Must be Reported; Mandated Benefits) that must be included in a health benefit plan. [~~Family coverage--The rating or pricing classification of coverage offered to an employee/member, spouse and all other dependents to be covered by the plan.~~]

(5) Mandated offer--An offer of coverage listed in §21.3406(c) of this title (relating to Mandates for Which Data Must be Reported; Mandated Offers) that must be offered and made available to the holder or sponsor of an individual or group health benefit plan. [~~Health benefit plan issuer--An insurer or health maintenance organization that issues a plan that provides benefits for medical and surgical expenses incurred as the result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document.~~]

(6) Medical billing codes--Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and diagnosis-related group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the Current Procedural Terminology (CPT) code set maintained by the American Medical Association, and the International Classification of Diseases (ICD) code sets developed by the World Health Organization. TDI's list of suggested mandated benefit codes is shown on its website, www.tdi.texas.gov. [~~Mandates--Benefits or coverages listed in §21.3406 of this subchapter (relating to Mandates for Which Data Must Be Reported) that are required to be included in an individual or group health benefit plan or required to be offered and made available to the holder of an individual or group contract or the purchaser of an individual or group health benefit plan.~~]

(7) Member months--The cumulative number of months that all enrollees were covered during the reporting year. [~~Number of claims paid--The total number of separate, individual claims paid by the health benefit plan issuer.~~]

(8) Reporting entity--A health benefit plan issuer or a third-party administrator that performs claims payment services for a health benefit plan issuer to which this subchapter applies. [~~Total number of lives covered--The total number of lives covered under a policy, contract or certificate,~~

~~including the certificate, contract or policyholder and all dependents covered by the policy, contract or certificate for a reporting year.~~]

(9) Reporting year--A one-year period, beginning each January 1 [~~October 1~~] and ending the following December 31 [~~September 30~~], for [~~during~~] which health benefit plan issuers must collect the data required by §21.3407 of this title [~~Subchapter~~] (relating to Reporting of Required Information).

(10) Third-party administrator--An administrator holding a certificate of authority under Insurance Code Chapter 4151 (concerning Third-Party Administrators).

§21.3403. Collection of Data Necessary to Provide Report.

A reporting entity must [~~Each health benefit plan issuer to which this subchapter applies shall~~] collect the data required by this subchapter for each mandated benefit and mandated offer listed [~~mandate set forth~~] in §21.3406 of this title [~~subchapter~~] (relating to Mandates for Which Data Must Be Reported) and must [~~shall~~] prepare and submit [~~file~~] a report as required by §21.3407 of this title [~~subchapter~~] (relating to Reporting of Required Information).

§21.3404. Deadline for Submission of Reports.

(a) First reporting date. The first reporting date for the rule will be June 1, 2018, for data collected from January 1, 2017, through December 31, 2017. Subsequent annual reporting will follow this schedule. [~~Health benefit plan issuers shall annually submit the report required by this subchapter no later than December 1, and shall include all data for benefits and coverages for which payment was made during the previous reporting year.~~]

(b) Submission of annual reports. A reporting entity must submit the reports required by this subchapter no later than June 1 following the reporting year. [~~Notwithstanding the requirements of~~

~~subsection (a) of this section, the first reporting date for the rule will be April 1, 2004, for data collected from January 1, 2003 through December 31, 2003.~~]

§21.3405. Exceptions to Required Reporting and Justification for Exceptions.

(a) Exceptions for confidential information. A reporting entity is not [~~A health benefit plan issuer subject to this subchapter shall not be~~] required to report data that:

(1) could reasonably be used to identify a specific enrollee [~~in a health benefit plan~~]; or

(2) violates confidentiality requirements of state or federal law or regulations [~~regulation~~] applicable to an enrollee [~~in a health benefit plan~~].

(b) Exceptions for certain HMOs. A reporting entity [~~A health benefit plan issuer~~] that is an HMO is not [~~shall not be~~] required to report data for a particular benefit or coverage if:

(1) the HMO does not directly process the claim because the services are prepaid under a capitated payment arrangement; or

(2) the HMO does not receive complete and accurate encounter data.

(c) Justification for exceptions. A reporting entity [~~A health benefit plan issuer~~] that does not report data for a reason listed [~~set forth~~] in subsection (a) of this section must submit, in addition to the report required by this subchapter, an addendum containing:

(1) a general description of the type of data that has been omitted;

(2) the specific provision of each state or federal law or regulation that is the basis for its omission [~~omitting the data~~]; and

(3) a certification that the data could not be identified in [~~such~~] a way that would allow [~~enable~~] it to be included in the report without violating subsection (a) of this section.

(d) Addendum required. A reporting entity [~~A health benefit plan issuer~~] that omits data for a reason listed [~~set forth~~] in subsection (b) of this section must submit, in addition to the report required

by this subchapter, an addendum describing [~~containing a description of~~] the arrangements or circumstances that except the reporting entity [~~health benefit plan issuer~~] from reporting the data as required.

§21.3406. Mandates for Which Data Must Be Reported.

(a) Data to be reported separately. For all mandated benefits and mandated offers to be reported, a reporting entity must report separately its data for individual, small group, and large group health benefit plans.

(b)[~~(a)~~] Mandated benefits. The following is a list of mandated benefits [~~mandates~~] about which data relating to a [~~group~~] health benefit plan must be filed under §21.3403 of this title [~~subchapter~~] (relating to Collection of Data Necessary to Provide Report):

(1) Certain Benefits Related to Acquired Brain Injury, Insurance Code §1352.003 and §1352.0035; [~~In Vitro Fertilization Procedures, Insurance Code Article 3.51-6, Section 3A and §11.510(1) of this title (relating to Mandatory Offers;)~~]

(2) Serious Mental Illness, Insurance Code §1355.004; [~~HIV or AIDS Related Illnesses, Insurance Code Articles 3.51-6, Section 3C; 3.51-6D; 3.50-2, Section 5(j)(1); 3.50-3, Section 4C(1); and 3.51-5A(a)(1) and §3.3057(d) of this title (relating to Standards for Exceptions, Exclusions, and Reductions Provision);~~]

(3) Autism Spectrum Disorder, Insurance Code §1355.015; [~~Chemical Dependency, Insurance Code Article 3.51-9, and Subchapter HH, §§3.8001-3.8030 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers);~~]

(4) Low-Dose Mammography, Insurance Code §1356.005; [~~Serious Mental Illnesses, Insurance Code Articles 3.51-14, 3.50-2 and §11.509(5) of this title (relating to Additional Mandatory Benefit Standards: Group Agreement Only);~~]

(5) Reconstructive Surgery Following Mastectomy, Insurance Code §1357.004; [~~Serious Mental Illnesses, Insurance Code Articles 3.50-3 and 3.51-5A(a)(2) and (b);~~]

(6) Diabetes Equipment, Supplies, and Self-Management Training, Insurance Code §1358.054; [~~Treatment in Psychiatric Day Treatment Facility, Insurance Code Article 3.70-2(F) and §§11.509(5) and 11.510(3) of this title;~~]

(7) Formulas for Phenylketonuria (PKU) or Other Heritable Diseases, Insurance Code §1359.003; [~~Loss or Impairment of Speech or Hearing, Insurance Code Article 3.70-2(G) and §11.510(2) of this title;~~]

(8) Temporomandibular Joint (TMJ) Diagnosis and Treatment, Insurance Code §1360.004; [~~Low Dose Mammography, Insurance Code Article 3.70-2(H);~~]

(9) Osteoporosis, Detection and Prevention, Insurance Code §1361.003; [~~Phenylketonuria (PKU), Insurance Code Article 3.79;~~]

(10) Certain Tests for Detection of Prostate Cancer, Insurance Code §1362.003; [~~Prescription Contraceptive Drugs and Devices and Related Services, Insurance Code Article 21.52L;~~]

(11) Certain Tests for Detection of Colorectal Cancer, Insurance Code §1363.003; [~~Temporomandibular Joint Procedures, Insurance Code Article 21.53A and §11.509(6) of this title;~~]

(12) Childhood Immunizations, Insurance Code §1367.053; [~~Osteoporosis, Detection and Prevention, Insurance Code Article 21.53C;~~]

(13) Hearing Screening for Children, Insurance Code §1367.103; [~~Immunizations, Insurance Code Articles 21.53F,and 20A.09F and §§11.506(2) and 11.508(a)(9)(G) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate, and Mandatory Benefit Standards: Group, Individual and Conversion Agreements);~~]

(14) Chemical Dependency Coverage, Insurance Code §§1368.004, 1368.005, and 1368.007; [~~Prostate Cancer Testing, Insurance Code Articles 21.53F and 3.50-4, Sec. 18D and §11.508(a)(9)(E) of this title;~~]

(15) Prescription Contraceptive Drugs and Devices and Related Services, Insurance Code §1369.104; [~~Diabetes Care, Supplies, and Services, Insurance Code Articles 21.53D and 21.53G and §§21.2601 - 21.2607 of this title (relating to Diabetes);~~]

(16) Certain Tests for Detection of Human Papillomavirus and Cervical Cancer, Insurance Code §1370.003; [~~Hearing Screening for Children, Insurance Code Article 21.53F;~~]

(17) Certain Tests for Detection of Ovarian Cancer, Insurance Code §1370.003; [~~Telemedicine/Telehealth, Insurance Code Article 21.53F and §11.1607(i), (j) and (k) of this title (relating to Accessibility and Availability Requirements);~~]

(18) Certain Tests for Early Detection of Cardiovascular Disease, Insurance Code §1376.003; and [~~Reconstructive Surgery Incident to a Mastectomy, Insurance Code Article 21.53I and §11.508(a)(5)(A) of this title;~~]

(19) Certain Amino Acid-Based Elemental Formulas, Insurance Code §1377.051. [~~Certain Benefits Related to Acquired Brain Injury, Insurance Code Article 21.53Q;~~]

[~~(20) Certain Tests For Detection of Colorectal Cancer, Insurance Code Article 21.53S;~~]

[~~(21) Reconstructive Surgery for Craniofacial Abnormalities in A Child, Insurance Code Article 21.53W; and~~]

[~~(22) Oral Contraceptives, §21.404(3) of this title (relating to Underwriting) and Prescription Contraceptive Drugs and Devices and Related Services, Insurance Code Article 21.52L.~~]

(c)[~~(b)~~] Mandated offers. The following is a list of mandated offers [~~mandates~~] about which data relating to a [~~individual~~] health benefit plan must be filed under §21.3403 of this title: [~~subchapter~~]

(1) Loss or Impairment of Speech or Hearing, Insurance Code §1365.003; [~~HIV or AIDS Related Illnesses, Insurance Code Articles 3.51-6, Section 3C; 3.51-6D; 3.50-2, Section 5(j)(1); 3.50-3, Section 4C(1); and 3.51-5A(a)(1), and §3.3057(d) of this title;~~]

(2) In Vitro Fertilization Procedures, Insurance Code §1366.003; and [~~Immunizations, Insurance Code Articles 21.53F and 20A.09F, and §§11.506(2) and 11.508(a)(9)(G) of this title;~~]

(3) Developmental Delays, Insurance Code §1367.204. [~~Prostate Cancer Testing, Insurance Code Articles 21.53F and 3.50-4, Sec. 18D and §11.508(a)(9)(E) of this title;~~]

[~~(4) Diabetes Care, Supplies, and Services, Insurance Code Articles 21.53D and 21.53G, and §§21.2601 - 21.2607 of this title;~~]

[~~(5) Hearing Screening for Children, Insurance Code Article 21.53F;~~]

[~~(6) Telemedicine/Telehealth, Insurance Code Article 21.53F and §11.1607(i), (j) and (k) of this title;~~]

[~~(7) Reconstructive Surgery Incident to a Mastectomy, Insurance Code Article 21.53I and §11.508(a)(5)(A) of this title;~~]

[~~(8) Certain Benefits Related to Acquired Brain Injury, Insurance Code Article 21.53Q;~~]

[~~(9) Certain Tests For Detection of Colorectal Cancer, Insurance Code Article 21.53S;~~]

[~~(10) Reconstructive Surgery for Craniofacial Abnormalities in A Child, Insurance Code Article 21.53W;~~]

[~~(11) Oral Contraceptives, §21.404 of this title (relating to Underwriting) and Prescription Contraceptive Drugs and Devices and Related Services, Insurance Code Article 21.52L; and~~]

[~~(12) Low Dose Mammography, Insurance Code Article 3.70-2(H).~~]

(d)[~~(c)~~] Suggested procedure and diagnosis codes. TDI [~~The Department~~] will provide[~~,~~] on its website, www.tdi.texas.gov, [~~the Department's Web site, www.tdi.state.tx.us,~~] suggested procedure and diagnosis codes that may be used in capturing the required data for the report. Regardless of whether a

reporting entity [~~health benefit plan issuer~~] uses the suggested codes or some other method of capturing the required information, each reporting entity must [~~health benefit plan issuer shall~~] maintain information and documentation supporting the accuracy and completeness of its [~~the~~] data and the report, including, but not limited to, a list of all procedural and diagnosis codes used in collecting data for the report for five years following the submission of the report on [~~upon~~] which the information was based. On [~~Upon~~] receiving a request from TDI, a reporting entity must [~~health benefit plan issuer shall~~] make available the supporting information described in this subsection.

§21.3407. Reporting of Required Information.

(a) Reporting data. A reporting entity must [~~A health benefit plan issuer shall~~] submit the data required by this section electronically by completing the Mandated Benefits and Mandated Offers Reporting Form found on TDI's website, www.tdi.texas.gov. A reporting entity must use medical billing codes to identify applicable claims for each mandated benefit and mandated offer of coverage. [~~accessing a link designated on the Department's Web site, www.tdi.state.tx.us, for reporting of the required information.~~]

(b) Issuer's information. For each reporting year, a reporting entity must [~~Each health benefit plan issuer shall~~] provide the following information [~~for the reporting year~~]:

(1) the year for which the data is being reported;

(2) the health benefit plan issuer's NAIC Number;

(3) the health benefit plan issuer's [~~company~~] name;

(4) the health benefit plan issuer's mailing address;

(5) the issuer type (insurance or HMO); [~~if applicable, any group NAIC number and group name;~~]

(6) whether a third-party administrator is submitting the report; [~~the name, title, direct telephone number, mailing address and email address of an individual who is responsible for the report~~]

(7) the name, title, direct telephone number, email address, and mailing address of an individual who is responsible for the report; [~~the total direct premiums earned in the state of Texas for group accident and health insurance policies or contracts which are subject to one or more of the mandates set forth in §21.3406(a) of this subchapter (relating to Mandates for Which Data Must be Reported);~~]

(8) whether the contact person's email address can be released; [~~the total direct premiums earned in the state of Texas for individual accident and health insurance policies or contracts which are subject to one or more of the mandates set forth in §21.3406(b) of this subchapter;~~]

(9) the submission date; and [~~the total dollar amount of claims incurred for the reporting year on all group policies or contracts for which premium is being reported; and~~]

(10) whether the health benefit plan issuer meets the reporting threshold for each reporting category (individual, small group, and large group). [~~the total dollar amount of claims incurred for the reporting year on all individual policies or contracts for which premium is being reported.~~]

(c) Reporting for all covered benefits. For each reporting year, a reporting entity must provide, for all covered comprehensive health benefit plans subject to mandated benefits and mandated offers, the following aggregated data: [~~Each health benefit plan issuer shall provide for each of the mandates set forth in §21.3406(a) of this subchapter the following information for the reporting year:~~]

(1) the total direct premiums earned; [~~the number of claims incurred;~~]

(2) the total dollar amount of the claims incurred; and

(3) the total member months. [~~the number of policies, contracts or certificates about which information is being reported; and~~]

[~~(4) the total dollar amount of administrative costs during the reporting year.~~]

(d) Reporting for all mandated benefits and mandated offers. For each reporting year, a reporting entity must provide the following information [~~Each health benefit plan issuer shall provide,~~] for each of the mandated benefits and mandated offers listed [~~mandates set forth~~] in §21.3406[~~(b)~~] of this title [~~subchapter~~] (relating to Mandates for Which Data Must Be Reported), aggregated separately by individual, small group, and large group health benefit plans: [~~the following information for the reporting year:~~]

(1) the total dollar amount of the claims incurred; [~~the number of claims incurred;~~]

(2) the total number of individual claims incurred; and [~~the total dollar amount of the claims incurred;~~]

(3) the total member months. [~~the number of policies, contracts or certificates about which the information is being reported; and~~]

[~~(4) the total dollar amount of administrative costs incurred during the reporting year.~~]

(e) Additional reporting data. A reporting entity must provide the following information:

(1) the medical billing codes used to capture the required data for the report;

(2) any additional information the reporting entity believes is pertinent to the data being reported, if applicable; and

(3) the certification on the data collection form.

[~~Each health benefit plan issuer shall provide, for each of the mandates set forth in §21.3406(a) of this subchapter, the average annual premium per policy, contract or certificate attributable to each mandate for each group certificate about which data is being reported, and must report separate data for certificates providing individual coverage and certificates providing family coverage during the reporting year.~~]

[~~(f) Each health benefit plan issuer shall provide the total number of group certificates issued or renewed during the reporting year, and the total number of certificates in force on a date to be~~

~~provided by the department in the reporting form, and must report separate data for the total number of certificates providing individual coverage and the total number of certificates providing family coverage during the reporting year.~~]

[~~(g) Each health benefit plan issuer shall provide the total number of lives covered under group certificates issued or renewed during the reporting year, and the total number of certificates in force on a date to be provided by the department in the reporting form, and must report separate data for the total number of certificates providing individual coverage and the total number of certificates providing family coverage during the reporting year.~~]

[~~(h) Each health benefit plan issuer shall provide, for each of the mandates set forth in §21.3406(b) of this subchapter, the average annual premium attributable to each mandate for individual policies about which data is being reported on a date to be provided by the department in the reporting form, and must report separate data for policies providing individual coverage and policies providing family coverage during the reporting year.~~]

[~~(i) Each health benefit plan issuer shall provide the total number of individual policies issued or renewed during the reporting year, and the total number of policies in force on a date to be provided by the department in the reporting form and must report separate data for total number of policies providing individual coverage and the total number of policies providing family coverage during the reporting year.~~]

[~~(j) Each health benefit plan issuer shall provide the total number of lives covered under individual policies issued, renewed or in force during the reporting year and must report separate data for the total number of policies providing individual coverage and the total number of policies providing family coverage during the reporting year.~~]

§21.3408. Compliance. A reporting entity that fails [~~Failure~~] to comply with this subchapter will be subject [~~shall subject any entity included in the scope of this subchapter~~] to the sanctions and penalties provided in [~~the~~] Insurance Code Chapters [~~28A and B,~~] 82 (concerning Sanctions), 83 (concerning Emergency Cease and Desist Orders), [~~and~~] 84 (concerning Administrative Penalties), 601 (concerning Privacy), and 602 (concerning Privacy of Health Information).

§21.3409. Severability. If a court holds invalid any section or portion of a section of this subchapter or holds invalid its applicability to any person or circumstance [~~is held invalid by a court~~], the remainder of the subchapter or the applicability of the provision to other persons or circumstances will [~~shall~~] not be affected.

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

Issued in Austin, Texas, on March 14, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance