SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
28 TAC §21.2821 and
Repeal of §21.2824

INTRODUCTION. The Texas Department of Insurance proposes to amend 28 TAC §21.2821, concerning reporting requirements, and to repeal §21.2824, concerning applicability. The amendments to §21.2821 expand the claims-related data elements that a managed care carrier (MCC) must report to the department on a quarterly basis and require electronic reporting of these data elements in order to determine carrier compliance with Insurance Code §843.342 and §1301.137. The repeal of §21.2824 removes outdated rule language.

EXPLANATION. Under Insurance Code §843.342 and §1301.137, carriers are required to pay a penalty and applicable interest for the late payment of clean claims. The proposed amendments to §21.2821 expand the data reporting requirements under the prompt pay reporting system so that the department can adequately determine compliance, lower the frequency of some reporting to reduce the regulatory burden on carriers, and provide for the data to be entered directly into the department's new electronic database to improve efficiency and limit the possibility of data entry errors. The repeal of §21.2824 removes language regarding applicability that is outdated.

In order to verify that the amount paid is correct, the amended rule would require that the quarterly report from managed care carriers required under §21.2821(a) include the total number of reported late-paid claims and the dollar value corresponding to those claims. This dollar value would be submitted for each time frame (i.e., claims paid late between 1and 45 days, claims paid late between 46 and 90 days, and claims paid late 91 days or greater). The rule also would require the carrier to submit a list of penalty and

certain interest payments, with associated claim numbers, so that the department can verify the amounts and tie the penalty and interest payments to actual claims paid.

The amended rule also requires that carriers report the number of complaints received regarding failure to pay a clean claim timely. This report will gather the number of such complaints received by a managed care carrier, which may not have been submitted to the department as formal complaints. Complaint numbers can be an indication of the quality of a carrier's claims payment processes.

While the rule currently requires quarterly reporting of data, it does not address reporting of penalty and interest payments for late-paid claims. In practice, carriers have been reporting penalty and interest data monthly since the dissolution of the Texas Health Insurance Risk Pool and transfer of its obligations and authority to the department. With these proposed rule amendments, monthly reporting will no longer be necessary; carriers will begin reporting the data quarterly. The department expects that the reduction in frequency of reporting will reduce the carriers' burden of compliance over time.

The proposed amendments also require carriers to submit their quarterly reports electronically by entering the data directly into the department's new electronic prompt pay reporting database in order to reduce the possibility of data entry errors, enhance the department's oversight capabilities, and increase efficiency.

Without the requirements to report the claims' dollar value, provide the claims numbers from which the penalty amount is derived, and engage in electronic data entry by the reporter, the only verification of compliance that the department can perform is to spot-check claims and claims payments via market-conduct and quality-of-care examinations. The new requirements will allow the department to better determine compliance with Insurance Code §843.342 and §1301.137.

Section 21.2821. Reporting Requirements. Amendments to this section require the reporting of additional data elements relating to the late payment of clean claims.

An amendment to subsection (a) revises the subsection to specify that, in addition to submitting quarterly claims payment information, an MCC must submit related penalty and interest payment information and information regarding complaints.

Amendments to the section also add new subsection (e), which lists and describes the information that an MCC must provide in the report required by subsection (a) of the section to satisfy the expanded data reporting requirements. The information required by the new subsection includes the following:

- the total dollar amount of clean claims the MCC reported after the end of the applicable statutory claims payment period, broken down by relevant time period;

- the penalty dollar amount of each clean claim the MCC paid late to noninstitutional preferred providers, broken down by relevant time period;

- the penalty dollar amount of each clean claim the MCC paid late to institutional preferred providers, broken down by relevant time period;

- the amount of interest, based on the penalty dollar amount, that the MCC paid to the department for certain late-paid clean claims that the MCC paid to a noninstitutional preferred provider;

- a list of each claim number the MCC paid late and the associated penalty dollar amount;

- a list of each claim number and the associated amount of interest paid to the department for certain late-paid clean claims; and

- the total number of complaints received by an MCC for failure to pay a claim.

The amendments to the section add a new subsection (f), which requires that the quarterly report required by subsection (a) of the section be submitted electronically in a format acceptable to the department as specified on the department's website.

Finally, the amendments to the section add a new subsection (g), which provides that the new reporting requirements in subsections (e) and (f) apply to reports submitted

under §21.2821(a) beginning with the report required to be submitted by May 15, 2021, for the months of January, February, and March of that year.

Section 21.2824. Applicability. The department proposes the repeal of §21.2824. The repeal of §21.2824 removes outdated provisions regarding applicability.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Debra Diaz-Lara, associate commissioner, Life and Health Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. Ms. Diaz-Lara made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Diaz-Lara does not anticipate any 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 amendments are in effect, Ms. Diaz-Lara expects that the proposed amendments will have the public benefits of ensuring that the department can better evaluate compliance with §843.342 and §1301.137, conserving agency resources, and reducing the regulatory burden and costs imposed on MCCs with the expansion of electronic reporting and the submission of claims-related information on a quarterly rather than a monthly basis. The proposed amendments will also benefit the public by enabling the department, through the analysis of complaints reported electronically to the department, to better identify problems associated with a carrier's failure to pay clean claims timely.

Ms. Diaz-Lara expects that the proposed amendments will impose an initial economic cost on MCCs that must implement the expanded reporting in compliance with the proposed rule. The initial cost will involve reprogramming computer systems to provide for reporting of the additional claims-related data required by the proposed amendments. Carriers are already collecting the additional data elements to be reported. Once the systems are reprogrammed, the burden of reporting claims-related data to comply with the rule on an ongoing basis is expected to remain static.

It is not feasible for the department to ascertain the actual cost of reprogramming computer systems to comply with the proposed amendments; MCCs are better suited to determine them. Every carrier has unique internal processes, resources, and technical capabilities that are not feasible for the department to evaluate. The exact method of compliance is a business decision, including the decision to employ staff or contract for some of these services.

Approximately 136 MCCs electronically report their monthly claims-related data to the department. Fewer than five carriers submit their reports by mail. While there may be initial costs to implement electronic reporting for those carriers currently reporting by mail, those costs are expected to be minimal and to involve reporting electronically through a spreadsheet system.

Though costs to each carrier will depend on the volume and degree of complexity of the claims-related information the carrier reports to the department, the department estimates the following possible needs: individual employee compensation for an administrative assistant at $16.82 per hour, computer programmer at $41.59 per hour, and a computer and information systems manager at $71.34 per hour for one to 20 hours of work to revise an insurer's internal procedures. The department also estimates individual employee compensation for an administrative assistant at $16.82 per hour and a computer programmer at $41.59 per hour for one to 20 hours of work to create, modify,

and test the code and scripts to run computer applications. These wages are based on the latest State Occupational Employment and Wage Estimates for Texas published by the U.S. Department of Labor (DOL, May 2019) at www.bls.gov/oes/current/oes_tx.htm.

Once carriers have made the programming changes, the reporting system will be automated and repetitive for each quarterly report. The reduction in reporting frequency from monthly to quarterly is expected to significantly reduce the compliance burden for carriers, which the department anticipates will more than offset initial programming costs, resulting in an overall reduction in costs for compliance with the rule.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses or on rural communities. The new amendments will not create an increase in cost of compliance. Although insurers may have initial programming costs associated with the rule change, the department expects the decreased frequency of reporting will more than offset those initial costs, as discussed in the Public Benefit and Cost Note section. 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 while this proposal may impose an initial cost on regulated persons, these initial costs will be more than offset by savings that result from a reduction in reporting frequency. Additionally, under Government Code §2001.0045(c)(2), the department is not required to repeal or amend another rule because the proposed rule amendments will reduce the burden or responsibilities imposed on regulated persons.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create a government program;
- will not require the creation of new 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 not create a new regulation;
- will expand an existing regulation;
- will not increase the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

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 will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., central time, on December 28, 2020. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, 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, MC

112-2 A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on December 28, 2020. If the department holds a public hearing, the department will consider written and oral comments presented at the hearing.

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
28 TAC §21.2821

STATUTORY AUTHORITY. The department proposes amendments to §21.2821 under Insurance Code §§843.151, 1301.007, and 36.001.

Insurance Code §843.151 provides that the Commissioner may adopt reasonable rules as necessary and proper to implement Chapter 843.

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

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 §21.2821 implement Insurance Code §843.151 and §1301.007.

TEXT.

§21.2821. Reporting Requirements.

(a) An MCC must submit to the department quarterly claims payment and related penalty and interest payment information, and information regarding complaints, in compliance with the requirements of this section.

(b) The MCC must submit the report required by subsection (a) of this section to the department on or before:

(1) May 15th for the months of January, February, and March of each year;

(2) August 15th for the months of April, May, and June of each year;

(3) November 15th for the months of July, August, and September of each year; and

(4) February 15th for the months of October, November, and December of each preceding calendar year.

(c) The report required by subsection (a) of this section must include, at a minimum, the following information:

(1) number of claims received from noninstitutional preferred providers;

(2) number of claims received from institutional preferred providers;

(3) number of clean claims received from noninstitutional preferred providers;

(4) number of clean claims received from institutional preferred providers;

(5) number of clean claims from noninstitutional preferred providers paid within the applicable statutory claims payment period;

(6) number of clean claims from noninstitutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(7) number of clean claims from institutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(8) number of clean claims from noninstitutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(9) number of clean claims from institutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(10) number of clean claims from noninstitutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period;

(11) number of clean claims from institutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period;

(12) number of clean claims from institutional preferred providers paid within the applicable statutory claims payment period;

(13) number of claims paid under the provisions of §21.2809 of this title (relating to Audit Procedures);

(14) number of requests for verification received under §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans);

(15) number of verifications issued under §19.1719 of this title;

(16) number of declinations of requests for verifications, under §19.1719 of this title;

(17) number of certifications of catastrophic events sent to the department;

(18) number of calendar days business was interrupted for each corresponding catastrophic event;

(19) number of electronically submitted, affirmatively adjudicated pharmacy claims received by the MCC;

(20) number of electronically submitted, affirmatively adjudicated pharmacy claims paid within the 18-day statutory claims payment period;

(21) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or before the 45th day after the end of the 18-day statutory claims payment period;

(22) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or after the 46th day and before the 91st day after the end of the 18-day statutory claims payment period; and

(23) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or after the 91st day after the end of the 18-day statutory claims payment period.

(d) An MCC must annually submit to the department, on or before August 15th, at a minimum, information related to the number of declinations of requests for verifications from July 1st of the prior year to June 30th of the current year, in the following categories:

(1) policy or contract limitations:

(A) premium payment time frames that prevent verifying eligibility for a 30-day period;

(B) policy deductible, specific benefit limitations, or annual benefit maximum;

(C) benefit exclusions;

(D) no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or for whom membership is canceled;

(E) preexisting condition limitations; and

(F) other;

(2) declinations due to an inability to obtain necessary information to verify requested services from the following persons:

(A) the requesting physician or provider;

(B) any other physician or provider; and

(C) any other person.

(e) In addition to the information reported under subsection (c) of this section, the report required by subsection (a) of this section must also include, at a minimum, the following information:

(1) the total dollar amount of the claims described in each of the following subparagraphs:

(A) clean claims from noninstitutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(B) clean claims from institutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(C) clean claims from noninstitutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(D) clean claims from institutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(E) clean claims from noninstitutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period; and

(F) clean claims from institutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period;

(2) the penalty dollar amount that the MCC paid to an institutional preferred provider for each clean claim that the MCC paid to the institutional preferred provider:

(A) on or before the 45th day after the end of the applicable statutory claims payment period;

(B) on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period; and

(C) on or after the 91st day after the end of the applicable statutory claims payment period;

(3) the penalty dollar amount that the MCC paid to a noninstitutional provider for each clean claim that the MCC paid to the noninstitutional preferred provider:

(A) on or before the 45th day after the end of the applicable statutory claims payment period;

(B) on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period; and

(C) on or after the 91st day after the end of the applicable statutory claims payment period:

(4) the amount of interest, based on the penalty dollar amount, that the MCC paid to the department for each clean claim that the MCC paid to the noninstitutional preferred provider on or after the 91st day after the end of the applicable statutory claims payment period;

(5) a list of each claim number and the associated penalty dollar amount as reported under subsection (e), paragraphs (2) and (3) of this section;

(6) a list of each claim number and the associated amount of interest paid as reported under subsection (e)(4) of this section; and

(7) the total number of complaints received by the MCC for failure to pay a clean claim timely.

(f) The quarterly report required in subsection (a) of this section must be submitted electronically as specified on the department's website.

(g) Subsections (e) and (f) of this section apply to reports submitted under subsection (a) of this section beginning with the report required to be submitted by May 15, 2021, for the months of January, February, and March of that year.

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
Repeal of 28 TAC §21.2824

STATUTORY AUTHORITY. The department proposes the repeal of §21.2824 under Insurance Code §36.001.

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 repeal of §21.2824 implements Insurance Code §36.001.

TEXT.

§21.2824. Applicability.

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 November 10, 2020.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance