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

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC Chapter 21, Subchapter PP, §§21.5001 – 21.5031 (relating to Out-of-Network Claim Dispute Resolution). The text of the proposed amendments was published in the October 13, 2017, issue of the *Texas Register* (42 TexReg 5642). The amendments to §§21.5002, 21.5010, 20.5011, and 21.5020 are adopted with changes to the proposed text, and §§21.5001, 21.5003, 21.5012, 21.5013, 21.5030, and 21.5031 are adopted without changes to the proposed text. The department made changes to §§21.5002, 21.5010, 20.5011, and 21.5020 in response to public comment, revised §21.5002(c) to remove the unnecessary word "only," and revised §21.5011(a) to capitalize the word "Commissioner."

REASONED JUSTIFICATION. The amendments are necessary because of changes made to Insurance Code Chapter 1467 by Senate Bill 507, 85th Legislature, Regular Session (2017). As a result of the legislation, 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, as amended by SB 507, expands the types of providers whose bills are covered by the statute 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 services or supplies 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.

The amendments also incorporate nonsubstantive changes that were included in the proposal to conform to agency style and usage guidelines.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received timely written comments from four commenters. Commenters in support of the proposal were AARP Texas, the Center for Public Policy Priorities, and the Texas Association of Health Plans. Commenters in support of the proposal with changes were the Texas Medical Association.

Comment on Proposal in General.

Three commenters supported the proposed amendments. One of these commenters urged the department to reconsider its practice of classifying each mediation request as a "complaint" against the issuer of the enrollee's benefit plan.

The commenter stated that Insurance Code Chapter 1467 Subchapter D directs the department to adopt rules "regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter." The commenter noted that both the current and proposed versions of §21.5030 provide that an individual may submit a complaint regarding a qualified claim or a mediation requested under §21.5010. The commenter stated that no statute or rule provides that a request for mediation under §21.5010 automatically constitutes a complaint, and noted that the Legislature contemplated complaints about mediations, not that a request for mediation is a complaint.

The commenter stated that a request for mediation under §21.5010 is not necessarily an expression of a grievance against the insurer but could rather be viewed as either a complaint against the provider for excessive billing or simply as a request for the provider and carrier to resolve the difference between the billed charges and the allowable amount.

Agency Response to Comment on Proposal in General.

The department appreciates the support for the proposal. With regard to whether mediation requests should be treated as complaints, the department agrees that it did not propose a change to §21.5030 that would require mediation requests to be treated as complaints. Because the rule proposal did not address how mediation requests should be categorized or give stakeholders an opportunity to comment on the issue, the department disagrees with the commenter and declines to adopt a formal rule on this issue at this time. The department will take these comments into account as it considers whether to make operational changes going forward.

Comment on §21.5002(a)(1).

One commenter recommended that the phrase "provided the claim is filed on or after November 1, 2010," be removed from §21.5002(a)(1) for consistency and to avoid confusion resulting from differing timeframes being referenced in §21.5002(a)(1) and §21.5002(a)(2).

Agency Response to Comment on §21.5002(a)(1).

Because of successive changes in the law and rules, it is possible for three different groups of claims to exist—those filed before November 1, 2010, those filed on or after November 1, 2010, and those for services provided on or after January 1, 2018. However, the savings clause in §21.5002(c) addresses each group of claims. Therefore, the department agrees with the commenter and removes the proposed phrase "provided the claim is filed on or after November 1, 2010," from §21.5002(a)(1).

Comment on §21.5002 (a)(2).

One commenter opposed adding the phrase "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," to §21.5002(a)(2), saying the language is unnecessary and confusing. The commenter stated that the phrase could be eliminated because the phrase "qualified claim," used earlier in the rule, is defined in §21.5010. The commenter also opposed the use of the "provided …" phrase in §21.5002(a)(2) without its use in §21.5002(a)(1), stating that this could mislead readers into thinking that §21.5002(a)(1) is not subject to the same limitations as §21.5002(a)(2).

Agency Response to Comment on §21.5002(a)(2).

The time limitation is contained in §21.5002(c), and the limitations on types of claims are set out in the "qualified claim" criteria in §21.5010. The department agrees with the commenter and does not adopt the "provided" phrase in §§21.5002(a)(1) and (2).

Comment on §21.5002(b) and (c).

One commenter noted that the department proposed adding "emergency care" as well as "health care or medical services or supplies" to the language in §21.5002(b).

The commenter asked under what circumstances the department anticipates that emergency care would not be a covered claim under the terms of the health benefit plan coverage, as health plans are generally required to provide coverage for emergency care under Texas law. The commenter asked whether the department was contemplating a circumstance where emergency care is provided outside of a provider's licensure or whether there was another circumstance the department contemplates with the proposed language in subsection (b).

The commenter also recommended modifying the savings clause to reflect that the subchapter applies only to a "qualified" claim. The commenter said that this would make it clear that §21.5002(c) does not broaden the scope of the subchapter.

Agency Response to Comment on §21.5002(b).

In the proposal, the department attempted to consistently add "emergency care" to the language of this subchapter to comply with SB 507. This was not intended to contemplate a circumstance such as that raised by the commenter. Since it is generally the case that health benefit claims are not subject to mediation unless they are covered claims under the terms of the health benefit plan coverage, the department agrees with this point raised by the commenter and simply limits this reference to health benefit claims and removes the phrase "including emergency care or health care or medical services or supplies."

With regard to the "qualified" language, the subchapter applies to claims in general, but provides for mediation for "qualified claims." The department believes the proposed terminology is clear and less subject to confusion than it would be without adding "qualified." Therefore, the department disagrees with this comment and declines to make the suggested change.

Comment on §21.5002(c).

One commenter recommended modifying the savings clause to reflect that the subchapter applies only to a "qualified" claim. The commenter said that this would make it clear that §21.5002(c) does not broaden the scope of the subchapter as set out in §21.5002(b). The commenter also recommended that the department use the singular form of "service or supply" in subsection (c) to more closely track the language in Insurance Code §1467.051.

Agency Response to Comment on §21.5002(c).

The subchapter applies to claims in general, but provides for mediation for "qualified claims." The department believes the proposed terminology is clear and less subject to confusion than it would be without adding "qualified claim." The department also believes that the use of the plural form "services or supplies" conforms to Insurance Code §1467.051, and is both clear and less awkward than the singular. The department disagrees with the commenter and declines to make the suggested changes, but has removed the word "only" as unnecessary, since the subchapter applies to claims in general.

Comment on §21.5003(3).

One commenter stated that the language "any combination of emergency care and health care or medical services and supplies" goes beyond the scope of SB 507, and opposed including it.

The commenter said that SB 507 does not specifically authorize a combination of both emergency care and other health care services or supplies, as the word "or" is used to denote an either/or basis for the claim. In addition, the "emergency care" definition referenced in SB 507 is fairly specific as to the scope and duration of services it encompasses (for example, medical screening or stabilization). The commenter said that the proposed language would potentially alter the scope and duration for the purpose of combining services to define a "claim."

The commenter further suggested that the rule be amended to include the requirement that the claim be for care, services, or supplies that "are furnished to the enrollee by the same individual emergency care provider or facility-based provider."

Agency Response to Comment on §21.5003(3).

The department proposed to broaden the language of §21.5003(3) to comply with SB 507. The use of the word "or" in Insurance Code §1467.051(a)(2), as amended, does not appear to separate items that cannot be combined. Though the commenter appears to be concerned that consumers would improperly aggregate multiple emergency and nonemergency claims, the department continues to believe, consistent with its prior allowance for combining claims from a single date of service or related to a continuing course of treatment, that in some circumstances it is appropriate to mediate multiple bills from the same provider together. It does not appear to have been the Legislature's intent that a provider might disaggregate claims so that no single claim would meet the $500 minimum threshold of §1467.051(a)(2). Inclusive, rather than exclusive, listings seem to be the case in many other instances. For instance, an "emergency care provider" may be a "health care provider," and a "facility-based provider" may also be an "emergency care provider" in §1467.001. Additionally, the definition of the phrase "emergency care" in Insurance Code §1301.155, referenced in SB 507, specifically includes "health care services."

Regarding the suggestion that the rule be amended to require that the claim be for care, services, or supplies furnished by the same individual provider, SB 507 does not appear to include such a requirement, nor does it seem likely that the Legislature intended to imply one. While a "provider" may be an individual, it seems possible that it may also be some other form of entity. The definition of "provider" in Insurance Code §843.002(24) includes a licensed person, a pharmacy, hospital, or other institution or organization, and a person wholly owned or controlled by one of them, including a physician-hospital organization, and "person" in §843.002 means "any natural or artificial person." Thus, it is possible for a bill from a provider to include the services of multiple persons—for example, services from multiple individuals working under the business structure of a single provider group. An insured receiving a single bill from the group would reasonably expect, based on the language of Chapter 1467, that the insured would be entitled to mediate that bill. If the multiple group members do not wish to be considered a single provider, but instead legally distinct providers, presumably they would bill the insured separately in their own names.

For these reasons, the department disagrees with the commenter and declines to make the suggested changes.

Comment on §21.5003(6).

One commenter supported the presumed intent of the language defining "enrollee" to conform the language to the expanded mediation authorized under SB 507 by adding references to the relevant chapters of the Insurance Code. However, the commenter said that the language was unnecessary because the definition of "health benefit plan," proposed in §21.5003(8), already makes the necessary conforming amendment that SB 507 requires, and the term "health benefit plan" is incorporated by reference in the definition of "enrollee."

The commenter also noted that if the department were to adopt its proposed amendments to the definition of "enrollee," this language would be duplicative, confusing, and less precise than the language used in the definition of "health benefit plan." The commenter stated that the definition of "health benefit plan" under proposed §21.5003(8) specifies that the preferred provider benefit plan to which it refers is limited to one offered by an insurer under Insurance Code Chapter 1301; the commenter said that the language in proposed §21.5003(6)'s definition of "enrollee" does not contain this limitation and could be construed (although erroneously) more broadly than the underlying statute would authorize. The commenter suggested that the department not amend this definition beyond renumbering it.

Agency Response to Comment on §21.5003(6).

The proposed language tracks the language defining "enrollee" in Insurance Code §1467.001(3) as amended by SB 507. The department therefore disagrees with the commenter and declines to make the suggested change.

Comment on §21.5010(c).

One commenter suggested that the words "health care or" be added to §21.5010(c)(1)(A) for consistency with SB 507.

Agency Response to Comment on §21.5010(c).

The department agrees that the change would be consistent with SB 507 and will make the suggested change.

Comment on §21.5011(a)(2).

One commenter raised two objections to the language in §21.5011(a)(2). First, the commenter said that it uses the word "sought" from the enrollee, rather than following the statutory language regarding the amount for which the enrollee is "responsible." Second, the commenter said that the language is silent about to whom the amount is owed. The commenter said that it is important to specifically reference the facility-based or emergency care provider in this context to make it clear that the claim must be for an amount owed to a specific individual provider, not an aggregate amount among multiple providers.

Agency Response to Comment on §21.5011(a)(2).

The department disagrees with the commenter. The language in question is a description of the content of the mediation request form, not the qualified claim criteria, which are in the preceding rule. The department believes that the form as described serves the purpose of eliciting the necessary information from an enrollee for the department to properly identify the qualified claim. The form specifically asks for the name of the provider. The department declines to make the suggested changes. Regarding the issue of multiple providers, and the department declines to make the suggested changes for the reasons discussed above.

Comment on §21.5011(a)(7).

One commenter was concerned that the proposed authorization language in the mediation request form was open ended and broadly drafted in terms of health plan/insurer/administrator representatives, yet restrictive in terms of physician or provider representatives. The commenter said the language could potentially permit disclosure of an enrollee's protected health information (PHI) for any purpose to representatives of health plans/insurers/administrators who are external to the health plan/insurer/administrator. The proposed language is not limited to the specific purpose of mediating the particular claim at issue.

The commenter suggested limiting the purpose of the disclosure to mediating the particular claim at issue, as does the department's current authorization form, which specifically references mediating the claim under the requirements of Insurance Code Chapter 1467.

The commenter also said that the proposal removes the existing authorization for the department to disclose PHI to the physician or other provider's representative or representatives. The commenter noted that this may have been an inadvertent deletion. The commenter recommended that the department amend the rules to clarify that the authorization would apply to a facility-based provider or emergency care provider and the applicable provider's representative or representatives.

Agency Response to Comment on §21.5011(a)(7).

The department agrees that the deletion was inadvertent. The department agrees to make both suggested changes.

Comment on §21.5012.

One commenter supported updating §21.5012 to conform to the requirements of SB 507. The commenter noted that further amendments to the procedural requirements regarding the scheduling of an informal settlement teleconference were considered in the introduced version of SB 507, but that language was removed from the enrolled bill and ultimately did not pass into law. The commenter expressed opposition to including that language, as well as any other amendments to §21.5012 that go beyond conforming the provision to the law as passed.

Agency Response to Comment on §21.5012.

No such amendments to the procedural requirements regarding the scheduling of an informal settlement teleconference were proposed. The department appreciates the supportive comment and agrees that no change is warranted.

Comment on §21.5020.

One commenter supported the proposed amendments to §21.5020 with regard to incorporating the insurer or administrator's obligations under Insurance Code §1467.0511. The commenter opposed the proposed incorporation of references to the facility-based provider or

emergency-care provider's notice requirements in the department regulations, stating that the department does not have regulatory authority over these providers.

The commenter said that providers' obligations should be set forth in their respective licensing board's rules, not in the department's rules. Thus, for physicians, this language should appear in the Texas Medical Board's rules. The commenter noted that physician billing falls within the very definition of the "practice of medicine" and is clearly under the purview of the Texas Medical Board, not the department.

The commenter stated that the department should limit its rules to those it licenses or otherwise regulates under the Insurance Code. To implement the commenter's suggestion, the department would need to: (1) strike the first phrase in proposed §21.5020 (a), which reads: "A bill sent to an enrollee by a facility-based provider or emergency care provider," and (2) strike from §21.5020(b) the two phrases that read "or facility-based provider or emergency care provider."

The commenter further recommended that the department replace the references to "chapter" made in subsection (b) with "subchapter" to correctly reference Subchapter PP.

Agency Response to Comment on §21.5020.

The language of this section was drafted to precisely track the language of §1467.0511, as added by SB 507. However, as the commenter notes, that language includes requirements regarding matters and persons not regulated by the department, and the department agrees to revise the text as proposed. The department has removed those references from the adopted rule. The department also agrees that the references to "chapter" should be to "subchapter" and has made those changes.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 1. GENERAL PROVISIONS

§§21.5001 – 21.5003

STATUTORY AUTHORITY. The amendments are adopted 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 include 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 of the State Office of Administrative Hearings 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.

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, 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); or

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

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

(c) This subchapter applies 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 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, provided that the care, services, or supplies:

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

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

(4) 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) 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) 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 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.

(11) 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) 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 or the provider's representative to settle a qualified claim of an enrollee.

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

(14) 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 that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator.

(15) Preferred provider--A facility, facility-based provider, or emergency care provider 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. MEDIATION PROCESS

§§21.5010 – 21.5013

STATUTORY AUTHORITY. The amendments are adopted 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.

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) health care or emergency care; or

(B) a health care or medical service or supply, provided by a facility-based provider in a facility that is a preferred provider with the insurer or that has a contract with the administrator.

(2) The aggregate amount for which the enrollee is responsible to the facility-based provider or emergency care provider 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 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 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 health care or 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 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 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 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 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;

(5) the name of the insurer or administrator;

(6) the name and address of the facility where services were rendered; and

(7) an authorization allowing the department to disclose the enrollee's protected health information or other confidential information for the purpose of mediating the claim at issue to the facility-based provider or emergency care provider, facility-based provider's or emergency care provider's representative or representatives, 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 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, 800-252-3439.

§21.5012. Informal Settlement Teleconference.

An insurer or administrator subject to mandatory mediation requested by an enrollee under this subchapter 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 or the facility-based provider's or emergency care provider'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 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. REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION

§21.5020

STATUTORY AUTHORITY. The amendments are adopted 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.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 3. REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION

§21.5020. Required Notice of Claims Dispute Resolution.

(a) 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 or administrator about a bill that may be eligible for mediation under this subchapter, the insurer or administrator is encouraged to:

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

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

DIVISION 4. COMPLAINT RESOLUTION AND OUTREACH

§§21.5030 – 21.5031

STATUTORY AUTHORITY. The amendments are adopted 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.

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 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, 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 been delayed or have not been given;

(3) whether the health care, medical service, or supply, or a combination of health care, medical service, or supply, 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;

(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. 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 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 adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on April 4, 2018

/s/ Norma Garcia
Norma Garcia
General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 TAC §§21.5001 - 21.5031.

/s/ Kent C. Sullivan
Kent C. Sullivan
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2018-5458**