

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 recommended 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]~~ 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 report 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]~~ 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 subchapter (relating to Collection of Data Necessary to Provide Report):

(1) Certain Benefits Related to Acquired Brain Injury, Insurance Code §1352.003; ~~[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, and §21.4403 of this title (relating to Required Coverage); [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, and §11.508(a)(1)(H)(iv) of this title (relating to Mandatory Benefit Standards: Group, Individual and Conversion Agreements); [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 Treatments, 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

§369.104; ~~[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;~~]

[~~(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 subchapter[~~:~~] (relating to Collection of Data Necessary to Provide Report):

(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)[(e)] Suggested procedure and diagnosis codes. TDI [The Department] will provide[,], on its website, [~~the Department's Web site,~~] www.tdi.texas.gov, [~~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 the department, 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 accessing the Mandated Benefits and Mandated Offers Reporting Form found [~~a link designated~~] 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. [~~the Department's Web site, www.tdi.state.tx.us, 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);~~ 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;

(7)[(6)] the name, title, direct telephone number, [~~mailing address and~~] email address, and mailing address of an individual who is responsible for the report;

(8) whether the contact person's email address can be released; [(7) ~~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);~~]

(9) the submission date; and [(8) ~~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;~~]

(10) whether the health benefit plan issuer meets the reporting threshold for each reporting category (individual, small group, and large group). [~~(9) 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) 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~~], aggregated separately by individual, small group, and large group health benefit plan: [~~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.

~~[(e) 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.