Subchapter OO. Disclosures by Out-of-Network Providers
28 TAC §21.4902

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 1. General Provisions
28 TAC §21.5002 and §21.5003

Division 5. Explanation of Benefits and Enrollee ID Card Requirements
28 TAC §21.5040

Division 7. Submission Requirements for Election by ERISA Plans
28 TAC §21.5060

Division 8. Emergency Medical Services Rate Submission and Payment Requirements
28 TAC §21.5070 and §21.5071

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§21.4902, 21.5002, 21.5003, and 21.5040, concerning the independent dispute resolution (IDR) process, and adopts new §§21.5060, 21.5070, and 21.5071, concerning submission requirements for certain entities. The commissioner adopts §§21.4902, 21.5002, and 21.5003 without changes to the proposed text published in the September 1, 2023, issue of the *Texas Register* (48 TexReg 4774). Sections 21.5040, 21.5060, 21.5070, and 21.5071 are adopted with changes made in response to public comment.

REASONED JUSTIFICATION. The amendments to §§21.4902, 21.5002, 21.5003, and 21.5040, and new §21.5060 are necessary to implement House Bill 1592, 88th Legislature, 2023, and Insurance Code Chapter 1275. Insurance Code §1275.002 as amended by HB 1592 permits a plan sponsor of a self-insured or self-funded plan established by an employer under the Employee Retirement Income Security Act of 1974 (ERISA) (29 USC

§1001 et seq.) to opt in to the Texas IDR process under Insurance Code Chapter 1467 by electing to apply Insurance Code Chapter 1275 to the plan during the relevant plan year. Insurance Code Chapter 1275 creates similar requirements for out-of-network billing that already exist for HMOs and preferred provider benefit plans, as well as for health benefit plans administered by the Employees Retirement System of Texas and Teacher Retirement System of Texas plans under Insurance Code Chapters 1551, 1575, and 1579.

The amendments to §§21.4902, 21.5002, and 21.5003 clarify that a plan sponsor may elect to apply Insurance Code Chapter 1275 to its self-insured or self-funded plan. Under Insurance Code §1275.004, Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies.

The amendments to §21.5040 require health benefit plans offered by nonprofit agricultural organizations and ERISA plans to include additional information in the explanation of benefits (EOB) provided to physicians or providers. The additional information includes a disclaimer that the plan opted in to the Texas IDR process for the relevant plan year and that the claim must proceed through the Texas IDR process. Amendments to §21.5040 also require health benefit plans offered by nonprofit agricultural organizations and ERISA plans to display a signifier on the ID card issued to enrollees that identifies the Texas IDR process as the IDR process claims must proceed through. The ID card requirement will apply to plans delivered, issued for delivery, or renewed on or after 90 days following the effective date of the section. The proposed text of this section has been modified in response to comment. Additional amendments to this section are discussed in the subsequent paragraphs as they relate to the implementation of Senate Bill 2476, 88th Legislature, 2023.

The adoption also adds new Division 7 and new §21.5060 to prescribe the form and manner of identifying information that plan sponsors must include to make an election for the relevant plan year under Insurance Code §1275.002. The identifying information must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov.

Amendments to §21.5040 and new Division 8, consisting of §21.5070 and §21.5071, are necessary to implement SB 2476. This bill authorizes political subdivisions to submit rates for emergency medical services (EMS) to TDI for use in payment by health benefit plans. SB 2476 requires health benefit plans to cover ground emergency medical services at (1) the rates submitted to TDI by a political subdivision; or (2) if no rates have been submitted, the lesser of either the EMS provider's billed charge or 325% of the current Medicare rate.

Additional amendments to §21.5040 require the explanation of benefits to include transport as added by SB 2476 and clarify that the right to pursue mediation or arbitration applies only to out-of-network claims subject to Insurance Code Chapter 1467.

New §21.5070 and §21.5071 prescribe the form and manner that political subdivisions must use if they wish to submit rates to TDI for use in EMS billing, and the EMS payment standards that apply to an applicable health benefit plan issuer or administrator. The rate submission must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov. The proposed text of these sections has been modified in response to comment.

New §21.5070 and §21.5071 adopt a single rate submission deadline. A modification to the rate submission schedule was requested by commenters and replaces the quarterly schedule that was included in the proposed text. The adopted text also requires health plans to apply the published rate data based on the date the claim is

incurred, rather than basing payments on the data published at the time the claim is submitted. The publication schedule will remove the ability of a political subdivision to submit rates to TDI more than once. For a rate to be reflected in the updated rate publication, a political subdivision must submit a rate by the submission deadline.

Health benefit plans must apply the rates, as reflected in the published rate database, to claims incurred during any plan year that begins before September 1, 2024. Claims incurred during a plan year that begins on or after September 1, 2024, are paid based on the lesser of the billed charge, the reported rate increased by 10%, or the reported rate increased by the Medicare Economic Index rate that applies to the first day of the new plan year.

The adopted text permits a political subdivision to submit EMS rates until the submission deadline of 30 days after the date the section is effective. TDI will publish the submitted rates no later than 10 business days after the submission deadline. The final submission deadline is modified from what was proposed in response to comment to better align with SB 2476, which requires health benefit plans to adjust the payment rates each plan year with reference to the provider's previous calendar year rates. The payment standard is clarified to prevent requiring a health benefit plan issuer or administrator to pay more than the EMS provider charges. Figure: 28 TAC §21.5071(e) provides illustrative examples of how the published rates apply, subject to maximum rate increase amounts for plans that renew on or after September 1, 2024.

The deadline for rate data will require health benefit plans to quickly update software and internal databases to reflect the published rates. SB 2476 applies to emergency medical services provided on or after January 1, 2024, and requires TDI to establish the publicly accessible database by January 1, 2024.

SB 2476 requires health benefit plans to make the payment using the submitted rate, if applicable, and the bill provides 30 or 45 days for payment of the claim, depending on whether the claim is electronic. The 30- or 45-day period provided by SB 2476 will provide health benefit plans with some lead time to update internal systems.

TDI recognizes that multiple political subdivisions may submit rates associated with the same ZIP code and that health benefit plans may occasionally have difficulty determining which rate applies to the EMS claim. TDI encourages health benefit plans and EMS providers to collaborate when multiple rates apply to a ZIP code and to use existing internal processes to resolve any claims in which an overpayment or underpayment occurs.

The new and amended sections are described in the following paragraphs.

Section 21.4902. The amendments to §21.4902 clarify that the section provides definitions for use in Subchapter OO and that an administrator as defined in Insurance Code §1467.001 may also include an administrator of a self-insured or self-funded plan under Insurance Code Chapter 1275 when election by a plan sponsor has occurred. The amendments expand the definition of "health benefit plan" to include a self-insured or self-funded plan for which the plan sponsor has elected to apply Insurance Code Chapter 1275. The amendments also add a definition of "ERISA" to reflect agency drafting style and plain language preferences.

The amendments add "Insurance Code" to a citation, add "an administrator of" to the definition of "administrator" for consistency in §21.4902(1), renumber paragraphs to reflect the expansion of definitions, and amend punctuation and grammar throughout.

Section 21.5002. This section describes the scope of Subchapter PP. The amendments to §21.5002 expand the applicability of Subchapter PP to a self-insured or

self-funded plan if election by the plan sponsor is submitted according to the requirements in new §21.5060. Amendments also change punctuation and grammar to reflect the addition of new paragraph (4) and add "Insurance Code" to an incomplete citation.

Section 21.5003. This section provides definitions for use in Subchapter PP. The amendments to §21.5003 clarify that, in addition to having the meaning assigned by Insurance Code §1467.001, for purposes of 28 TAC Chapter 21, Subchapter PP, "administrator" also includes an administrator of a self-insured or self-funded plan under Insurance Code Chapter 1275 when election by a plan sponsor has occurred. The amendments expand the definition of "health benefit plan" to include a self-insured or self-funded plan for which the plan sponsor has elected to apply Insurance Code Chapter 1275. The amendments also add a definition of "ERISA" to reflect agency drafting style and plain language preferences.

Amendments add "Insurance Code" to a citation, add "an administrator of" to the definition of "administrator" for consistency in §21.5003(1), renumber paragraphs to reflect the expansion of definitions, and amend punctuation and grammar throughout the section.

Section 21.5040. This section provides the contents required in an explanation of benefits for to an enrollee, physician, and provider. The amendments clarify that a plan subject to §21.5040 must give written notice in an EOB as specified in the section in connection with transport provided by a non-network or out-of-network provider, as added by SB 2476. The amendments also clarify that the notice explaining that a physician or provider may request mediation or arbitration for a payment dispute should be included only for a claim that is subject to mediation or arbitration under Insurance Code

Chapter 1467. The amendments to the titles of Division 5 and §21.5040 reflect the expanded scope of the ID card requirements.

The amendments also add new subsections (b) and (c). Section 21.5040(b) includes additional requirements for EOBs provided by certain health benefit plans. Section 21.5040(c) adds information that must be included in the ID card provided to enrollees. To reflect the addition of subsections (b) and (c), the previously existing rule text has been designated as subsection (a). The new requirements in §21.5040(b) and (c) apply only to a health benefit plan offered by a nonprofit agricultural organization or a self-funded or self-insured plan under ERISA where a plan sponsor has elected to apply Insurance Code Chapter 1275.

Section 21.5040(b)(1) requires a health benefit plan offered by a nonprofit agricultural organization under Insurance Code Chapter 1682 to include in the EOB to physicians and providers instructions to identify the plan type as "Ag Plan" when requesting mediation or arbitration. Similarly, §21.5040(b)(2) requires health benefit plans offered by ERISA plans that have opted in to the Texas IDR process under Insurance Code Chapter 1275 to include in the EOB a statement about the opt-in, a prohibition against using the federal IDR process, and instructions to physicians and providers to identify the plan type as "ERISA Opt-In" when requesting mediation or arbitration.

The text of §21.5040(b)(2) as proposed has been modified in response to comment. As adopted, §21.5040(b)(2) does not include the proposed requirement to provide the plan name and effective date of the election and instead substitutes a more general disclosure in the EOB.

Section 21.5040(c) requires a health benefit plan offered by a nonprofit agricultural organization or self-insured or self-funded ERISA plan to include the letters "TXI" on the

ID cards issued to enrollees. This requirement applies to a plan that is delivered, issued for delivery, or renewed on or after 90 days following the section's effective date.

The text of §21.5040(c) as proposed has been modified in response to comment to replace "TXIDR" with "TXI" on the front of the ID card and to add quotation marks in the rule text around "TXI." In addition, a clarifying modification to §21.5040(c) replaces "of" with "following" to state that the requirements apply 90 days following the effective date of §21.5040.

Section 21.5060. New §21.5060, in new Division 7, provides submission requirements for a plan sponsor that elects to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan for the relevant plan year. Submission requirements include:

- the name and contact information of both the plan sponsor and, if applicable, the administrator;

- the health benefit plan year start and end dates;

- the requested effective date of the election, which must be at least 30 days after the date the identifying information is submitted;

- the group number of the health benefit plan; and

- the number of enrollees covered under the health benefit plan.

Identifying information must be submitted to TDI as specified on TDI's website at www.tdi.texas.gov. This requirement ensures that a plan sponsor is able to successfully elect to apply Insurance Code Chapter 1275 (including the Texas IDR process) and that IDR claims submitted by physicians or providers are correctly matched to the ERISA plan.

The text of §21.5060(a) as proposed has been modified in response to comment to delete the phrase "in out-of-network claim dispute resolution," to clarify that an ERISA

plan that elects to apply Insurance Code Chapter 1275 must comply with all the provisions in that chapter, not just those related to the dispute resolution process. In addition, the text of §21.5060(a)(3) as proposed has been modified to correct a grammatical error by adding an "s" at the end of "dates."

The text of §21.5060(a)(4) as proposed has been modified in response to comment to clarify that the requested effective date must be the same as the start date of the relevant plan year, except as provided in newly added subsection (d). Section 21.5060(d) is a new addition from the text as it was proposed and provides an exception to the modified rule text in §21.5060(a)(4). Section 21.5060(d) clarifies that a plan with a plan year start date between September 1, 2023, and February 1, 2024, may make an election with a requested effective date that is after the first day of the relevant plan year if the information required under §21.5060(a) is provided no later than 45 days after the effective date of the section.

The text of §21.5060(b) as proposed has been changed in response to comment to clarify that the election applies to all of Insurance Code 1275, and not just the Texas IDR process, and applies to claims incurred during the relevant plan year.

The section requires a plan sponsor to renew its election each plan year, update identifying information required in the section, and make the election 30 days before the date the relevant plan year begins. Once a plan sponsor opts in to the Texas IDR process for the relevant plan year, the plan sponsor may not opt out until the end of the relevant plan year.

Section 21.5070. New §21.5070, in new Division 8, provides EMS rate submission and claims requirements. Section 21.5070 provides the form and manner for a political subdivision to submit rates for emergency medical services. Political subdivisions that

choose to submit rates to TDI must comply with the data submission requirements, including providing certain identifying information and submitting rate information using the method provided on TDI's website at www.tdi.texas.gov.

Identifying information includes:

- the political subdivision's name and contact information;

- the National Provider Identification number of each EMS provider that is subject to the rates set by the political subdivision, if known;

- each ZIP code subject to the rates set, controlled, or regulated by the political subdivision; and

- applicable billing codes, code types, and dollar amounts for each health care service, supply, or transport rate that is set, controlled, or regulated by the political subdivision.

A claim submitted by an EMS provider or its designee must include the ZIP code in which the health care service, supply, or transport originated. A political subdivision or EMS provider subject to the rule may not issue a bill that exceeds the amount of the rate set, controlled, or regulated by the political subdivision.

Political subdivisions that choose to submit rates to TDI must comply with the single submission deadline adopted in §21.5070(d). The text of §21.5070(d) and (e) as proposed has been modified in response to comment to replace the quarterly schedule with a single deadline for submission and publication. Data for calendar year 2024 is due 30 days after the section's effective date. TDI will publish data within 10 business days of the reporting deadline. Because the reporting schedule is simplified from the proposed rule, proposed §21.5070(h) and Figure §21.5070(h) are not adopted.

Political subdivisions are not required to submit rates under SB 2476. However, if a political subdivision chooses not to submit rates by the submission deadline and has no published rates for a particular health care service, supply, or transport, then the health benefit plan must determine the applicable rate according to the formulas in SB 2476 and implemented in §21.5071(b)(2).

Additionally, because some of the text of §21.5070(d) and (e) as proposed has been modified to allow submission once during the effective period of SB 2476, §21.5070(f) as proposed is not adopted. As proposed, subsection (f) permitted a political subdivision to remove a submitted rate according to the proposed submission schedule. Because §21.5060(f) is not adopted, subsection (g) as proposed has been designated as new subsection (f).

Section 21.5071. New §21.5071, in new Division 8, provides emergency medical service rate payment requirements. Section 21.5071 clarifies that certain health benefit plans must pay EMS provider claims under SB 2476. Health benefit plan issuers and administrators must pay EMS provider claims at the rate submitted by a political subdivision or, if no rate has been submitted under §21.5070, according to the rate specified in SB 2476 and implemented in §21.5071(b)(2).

The text of §21.5071(b)(1) as proposed has been modified in response to comment to clarify that the health benefit plan must pay the lesser of the billed charge or the applicable rate published by TDI. TDI has also modified §21.5071(b)(1) and (2) to remove the phrase, "consistent with the time frames addressed in subsection (c) of this section." This phrase is no longer needed, since the rate data will only be published once.

Health benefit plan issuers and administrators must apply published rates by the implementation schedule in §21.5071(c) and (d). In response to comment, TDI has

replaced the proposed quarterly schedule in §21.5071(c) with a single implementation date to align with the single submission deadline in §21.5070(d). In response to comment, TDI has also replaced the proposed references to the claim submission date with references to the claim incurred date.

For claims incurred during a plan year that starts before September 1, 2024, plans must apply the applicable rate published in TDI's rate database for 2024. For claims incurred during a plan year that starts on or after September 1, 2024, plans must pay the lesser of the billed charge, the published rate for 2024 increased by 10%, or the published rate for 2024 increased by the Medicare Economic Index rate.

SB 2476 uses the term "Medicare Inflation Index." TDI interprets that term to mean the Medicare Economic Index (MEI), a measure of inflation faced by physicians with respect to their practice costs and general wage levels that is updated annually. The MEI is available on the CMS website at www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata. The MEI rate is established on a calendar year basis. TDI adds text to clarify that the applicable MEI rate is the rate that applies to the first day of the new plan year. For a plan year that renews in September of 2024, the MEI for calendar year 2024 applies. For a plan year that renews in January of 2025, the calendar year 2025 MEI applies.

TDI has modified the text of §21.5071(d) in response to comment to clarify that a health benefit plan issuer or administrator must adjust the applicable rate required by SB 2476 for a plan year that starts on or after September 1, 2024. TDI has modified the text of §21.5071(d) to simplify the explanation for how rates must be adjusted for a new plan year, and align this section with the modifications in §21.5071(b) that clarify that the payment standard is the lesser of the billed charge or the applicable rate. The proposed

definitions for "plan year" and "calendar year rate" are not adopted because they are no longer needed within the simplified text of the subsection. For claims incurred during a plan year that starts on or after September 1, 2024, plans must pay the lesser of the billed charge, the published rate for 2024 increased by 10%, or the published rate for 2024 increased by the Medicare Economic Index rate that applies to the first day of the new plan year.

Figure: 28 TAC §21.5071(e) provides examples of the published rates health benefit plans must use when adjusting a payment under SB 2476, depending on the renewal date of the health benefit plan. These examples have been updated from those proposed to conform to the changes made in §21.5071 and previously contained in §21.5071(d)(2).

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received five written comments and two commenters spoke at a public hearing on the proposal held on September 26, 2023. Commenters in support of the proposal with changes were Emergency Department Practice Management Association, Texas Association of Health Plans, Texas EMS Alliance, Texas Medical Association, Texas Ophthalmological Association, Texas Orthopaedic Association, Texas Osteopathic Medical Association, and Texas Society of Anesthesiologists, and U.S. Anesthesia Partners.

Comments on §21.5003

Comment: One commenter recommends adding the title of Insurance Code Chapter 1682 in §21.5003(11)(C).

Agency Response: TDI declines to make the change because the chapter title for Insurance Code Chapter 1682 is provided in §21.5003(1). Consistent with TDI drafting and

style preferences, the title is listed only for the first instance in which the chapter is cited within each section.

Comments on §21.5040

Comments: One commenter states their support for including information on the EOB that indicates that the plan has opted in to the Texas IDR system, but the commenter emphasizes that requiring the plan name and effective date of election as proposed in §21.5040(b)(2) will create significant administrative challenges without providing additional value. Another commenter supports including the information on the EOB as proposed and has requested that the EOB specify the entire plan year, not just the effective date.

Agency Response: The purpose of the EOB notice is to inform the provider that the claim contained on the EOB is subject to the Texas IDR process. TDI agrees with the first commenter that the EOB notice does not need plan-specific information in order to serve its purpose and has modified §21.5040(b)(2) to remove the plan-specific language. As a result, TDI declines to specify the entire plan year on the EOB, as suggested by the second commenter.

Comments: One commenter asks TDI to clarify in §21.5040 that the EOB and ID card requirements for ERISA plans that have opted in apply only to Texas residents. The commenter notes that (1) Texas does not have jurisdiction over services provided to nonresidents, (2) the benchmarking database used by arbitrators in the Texas IDR system includes only rate data for Texas ZIP codes, and (3) IDR for out-of-state claims is effectively unworkable.

Agency Response: TDI agrees that Insurance Code Chapter 1275 applies to plans issued to Texas residents and to claims for services provided by Texas providers. TDI declines to make a change, but affirms that the requirements in §21.5040 do not apply to ID cards issued to non-Texas residents, or to EOBs issued for claims provided by out-of-state providers.

Comments: Two commenters support the new requirements for the ID card and EOBs to indicate participation in the Texas IDR system. The commenters state that this information is critical for physicians and providers to properly process claim disputes. While the vast majority of claims are submitted electronically, and EOBs are returned electronically in an 835-remittance file, the commenters note that some carriers in Texas have provided information about a claim's eligibility for IDR only in a paper or PDF format, which creates a significant administrative burden. The commenters request that the rules require that for claims submitted electronically, the information required on the EOB must be "provided in the form of a searchable, standardized remark code or similar searchable language in an electronic explanation of benefits file."

Agency Response: TDI appreciates the commenters' support for the new requirements and agrees that the information on the ID cards and EOB is needed to enable providers to discern which claims are subject to the Texas IDR process. The submission of ineligible claims creates a substantial burden for TDI and the responding health plans. TDI agrees that health plans should use a standardized and searchable electronic method for providing the required information within EOBs. TDI will monitor this issue and consider addressing it in future rules if health plans do not conform to best practices for conveying this information.

Comments: One commenter requests that the ID card requirement in §21.5040(c) be modified to include only three characters, as requiring the five characters in "TXIDR" would require one or more health plans to make programming changes. Another commenter supports retaining the five characters, as fewer characters would not adequately inform the physician, provider, or enrollee of which IDR program a claim arising under the health plan must proceed through.

Agency Response: TDI agrees to make a change to shorten "TXIDR" to a three-character descriptor. TDI replaces "TXIDR" as proposed with "TXI." TDI recognizes that a shorter descriptor conveys less information but recognizes that the EOB contains the most pertinent information. TDI seeks to balance the benefit of requiring additional information with the cost of implementing new requirements.

Comment: One commenter requests that quotation marks be added to the requirement in §21.5040(c), for ID cards to include the letters "TXIDR." The commenter also asks that the rule require "TXIDR" to be prominently displayed on the front of the ID card and on other forms of identifying an enrollee's plan information, such as electronic ID cards. The commenter states that these changes would align with corresponding rules for TDI-regulated HMO and PPO plans in §21.2820.

Agency Response: TDI agrees in part and has modified the rule to add quotation marks to the new three-character descriptor "TXI," and require the information to be located on the front of the ID card. TDI declines to broaden the ID card requirement to apply to other documents but believes the rule text is sufficiently clear to require the information on any ID card, whether it is issued electronically or in physical form.

Comments: Two commenters request that TDI publish information listing each ERISA plan that opts in to the Texas IDR process. One of the commenters suggests additional rule text that would address this issue.

Agency Response: TDI agrees that this information may be of use to the public but declines to make a change to the rule text, as it is outside the scope of this rule as proposed. TDI will have the information available and will review the best method for providing this information to the public.

Comments on §21.5060

Comment: One commenter notes that the language in §21.5060 may create confusion by referring to a plan sponsor electing to "participate in out-of-network dispute resolution under Insurance Code Chapter 1275," when the law refers to an election to apply Chapter 1275 in its entirety to the plan for the relevant plan year.

Agency Response: TDI agrees and has modified §21.5060 in two places to delete the words "in out-of-network claim dispute resolution," and clarify that the election refers to Insurance Code Chapter 1275.

Comment: One commenter recommends that TDI modify §21.5060 to state that an election made by an ERISA plan to apply Insurance Code Chapter 1275 must span the entire plan year and must be made 60 days in advance of the plan year. The commenter also suggests clarifying that the election applies to claims that are incurred during the relevant plan year, including a dispute that may proceed through the Texas IDR process after the end of the relevant plan year.

Agency Response: TDI declines to increase the election requirement from 30 to 60 days, as 30 days provides sufficient time for TDI to update its website. In general, TDI agrees that Insurance Code §1275.002 requires that an ERISA plan opt in for the entirety of a plan year. However, TDI believes an exception is appropriate for plan years that started after the statute became effective and before TDI's rules were operational. TDI added new subsection (d) to §21.5060 to clarify that an election applies to the entirety of the plan year, except for plans starting between September 1, 2023, and February 1, 2024. Such plans may elect an effective date after the first day of the relevant plan year if they submit the election within 45 days of this rule taking effect. TDI also modified §21.5060(b) to clarify that the election applies with respect to claims incurred during the plan year to which the election applies, even if the dispute occurs after the relevant plan year ends.

Comment: One commenter asks for clarification on §21.5060(a)(6), which requires ERISA plans to provide the number of enrollees covered by the plan when opting to participate in Insurance Code Chapter 1275. The commenter notes that this number changes frequently, and asked whether it should be reported as of a specific date, or if plans can provide an approximate number.

Agency Response: A plan sponsor should provide the number of enrollees covered under the health plan based on the best information available at the time the information is submitted--such as the number of enrollees on the last day of the previous month. While TDI understands that this number changes frequently, this data will inform policymakers on the general number of Texans participating in plans under Insurance Code Chapter 1275.

General comments on Division 8:

Comment: One commenter requests that the rules clarify that an out-of-network EMS provider may not balance bill a patient, and suggests TDI adopt language similar to that used in 28 TAC §21.4903.

Agency Response: TDI agrees that the Insurance Code, as amended by SB 2476, prohibits an EMS provider from balance billing for EMS services provided between January 1, 2024, and August 31, 2025. However, TDI declines to make a change to the rule text because the statutory prohibition is sufficiently clear and does not need to be repeated in rule.

Comment: One commenter notes that political subdivisions typically establish EMS mileage rates in addition to base transport charges. Mileage rates are not flat fees, but are multiplied by the number of miles that the patient is transported.

Agency Response: TDI thanks the commenter for this information. TDI's data portal includes HCPCS code A0425, which political subdivisions may use to report their mileage rates. The data portal also allows political subdivisions to enter any other applicable codes for which rates are set.

Comment: Two commenters note that claim information may not always be sufficient to determine the applicable political subdivision and recommend that the rules include how incorrect payment amounts should be addressed. Another commenter suggests that when there is uncertainty about the correct payment amount, the health plan should be permitted to pay either rate and handle corrections through an internal appeals process.

Agency Response: TDI appreciates the challenge posed by the fact that standard claim fields may be insufficient to determine the applicable payment amount but declines to make a change. TDI expects health plans to act in good faith to attempt to determine the

correct payment amount and encourages health benefit plans and EMS providers to work together to determine that amount.

Comment: One commenter suggests specifying timeframes for notifications of and corrections to underpayments and overpayments, consistent with 28 TAC §21.2809. Another commenter suggests that any incorrect payments should be resolved through an internal appeals process.

Agency Response: TDI appreciates the suggestion regarding timeframes but declines to make the change, as it is outside the scope of this rule project. TDI encourages health plans and EMS providers to use existing internal processes to resolve any underpayments or overpayments that may occur.

Comments on §21.5070

Comments: Two commenters recommend replacing the reporting schedule in §21.5070(e), which as proposed allows for four opportunities to report, with an annual reporting schedule. The commenters indicate that allowing rates to change up to four times in a plan year creates administrative and pricing challenges for plans. They state that the intent of the legislation was to limit opportunities to increase rates, since the statute specifically addresses rate increases. One of the two commenters suggests an alternative approach that would not allow a political subdivision to submit its rates more than once.

Agency Response: TDI agrees with the commenters and has modified §21.5070(d) and (e) to replace the four reporting periods with a single reporting deadline. The adopted rule extends the rate submission deadline to 30 days from the date the rule is adopted

for political subdivisions to submit data for calendar year 2024. Since the data reporting schedule has been simplified, TDI has not adopted Figure: 28 TAC §21.5070(h). Instead, §21.5070(e) clarifies that TDI will publish data no later than 10 business days following the data reporting deadline. Likewise, §21.5071(c) is simplified to indicate that the data reported for calendar year 2024 applies to claims incurred during a plan year that starts before September 1, 2024. TDI makes a conforming change to §21.5071(d) to clarify the adjusted payment standard for a plan that renews on or after September 1, 2024. The examples are moved to Figure 28 TAC §21.5071(e) and updated consistent with the modified reporting deadline and simplified instructions for adjusting the payment rate at plan renewal.

Comments on §21.5071

Comment: One commenter notes that in §21.5071(c), the proposal used the term "claims submitted," while the examples used "claims submitted" and "claims incurred" interchangeably. The commenter asks TDI to clarify that the relevant date is the date the service is provided--that is, the date the claim is incurred--and not the date the claim is submitted.

Agency Response: TDI agrees and has changed the language in §21.5071(c) to use the term "claim incurred." TDI also makes conforming changes in §21.5071(d), and in the examples contained in Figure: 28 TAC §21.5071(e).

Comment: One commenter recommends that TDI modify §21.5071(d) to refer to Medicare's Ambulance Inflation Factor (AIF), rather than the Medicare Economic Index, because CMS uses the AIF to adjust Medicare's ambulance fee schedule.

Agency Response: TDI declines to make the requested change. TDI maintains its interpretation that when the statute uses the term "Medicare Inflation Index," it is referring to the Medicare Economic Index.

Comment: Two commenters indicate that the rate increase provision in §21.5071(d) was intended to apply only to the extent that a political subdivision has increased its rates. The commenters state that the purpose of the provision was to limit the amount of such increases. Without clarification, the automatic adjustment of required payments could result in health plans reimbursing providers more than the locally set rates.

Agency Response: TDI appreciates the commenters' concerns and has made changes to address the issue. First, TDI notes that §21.5070(b) makes clear that a billed charge is prohibited from exceeding the rate set by the political subdivision. TDI agrees that it would be inappropriate to require payment of a rate that exceeds the amount billed. Therefore, TDI modifies §21.5071(b)(1) to clarify that the issuer or administrator must pay the lesser of the billed charge or the applicable rate for the political subdivision. TDI makes conforming changes to §21.5071(d) to clarify that the subsection does not require a payment to exceed the amount billed.

Subchapter OO. Disclosures by Out-of-Network Providers
28 TAC §21.4902

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.4902 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes a plan sponsor to elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for

the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

TEXT.

§21.4902. Definitions.

Words and terms defined in Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, have the same meaning when used in this subchapter unless the context clearly indicates otherwise, and the following words and terms have the following meanings when used in this subchapter unless the context clearly indicates otherwise.

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, and an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing

Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, offering a health benefit plan.

(2) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

(3) Health benefit plan--A plan that provides coverage under:

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

(B) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans;

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682; or

(D) a self-insured or self-funded plan established by an employer under ERISA (29 USC §1001 et seq.) for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 1. General Provisions
28 TAC §21.5002 and §21.5003

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5002 and §21.5003 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes a plan sponsor to elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

TEXT.

§21.5002. Scope.

(a) This subchapter applies to a qualified mediation claim or qualified arbitration 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, including an exclusive provider benefit plan;

(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; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations;

(3) offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations; or

(4) offered by a self-insured or self-funded plan established by an employer under ERISA if the plan sponsor submitted election according to §21.5060 of this title (relating to Election Submission Requirements).

(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) Except as provided in §21.5050 of this title (relating to Submission of Information), this subchapter applies to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2020. A claim for health care or medical services or supplies provided before January 1, 2020, 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. This subchapter applies to a claim filed for emergency care or health care or medical services or supplies by the administrator of a health benefit plan under Insurance Code Chapter 1682.

§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--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, and an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, offering a health benefit plan.

(2) Arbitration--Has the meaning assigned by Insurance Code §1467.001.

(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) Diagnostic imaging provider--Has the meaning assigned by Insurance Code §1467.001.

(5) Diagnostic imaging service--Has the meaning assigned by Insurance Code §1467.001.

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

(7) Emergency care provider--Has the meaning assigned by Insurance Code §1467.001.

(8) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

(9) Enrollee--Has the meaning assigned by Insurance Code §1467.001.

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

(11) Health benefit plan--A plan that provides coverage under:

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

(B) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans;

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682; or

(D) a self-insured or self-funded plan established by an employer under ERISA for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

(12) Facility-based provider--Has the meaning assigned by Insurance Code §1467.001.

(13) 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, including an exclusive provider benefit plan, under Insurance Code Chapter 1301.

(14) Mediation--Has the meaning assigned by Insurance Code §1467.001.

(15) Mediator--Has the meaning assigned by Insurance Code §1467.001.

(16) Out-of-network claim--A claim for payment for medical or health care services or supplies or both furnished by an out-of-network provider or a non-network provider.

(17) Out-of-network provider--Has the meaning assigned by Insurance Code §1467.001.

(18) Party--Has the meaning assigned by Insurance Code §1467.001.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 5. Explanation of Benefits and Enrollee ID Card Requirements
28 TAC §21.5040

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5040 under Insurance Code §§1275.004, 1301.007, 1467.003, and 36.001.

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

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

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

TEXT.

§21.5040. Required Explanation of Benefits and Enrollee Identification Card Information.

(a) General requirements for explanation of benefits. A health benefit plan issuer or administrator subject to Insurance Code §1271.008, concerning Balance Billing Prohibition Notice; §1275.003, concerning Balance Billing Prohibition Notice; §1301.010, concerning Balance Billing Prohibition Notice; §1551.015, concerning Balance Billing Prohibition Notice; §1575.009, concerning Balance Billing Prohibition Notice; or §1579.009, concerning Balance Billing Prohibition Notice must provide written notice in accordance with this section in an explanation of benefits in connection with a health care or medical service or supply or transport provided by a non-network provider or an out-of-network provider:

(1) to the enrollee and physician or provider, which must include:

(A) a statement of the billing prohibition, as applicable; and

(B) the total amount the physician or provider may bill the enrollee under the health benefit plan and an itemization of in-network copayments, coinsurance, deductibles, and other amounts included in that total; and

(2) to the physician or provider, for a claim that is subject to mediation or arbitration under Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, a conspicuous statement in not less than 10-point boldface type that is substantially similar to the following: "If you disagree with the payment amount, you can request mediation or arbitration. To learn more and submit a request, go to www.tdi.texas.gov. After you submit a complete request, you must notify {HEALTH BENEFIT PLAN ISSUER OR ADMINISTRATOR NAME} at {EMAIL}."

(b) Specific requirements for explanation of benefits provided by health benefit plans subject to Insurance Code Chapter 1275. In addition to the requirements in subsection (a) of this section, the following requirements apply.

(1) For a health benefit plan offered by a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, the notice to a physician or provider for a claim must also include the following instruction that is substantially similar to the following: "The request for mediation or arbitration must identify the plan type as 'Ag Plan.'"

(2) For a self-insured or self-funded plan under ERISA where the plan sponsor has elected to apply Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-Of-Network Claim Dispute Resolution for Certain Plans, to the plan for the relevant plan year, the notice to a physician or provider for a claim must also include a statement that is substantially similar to the following: "The plan sponsor has opted in to the Texas Independent Dispute Resolution Process under Insurance Code

Chapter 1275 for this plan year. A dispute related to this claim must proceed through the Texas process and may not proceed through the Federal No Surprises Act Independent Dispute Resolution Process. The request for mediation or arbitration must identify the plan type as 'ERISA Opt-In.'"

(c) Requirements for ID cards issued to enrollees of health benefit plans subject to Insurance Code Chapter 1275. For a plan that is delivered, issued for delivery, or renewed on or after 90 days following the effective date of this section, a health benefit plan issuer or administrator that is subject to Insurance Code §1275.003 must include the letters "TXI" on the front of the ID card issued to enrollees.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 7. Submission Requirements for Election by ERISA Plans
28 TAC §21.5060

STATUTORY AUTHORITY. The commissioner adopts new §21.5060 under Insurance Code §§1275.002, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.002 authorizes the commissioner to prescribe the form and manner in which a plan sponsor may elect to apply Insurance Code Chapter 1275 to a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

TEXT.

§21.5060. Election Submission Requirements.

(a) A plan sponsor of a self-insured or self-funded plan may elect to participate under Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans, by providing identifying information to the Texas Department of Insurance as specified on the department's website at www.tdi.texas.gov, including:

(1) the name and contact information of the plan sponsor;

(2) the name and contact information of the administrator of the health benefit plan, if applicable;

(3) the health benefit plan year start and end dates;

(4) the requested effective date, which, except as provided in subsection (d) of this section, must be the same as the start date of the relevant plan year and at least 30 days after the date the identifying information is submitted;

(5) the group number of the health benefit plan; and

(6) the number of enrollees covered under the health benefit plan.

(b) Election under subsection (a) of this section applies only to the relevant plan year. A plan sponsor must elect to apply Insurance Code Chapter 1275 (which includes an

election to participate in out-of-network claim dispute resolution for applicable claims incurred during the relevant plan year) with respect to each plan year and must provide or update identifying information required by this section. A plan sponsor that elects to apply Insurance Code Chapter 1275 to a plan for the relevant plan year may not opt out until the end of that relevant plan year.

(c) A plan sponsor or its authorized representative may provide the identifying information required by this section.

(d) A health benefit plan with a plan year start date between September 1, 2023, and February 1, 2024, may make an election with a requested effective date that is after the first day of the relevant plan year if the information required under subsection (a) of this section is submitted not later than 45 days after the effective date of this section. An election for a plan year with a start date after February 1, 2024, must apply for the entirety of the plan year.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 8. Emergency Medical Service Rate Submission and Payment Requirements
28 TAC §21.5070 and §21.5071

STATUTORY AUTHORITY. The commissioner adopts new §21.5070 and §21.5071 under Insurance Code §§38.006, 1301.007, and 36.001.

Insurance Code §38.006 authorizes the commissioner to prescribe the form and manner by which political subdivisions may submit rates for ground ambulance services.

Insurance Code §1301.007 directs the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

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

TEXT.

§21.5070. Rate Database for Emergency Medical Services Providers.

(a) Consistent with Insurance Code §38.006, concerning Emergency Medical Services Provider Balance Billing Rate Database, this section applies to:

(1) a political subdivision that sets, controls, or regulates a rate charged for a health care service, supply, or transport provided by an emergency medical services (EMS) provider, other than an air ambulance; and

(2) an EMS provider or its designee that provides a health care service, supply, or transport on behalf of a political subdivision that sets, controls, or regulates a rate.

(b) A political subdivision or EMS provider subject to this section may not issue a bill for a health care service, supply, or transport that exceeds the amount of the rate set, controlled, or regulated by the political subdivision.

(c) A political subdivision that chooses to submit data to the Texas Department of Insurance (TDI) under this section must submit data using the data submission method available at www.tdi.texas.gov and must include at a minimum:

(1) the political subdivision's name and contact information;

(2) if known, the National Provider Identification (NPI) number of each EMS provider that provides a health care service, supply, or transport that is subject to rates set, controlled, or regulated by the political subdivision;

(3) each ZIP code that is subject to the rates set, controlled, or regulated by the political subdivision; and

(4) the applicable billing code, code type, and dollar amount for each health care service, supply, or transport rate that is set, controlled, or regulated by the political subdivision.

(d) The data submission deadline for a political subdivision that chooses to submit data is 30 days after the date this section becomes effective.

(e) TDI will publish data reported by a political subdivision no later than 10 business days after the data reporting deadline specified in subsection (d) of this section.

(f) A claim submitted by an EMS provider or its designee for a health care service, supply, or transport provided on behalf of a political subdivision must include the ZIP code in which the health care service, supply, or transport originated.

§21.5071. Payments to Emergency Medical Services Providers.

(a) This section applies to a health benefit plan issuer or administrator that is subject to one of the following statutes:

(1) Insurance Code §1271.159, concerning Non-Network Emergency Medical Services Provider;

(2) Insurance Code §1275.054, concerning Out-of-Network Emergency Medical Services Provider Payments;

(3) Insurance Code §1301.166, concerning Out-of-Network Emergency Medical Services Provider;

(4) Insurance Code §1551.231, concerning Out-of-Network Emergency Medical Services Provider Payments;

(5) Insurance Code §1575.174, concerning Out-of-Network Emergency Medical Services Provider Payments; or

(6) Insurance Code §1579.112, concerning Out-of-Network Emergency Medical Services Provider Payments.

(b) For a covered health care or medical service, supply, or transport that is provided to an enrollee by an out-of-network emergency medical services (EMS) provider, a health benefit plan issuer or administrator must pay:

(1) for a service or transport that originated in a political subdivision that sets, controls, or regulates the rate, the lesser of the billed charge or the applicable rate for that political subdivision that is published in the EMS provider rate database established by the department and adjusted as required in subsection (d) of this section; or

(2) if there is not a rate published in the EMS provider rate database for the political subdivision in which the service or transport originated, the lesser of:

(A) the provider's billed charge; or

(B) 325% of the current Medicare rate, including any applicable extenders or modifiers.

(c) For claims incurred during a plan year that starts before September 1, 2024, for a claim for emergency medical services that is provided on or after January 1, 2024, and before September 1, 2025, a health benefit plan issuer or administrator that must

make a payment consistent with subsection (b)(1) of this section must use the rate data published in the department's EMS provider rate database for calendar year 2024.

(d) For claims incurred during a plan year that starts on or after September 1, 2024, a health benefit plan issuer or administrator that must make a payment consistent with subsection (b)(1) of this section must pay the lesser of:

(1) the billed charge;

(2) the rate published in the department's EMS provider rate database for calendar year 2024 increased by 10%; or

(3) the rate published in the department's EMS provider rate database for calendar year 2024 increased by the Medicare Economic Index rate that applies to the first day of the new plan year.

(e) Figure: 28 TAC §21.5071(e) provides examples illustrating how a health benefit plan should apply published rates to a plan year under subsection (d) of this section.

Figure: 28 TAC §21.5071(e)

Example 1. A plan renews on September 1, 2024. For claims incurred on or after September 1, 2024, the health benefit plan issuer or administrator must pay the lesser of the billed charge, the published rate increased by 10%, or the published rate increased by the Medicare Economic Index.

Example 1-a. The political subdivision adopted a new rate effective for services provided on or after June 1, 2024. The new rate is a 5% increase from the rates submitted by the political subdivision for calendar year 2024, which is higher than the Medicare Economic Index rate for calendar year 2024. Starting June 1, 2024, the provider bills the new rates established by the political subdivision.

i. For claims incurred on or after June 1, 2024, and before September 1, 2024, the health benefit plan issuer or administrator continues to reimburse based on the rate submitted for calendar year 2024.

ii. For claims incurred on or after the plan's renewal date of September 1, 2024, the health benefit plan issuer or administrator calculates the applicable rate by adding the calendar year 2024 rate to the product of the calendar year 2024 rate and the Medicare Economic Index.

Example 2. A plan renews on March 1, 2025. For claims incurred on or after March 1, 2025, the health benefit plan issuer or administrator must pay the lesser of the billed charge, the published rate increased by 10%, or the published rate increased by the Medicare Economic Index.

Example 2-a. The political subdivision adopted a new rate effective for services provided on or after January 1, 2025. The new rate is a 3% increase from the rates submitted by the political subdivision for calendar year 2024, which is less than the Medicare Economic Index rate for calendar year 2025. Starting January 1, 2025, the provider bills the new rates established by the political subdivision.

i. For claims incurred on or after January 1, 2025, and before March 1, 2025, the health benefit plan issuer or administrator continues to reimburse based on the rate submitted for calendar year 2024.

ii. For claims incurred on or after the plan's renewal date of March 1, 2025, the health benefit plan issuer or administrator pays the billed charge amount.

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 December 14, 2023.

DocuSigned by:
Jessica Barta
5DAC5618BBC74D4...

Jessica Barta, General Counsel
Texas Department of Insurance

Amended 28 TAC §§21.4902, 21.5002, 21.5003, 21.5040, and new 28 TAC §§21.5060, 21.5070, and 21.5071 are adopted.

DocuSigned by:
C Brown
FC5D7EDDFFBB4F8...

Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2023-8410