2021-6833

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
28 TAC §21.2821

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC §21.2821, concerning reporting requirements, and withdraws the repeal of §21.2824, concerning applicability. The Texas Department of Insurance (TDI) adopts §21.2821 with changes to the proposed text published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8483).

REASONED JUSTIFICATION. Under Insurance Code §843.342 and §1301.137, managed care carriers (MCCs) are required to pay a penalty and applicable interest for the late payment of clean claims. The adopted amendments to §21.2821 expand the data reporting requirements under the prompt pay reporting system so that TDI can adequately determine compliance, lower the frequency of some reporting to reduce the regulatory burden on MCCs, and provide a new mechanism for the electronic reporting of data to improve efficiency and limit the possibility of data entry errors.

While the current rule requires quarterly reporting of data, it does not address reporting of penalty and interest payments for late-paid clean claims. In practice, MCCs have been reporting penalty and interest data monthly since the dissolution of the Texas Health Insurance Pool and transfer of its obligations and authority to TDI. With these adopted rule amendments, monthly reporting will no longer be necessary; MCCs will begin reporting the data quarterly. TDI expects that the reduction in frequency of reporting along with the changes and clarifications made in response to comment on the proposed rule will reduce the carriers' burden of compliance over time.

In order to verify that the amount paid is correct, the amended rule requires that the quarterly report from MCCs required under §21.2821(a) include the total number of reported late-paid claims and the aggregate dollar value corresponding to those claims. This dollar value will be submitted for each time frame (i.e., claims paid late between 1 and 45 days, claims paid late between 46 and 90 days, and claims paid late 91 days or greater). The amended rule also requires the carrier to report the dollar amount paid late on each clean claim, for each applicable time frame. In response to comment, TDI has removed language from the rule requiring carriers to report claim numbers to TDI. It also requires the carrier to report the associated penalty dollar amount it paid to the preferred provider. Additionally, it requires an MCC to report the amount of interest, based on the penalty dollar amount, that the MCC paid to TDI for each clean claim that the MCC paid to a noninstitutional preferred provider on or after the 91st day after the end of the applicable statutory claims payment period. The purpose of this reporting is to enable TDI to verify the amounts and tie the penalty and interest payments to actual claims paid.

TDI has made a change in response to comments to require claim-level data to be reported using a unique identifier for each claim that is not the claim number. HIPAA privacy rules provide a mechanism for covered entities to de-identify and re-identify protected health information (PHI), similar to the unique identifier concept used in the rule. The amended rule provides that this unique identifier will be generated and maintained solely by the MCC and will consist of no more than 15 characters. The amended rule provides further that the unique identifier may not contain any of the identifiers listed in 45 C.F.R. §164.514(b)(2), concerning requirements for de-identification of PHI. Additionally, the amended rule requires the MCC to relate the unique identifier back to the claim on request by TDI during an examination. To the extent that MCCs

already have processes in place to create a unique code to identify claims in connection with de-identification of confidential information, TDI anticipates that the MCC could use the same process to create and maintain the unique identifier required by the rule.

The amended rule also requires that carriers report the number of written complaints received regarding failure to pay a clean claim on time. This report gathers the number of such complaints received by an MCC, including those that may not have been submitted to TDI as formal complaints. Complaint numbers can be an indication of the quality of a carrier's claims payment processes. In response to comment, the rule has been revised to require the submission of the total number of written complaints (and not oral complaints) for failure to pay a clean claim on time.

The first report including the data submissions required by the new rule will be due to TDI by May 15, 2022, for data from the months of January, February, and March of that year. Subsequent reports must meet the submission deadlines set forth in §21.2821(b). This change in the initial submission date was made in response to commenters' concerns about the additional time carriers will need to gather and submit all the required information.

In response to comment, TDI is developing a process by which MCCs will upload a file with the claim-level data rather than entering it manually into the portal. Technical instructions, to be developed with input from stakeholders, will be available later. TDI expects that this will allow MCCs to automate reporting of claim-level data. TDI expects that this file will be available for use by MCCs well in advance of the first reporting deadline in May of 2022, and TDI will monitor the implementation and make adjustments as appropriate. The rest of the data will be entered through the portal directly into TDI's new electronic prompt pay reporting database. Electronic submission will reduce the

possibility of data entry errors, enhance TDI's oversight capabilities, and increase efficiency.

The revised rule requires MCCs to report the dollar value of late-paid clean claims (using a unique identifier as described in the rule), the associated penalty dollar amount, and interest as applicable. Without this information the only verification of compliance that TDI can perform is to spot-check claims and claims payments via market-conduct and quality-of-care examinations. The new requirements allow TDI to determine compliance with Insurance Code §843.342 and §1301.137.

TDI withdraws the repeal of §21.2824 in response to commenters' concerns that deletion of the provision would eliminate a provision that is useful in determining the scope of the prompt pay law.

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

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

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

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

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

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

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

- for each clean claim that the MCC paid late, the associated penalty dollar amount; and

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

The text of §21.2821(e)(2) and (3) as proposed has been changed by deleting the term "penalty," and inserting the term "late" in each paragraph. The purpose of the change is to clarify that (1) the subsection requires the reporting of the dollar amount of late-paid clean claims paid to institutional preferred providers--not the reporting of penalties associated with those dollar amounts--and (2) the reporting of dollar amounts refers to late-paid clean claims. A separate subsection addresses reporting of penalties.

The text of §21.2821(e)(3) as proposed has been changed by replacing the term "noninstitutional provider" with "noninstitutional preferred provider" to be consistent with the other provisions of §21.2821.

The text of §21.2821(e)(4) as proposed has been changed by replacing the phrase "the noninstitutional preferred provider" with "a noninstitutional preferred provider."

The text of §21.2821(e)(6) as proposed has not been adopted because it is duplicative language. The subsequent subsection has been redesignated accordingly.

In response to comment, the text of proposed §21.2821(e)(7) (which is adopted as subsection (e)(6)) has been changed by replacing the term "complaints" with "written complaints" to clarify that MCCs are required to report to TDI only the total number of written complaints received by the MCC for failure to pay a clean claim on time.

In response to comment regarding the confidentiality of claim numbers, the text of §21.2821 as proposed has been changed to require the reporting of claims using unique identifiers instead of reporting by claim numbers. The amendments to the section add new subsection (f), which describes the creation and maintenance of the unique identifiers by MCCs and access to the underlying claims by TDI. As a result of adding this new subsection, the subsections after it are redesignated accordingly.

Subsection (g), which was proposed as subsection (f), requires that the quarterly report required by subsection (a) be submitted electronically as specified on TDI's website.

Finally, the text of subsection (h), which was proposed as subsection (g), was changed to include the new subsection (f) added with this adoption and to revise the reporting date. As adopted, subsection (h) provides that the new reporting requirements in subsections (e), (f), and (g) apply to reports submitted under subsection (a), beginning with the report required to be submitted by May 15, 2022, for data for the months of January, February, and March of that year.

Section 21.2824. Applicability. In response to comments, TDI withdraws the repeal of §21.2824. Several commenters indicated that the applicability provision was useful to them, as it provided clarity in assessing the application of the prompt pay law.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received written comments and comments at a public hearing held on February 2, 2021. Commenters against the proposed amendments to §21.2821 were Superior HealthPlan and Texas Association of Health Plans. Commenters against the proposed repeal of §21.2824 were PPO Check and Texas Hospital Association.

Comments on §21.2821

Comment. A commenter requests that TDI explain how it intends to utilize the reporting requirements to adequately determine compliance, including in comparison to its current practice.

Agency Response. Currently, TDI is unable to determine whether the dollar values of late-paid clean claims, penalties, and applicable interest comply with statutory requirements, except through random sampling in an examination. Investigation through random sampling in an exam does not necessarily reveal the existence or potential scope of noncompliance. By requiring MCCs to report claim-level information, including the dollar values of claims, late-payment penalties, and applicable interest, TDI can verify those dollar values. Reporting of these dollar values will assist TDI in an exam and ensure that TDI has the information needed to evaluate compliance with Insurance Code §843.342 and §1301.137.

Comment. A commenter requests that the rule be revised to clarify that the proposed quarterly reporting is in lieu of the current monthly reporting and payment of penalties to TDI.

Agency Response. TDI declines to make a change to the rule text but provides the requested clarification. The current monthly reporting process is a result of legislation

passed by the Texas Legislature in 2013 (Senate Bill 1367), which dissolved the Texas Health Insurance Pool and transferred the pool's administrative and financial responsibilities to TDI. With the adoption of this rule, MCCs will now complete the payment and related reporting as set forth in the rule quarterly in lieu of the current monthly payment and reporting process. MCCs that wish to continue paying monthly may do so; full payment for the quarter is due by the reporting due date set out in §21.2821(b).

Comment. A commenter requests that TDI confirm that (1) its share of penalty or interest payments will be paid quarterly rather than monthly, in accordance with the proposed quarterly reporting schedule; (2) any interest stops accruing when the provider's portion of the penalty and interest is paid to the provider; and (3) payments to TDI may be made either by wire or by check. The commenter also asks whether the penalty and interest payment will be due quarterly with the rule change.

Agency Response. TDI's share of penalty or interest payments will be due quarterly as set out in §21.2821. As mentioned previously, full payment for a quarter is due by the reporting due date, but MCCs have the option to continue paying monthly if they would like to. Interest stops accruing when the provider's portion of the penalty and interest is paid in full. TDI is in the process of updating its electronic services, including online payments; until this update is completed, payments will continue to be made to TDI by wire or by check.

Comment. A commenter disputes TDI's determination that, while this proposal may impose an initial cost, these initial costs will be more than offset by savings that result from a reduction in reporting frequency. The commenter notes that changing from

monthly to quarterly reporting will not offset the costs created by the extensive increase in the amount of data required by the proposal. The commenter notes that the proposal requires unnecessary data and actually increases carriers' burdens with no corresponding benefits to consumers, and requests clarification regarding how the proposal will reduce the regulatory burden on carriers with the introduction of extensive additional data requirements.

Agency Response. TDI has made clarifications in this adoption order intended to address concerns about undue burden on carriers. TDI anticipates that allowing carriers to submit claim-level information using a file rather than manually entering data into the portal will allow carriers to automate the reporting of the data. While this will involve an initial programming cost, moving the reporting from monthly to quarterly should reduce the burden on MCCs over time. TDI expects that carriers will not be required to create new data to report; rather, carriers will report data that they already are collecting. The rule provides a public benefit by promoting the timely and correct payment of clean claims. By requiring carriers to report the dollar values of claims, late-payment penalties, and applicable interest, TDI can verify those dollar values. Reporting of dollar values will assist TDI in meeting its oversight responsibilities and ensure compliance with Insurance Code §843.342 and §1301.137.

Comment on §21.2821(b) and (g)

Comment. A commenter requests that TDI extend the due dates for reporting by an additional month after the close of the reporting period, as carriers will need more time to gather and submit all of the information included in the proposal. The commenter noted that the current turnaround time of about six weeks is tight for carriers; carriers will

need more time to gather and submit the additional information included in the proposal. The commenter also requests that TDI provide a start date for reporting time periods that is later than January 1st, to address carriers' programming needs.

Agency Response. TDI declines to make a rule change extending the due dates for quarterly reporting by an additional month. It is important for TDI to collect data as soon as possible to meet its oversight responsibilities. As MCCs already collect the data being requested under subsection (e), TDI anticipates that adding an additional month to submit the quarterly report would be unnecessary. However, TDI is extending implementation of the new reporting requirements by one year in light of the clarifications being made in response to comments about manual entry and to allow carriers time to address programming needs. Section 21.2821(h) has been revised to provide that the new reporting provisions apply to reports submitted under subsection (a), beginning with the report required to be submitted May 15, 2022, for the months of January, February, and March of that year. Subsequent reports must meet the submission deadlines set forth in §21.2821(b). Further, TDI will monitor implementation of the technical instructions as it relates to the first required reporting period and make adjustments as appropriate.

Comment on §21.2821(e)(1) - (e)(3)

Comment. A commenter notes that the term "total dollar amount" is undefined in the rule. The commenter asks whether the term refers to the amount billed, allowed, or paid. The commenter also requests that TDI explain how this information is useful to TDI. Additionally, the commenter requests that TDI clarify that this information is to be reported in the aggregate and not for each claim. If the term refers to allowed or paid amounts for particular claims, then the commenter objects because allowed or paid

amounts for particular claims will reveal proprietary and confidential negotiated network rates.

The commenter also objects to the reporting or disclosure of penalty dollar amounts that an MCC paid to a preferred provider for late-paid clean claims if the reporting requires matching the penalty amount to the claim amount. The commenter objects because the disclosure will reveal or allow calculation by reverse engineering of proprietary and confidential negotiated network rates.

The commenter also notes that the requirement for claim-by-claim reporting does not address issues regarding "pay and pursue" subrogation practice, or unclean claims paid timely. In addition, the commenter notes that claim-by-claim reporting raises questions regarding whether to adjust previously filed reports when there have been subsequent adjustments to the previously filed reports. The commenter also notes that reporting of such adjustments would greatly increase the administrative difficulty of reporting.

Agency Response. The term "total dollar amount" refers to the dollar amount of all clean claims paid after the end of the applicable statutory claims payment period, broken down by the time periods described in subsection (e)(1). The purpose of this data collection is to allow TDI to determine patterns in late payment of clean claims that warrant further investigation.

In response to the commenter's request to clarify that the total dollar amount to be reported is in the aggregate and not for each claim, TDI notes that §21.2821(e)(1) requires the reporting of certain total dollar amounts, whereas §21.2821(e)(2) - (e)(5) require the reporting of claim-specific amounts relating to claims, penalties, and interest. TDI has made changes to the rule text in subsection (e)(2) and (3) to make this clearer.

Reporting of this data will allow TDI to verify penalty and interest amounts and conduct targeted inquiries rather than random sampling. Using reported data will allow TDI to ensure compliance while making more efficient use of agency resources.

TDI takes seriously commenter concerns about the confidentiality of the collected information and about the potential reverse engineering of proprietary negotiated network rates. TDI notes that the rule does not collect information relating the claim to a particular medical service or provider.

Further, TDI will maintain confidentiality of the collected information as provided by law. TDI notes when items are marked confidential or proprietary, or when information may be protected from disclosure in referring requests. Information marked proprietary by carriers may be referred to the Office of the Attorney General for a determination under the Public Information Act, and the carrier notified to provide an opportunity for the carrier to make arguments against the release of the information.

Regarding the issue of "pay and pursue" subrogation practice, or unclean claims paid timely, TDI notes that the rule addresses clean claims paid late, not the circumstances surrounding the claim. Regarding the comment concerning adjustment of previously filed reports, TDI notes that requests to adjust previously filed reports under the current reporting requirements are infrequent. In rare cases, TDI has worked with an MCC to make a correction to a previously filed report. Such requests are considered on a case-by-case basis and should be uncommon.

Comment on §21.2821(e)(2) - (e)(6)

Comment. A commenter requests that TDI clarify how the MCC will report several items if it must enter the data for each unique claim versus uploading an Excel spreadsheet.

Agency Response. As addressed elsewhere in this adoption order, TDI will develop a process by which MCCs can upload a file with claim-level data rather than entering the data manually for each unique claim. TDI notes that subsection (e)(6) has been deleted as duplicative.

Comment on §21.2821(e)(4)

Comment. A commenter notes that, given the timing of the reporting and the time period for MCCs' payments of interest to TDI, a claim could be included on a report for a calendar year, but the interest not yet paid to TDI. The commenter requests that TDI clarify how interest payments are to be paid across reporting periods. The commenter also requests that TDI consider allowing MCCs to report the provider and TDI shares of penalties and interest assessed, with the caveat that the portion payable to TDI reflected in the report may be paid either within that quarter or the following quarter.

Agency Response. In most cases, the claims payment and penalty payment are made in the same reporting period. The reporting of a late-payment penalty in one reporting period and the payment of interest thereon in a subsequent reporting period occasionally happens under the current rule. These rule amendments do not make changes that address this situation, and TDI anticipates that this may infrequently happen under the new adopted rule.

Comments on §21.2821(e)(5)

Comment. A commenter recommends that, because claim numbers are PHI, TDI should consider and ensure that it is requiring the minimum necessary to accomplish its intended purpose. The commenter also recommends that TDI should explain how it is

accomplishing this with the proposal. In addition, the commenter recommends that TDI should describe the purpose in requiring every Texas MCC to submit claim-level information on a routine basis, when it is likely subject to an open records request and would require costly challenges to disclosure.

Agency Response. The purpose of the disclosure is to promote the integrity of the health care claim reimbursement system. By requiring MCCs to report claim-level information--including the dollar values of claims, late-payment penalties, and applicable interest--TDI can verify those dollar values. Reporting of these dollar values will assist TDI in an exam and is essential to ensuring that TDI has the information needed to evaluate compliance with Insurance Code §843.342 and §1301.137.

TDI is sensitive to the commenter's concerns about confidential claim numbers. In response to this comment, TDI has added language to the rule to safeguard the privacy of claim numbers. The amended rule requires the carrier to submit claim-level data identified by a unique identifier and not by claim number. HIPAA privacy rules provide a mechanism for covered entities to de-identify and re-identify PHI, similar to the unique identifier concept used in the rule. The amended rule provides that this unique identifier will be generated and maintained solely by the MCC and will consist of no more than 10 characters. The amended rule provides further that the unique identifier may not contain any of the identifiers listed in 45 C.F.R. §164.514(b)(2), concerning requirements for de-identification of PHI. Additionally, the amended rule requires the MCC to relate the unique identifier back to the claim on request by TDI during an examination. To the extent that MCCs already have processes in place to create a unique code to identify claims in connection with de-identification of confidential information, TDI anticipates that the

MCC could use the same process to create and maintain the unique identifier required by the rule.

In response to the commenter's statement that claim-level information submitted to TDI on a routine basis likely would be subject to an open records request, TDI notes that MCCs with concerns about the confidentiality of their submissions have the option to designate information submitted to TDI as "proprietary." TDI has controls in place to reduce the risk of unauthorized exposure of information when responding to an open records request. In response to the commenter's statement that claim-level information submitted to TDI on a routine basis would require costly challenges to disclosure, TDI notes that the Office of the Attorney General has procedures in place to direct a governmental body's response to an open records request for material that may have been the subject of a previous determination by the Attorney General. While what constitutes a "previous determination" may be narrow in scope, the reliance on previous determinations may help reduce the frequency and the cost of responding to a challenge to disclosure.

Comment. A commenter notes that the current method of filing TDI Form FIN593 on a monthly basis allows MCCs the opportunity to offset overpayment refunds by reducing the monthly payment to the state. The commenter requests clarification regarding how MCCs should account for such offsets in the reporting process.

Agency Response. TDI declines to make a change to the adopted rule. There is no offset provision in TDI Form FIN593 or in TDI rule. This rule does not address offsets or recoupments, which are separate issues.

Comments on §21.2821(e)(7) (redesignated as (e)(6) in the adoption)

Comment. A commenter objects to the complaint reporting provision as administratively burdensome and unnecessary because TDI tracks formal complaints that it receives and regularly reviews carriers' complaint records as part of the exam process.

Agency Response. TDI declines to remove the complaint reporting provision from the rule. As required by Insurance Code §843.260, an HMO is required to maintain a complaint and appeal log regarding each complaint. Insurers are required under 28 TAC §21.2503 to maintain a complete record of all complaints. Under 28 TAC §21.2504(c)(3)(A) and (B), this record includes information regarding claims procedures and delays. In addition, Insurance Code §542.005 requires insurers to maintain a complete record of complaints, including an indication of the nature of each complaint. Section 542.005 defines "complaint" as "any written complaint primarily expressing a grievance." The rule does not require that MCCs collect complaint information that they are not already required to collect. The number of complaints about failure to pay a clean claim on time can be an indication of problems with an MCCs claims payment processes. Reporting of this data will allow TDI to conduct targeted inquiries to assess these processes.

Comment. A commenter requests that, if TDI does include a requirement for the reporting of complaints, TDI confirm that "complaint" as applied to HMO plans means a communication from a provider only when the provider is designated to act on behalf of an HMO enrollee; "complaint" should not include an inquiry that can be easily resolved. The commenter also requests that TDI confirm that the term "complaint" does not include an HMO provider's request or demand for payment of a late or allegedly underpaid claim or prompt pay penalties for purposes of the proposed rule.

Agency Response. In response to comment, TDI makes a change to §21.2821(e)(6) by adding "written" to the paragraph. TDI notes that the rule does not establish a definition of "complaint" for HMOs that differs from what is already in statute. The Texas Health Maintenance Organization Act, Insurance Code Chapter 843, addresses complaints for HMOs.

Section 843.002(5) defines a "complainant" as "an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint." The act defines "complaint" in §843.002(6), as "any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation." That definition excludes "a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee."

While the HMO Act defines "complaint" to include both oral and written complaints, TDI recognizes that the majority of complaints regarding failure to pay a clean claim on time are submitted to HMOs by providers in writing and not orally; in recognition of this reality, TDI will require carriers to report only written complaints for failure to pay a clean claim on time. TDI has revised the rule to reflect this change.

Additionally, regarding the underpayment issue, TDI notes that a provider may submit a complaint about failure to pay a claim in full within the statutory claims payment period. Written complaints to carriers about underpayments of clean claims, penalties, and applicable interest should be counted and reported.

Comment. A commenter requests that TDI confirm that, for insurers that issue a preferred and exclusive provider benefit plan, as defined by Insurance Code §542.002, "complaint" as used in the proposal means "any written communication primarily expressing a grievance" and "not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding and/or supplying the appropriate information. . . ." as provided in 28 TAC §21.2502.

Agency Response. TDI notes that the rule does not establish a definition of "complaint" for preferred or exclusive provider benefit plans that differs from established rules regarding complaints. Insurers that issue a preferred or exclusive provider benefit plan are required to maintain a complete record of all complaints they receive, as required under 28 TAC §21.2503. "Complaint," as the term is used with regard to insurers (including insurers that issue a preferred or exclusive provider benefit plan) and as provided in 28 TAC §21.2502(2), means "any written communication to an insurer, not solicited by such insurer, concerning coverage offered or issued by such insurer in this state and primarily expressing a grievance." It excludes from the definition of complaint "a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding and/or supplying the appropriate information to the satisfaction of the person submitting the written communication, as applicable." The rule includes insurers that issue a preferred or exclusive provider benefit plan in the scope of its reporting requirements. They are required to report to TDI the total number of those written complaints that relate to failure to pay a clean claim on time.

Comment. A commenter recommends that the reporting of complaints be limited to only written complaints specific to the issue of prompt payment, as opposed to inquiries as to the status of a claim or complaints regarding coverage of a particular service.

Agency Response. As to the category of reportable complaint types, the complaint reporting requirement applies only to those complaints based on failure to pay a clean claim on time. The subject rule does not change the definitions of "complaint" in statute and rule with regard to HMOs or preferred or exclusive provider benefit plans. With the change noted previously, it does narrow the universe of those complaints for reporting purposes under §21.2821(e)(6) to only the total number of written complaints for failure to pay a clean claim on time.

Comment. One commenter notes that some carriers do not currently capture informal complaints/inquiries that may be received from all areas of the company (such as customer services, provider network, appeals, etc.). The commenter also notes that it would be burdensome and costly to build such a tracking system. The commenter notes that reporting complaints received in the first quarter of 2021 could be problematic if the requirement is broader than a carrier's current internal complaint tracking, as not all carriers currently track complaints in this manner. The commenter recommends that complaints be stricken from the reporting requirements. Alternatively, the commenter recommends that TDI delay complaint reporting requirements until carriers have time to develop and implement tracking systems specific to TDI's interpretation of requirements.

Agency Response. TDI declines to remove complaint reporting provisions from the rule. As noted previously, the rule does not require carriers to build a complaint tracking system or track different complaints in ways other than what is already required in statute and

rule. MCCs are required under existing laws to maintain a record of each complaint they receive. This rule does not change that requirement. Existing exclusions from the definition of "complaint," as set forth in the Health Maintenance Act and the exclusive and preferred provider benefit plan rules, will apply to complaint reporting by HMOs and insurers that issue a preferred or exclusive provider benefit plan in this rule. As the rule does not require a carrier to report a list of each complaint, but instead requires the reporting only of the total number of written complaints received by the carrier for failure to pay a clean claim on time, TDI believes that the burden on carriers to report such complaints will be minimal.

With regard to the commenter's request to delay the complaint reporting requirement, TDI is delaying the applicability of the new rule's required reporting (which includes complaint reporting) as noted elsewhere in this adoption order.

Comment on §21.2821(g)

Comment. A commenter recommends that TDI clarify how the process of electronically submitting a quarterly report will work. The commenter also recommends that TDI develop a template with detailed instructions that does not require manual input of each claim and penalty/interest amount, as manual entry would inevitably lead to data entry errors. The commenter states that a standard template that does not require manual input of information for each claim would be helpful to carriers and would increase accuracy and uniformity. Alternatively, the commenter recommends that TDI revise the reporting template (currently TDI Form FIN593) and publish it for public comment. The commenter also recommends that carriers be allowed a secure method to upload their internal reports into TDI's reporting system so that manual input is not required. The commenter suggests

that TDI consider allowing an Excel spreadsheet or Adobe PDF report that can be uploaded using a comma-separated values (CSV) file template. Also, the commenter recommends that the process should be flexible enough to accommodate different carriers' systems.

Agency Response. TDI thanks the commenter for its comments regarding data input. As previously stated, TDI is developing a process by which MCCs will upload a file with the claim-level data. This process will allow MCCs to automate claim-level reporting. TDI will solicit feedback from stakeholders while developing the technical instructions for the file reporting to address compatibility with different carriers' systems. TDI will monitor implementation of the technical instructions as they relate to the first required reporting period and make adjustments as appropriate. TDI declines the commenter's request to revise the current reporting form (TDI Form FIN593), as the automated reporting system being implemented is intended to preclude the need for this form. Carriers will no longer use TDI Form FIN593 when they start reporting using the new process. Regarding the commenter's request for a secure method to upload information, TDI anticipates that the protections built into the TDI reporting system, combined with the required reporting of de-identified information (as is contemplated in the revised rule), will provide a secure method for carriers to upload their reports.

Comments on §21.2824

Comments. Two commenters oppose the proposed repeal of §21.2824. One opposing commenter notes that the applicability provision is useful and provides some clarity. One commenter asks where the suggestion to repeal §21.2824 came from, and why the repeal was proposed. Another commenter in opposition to the proposed repeal notes that

§21.2824 provides important clarification about the types of entities that are subject to the prompt pay laws.

Agency Response. TDI acknowledges the commenters' concerns about the effect of the deletion of §21.2824. TDI proposed the repeal as part of an ongoing effort to eliminate obsolete or outdated provisions. While TDI still thinks that the provision is no longer needed, TDI is withdrawing the proposed repeal of §21.2824 because stakeholders have indicated that the provision is useful to them.

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
28 TAC §21.2821

STATUTORY AUTHORITY. The Commissioner adopts the amendments to §21.2821 under Insurance Code §§843.151, 1301.007, and 36.001.

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

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

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.

§21.2821. Reporting Requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) policy or contract limitations:

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

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

(C) benefit exclusions;

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

(E) preexisting condition limitations; and

(F) other;

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

(A) the requesting physician or provider;

(B) any other physician or provider; and

(C) any other person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) the total number of written complaints received by the MCC for failure to pay a clean claim on time.

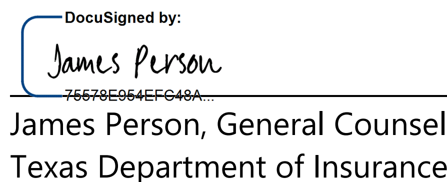
(f) The claim-level data required by subsections (e)(2) - (e)(5) must be reported using a unique identifier for each claim, created and maintained solely by the MCC, that is not the claim number. The unique identifier must consist of no more than 15 characters and may not contain any of the identifiers listed in 45 C.F.R. §164.514(b). The MCC must relate the unique identifier back to the claim on request by the department during an examination.

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

(h) Subsections (e), (f), and (g) of this section apply to reports submitted under subsection (a) of this section beginning with the report required to be submitted by May 15, 2022, for the months of January, February, and March of that year.

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 May 18, 2021 .

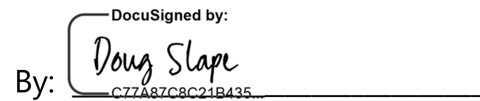


James Person, General Counsel
Texas Department of Insurance

2021-6833

The Commissioner adopts amendments to 28 TAC §21.2821.

Commissioner of Insurance

By: 

Doug Slape
Chief Deputy Commissioner
Tex. Gov't Code §601.002
Commissioner's Order No. 2018-5528