SUBCHAPTER TT. ALL-PAYOR CLAIMS DATABASE
28 TAC §§21.5401 - 21.5406

INTRODUCTION. The Commissioner of Insurance adopts new 28 TAC §§21.5401 - 21.5406, concerning the all-payor claims database.

The Commissioner adopts §21.5406 without changes and §§21.5401 - 21.5405 with changes to the proposed text published in the April 8, 2022, issue of the *Texas Register* (47 TexReg 1861). The adoption implements House Bill 2090, 87th Legislature, 2021.

REASONED JUSTIFICATION. Insurance Code Chapter 38, Subchapter I, requires establishment of an all-payor claims database to increase public transparency of health care information and improve the quality of health care in this state. Insurance Code §38.403 provides that the Commissioner is to adopt rules establishing fixed terms for members of a stakeholder advisory group. Insurance Code §38.404 requires the Texas Department of Insurance (the department) to collaborate with the Center for Health Care Data at The University of Texas Health Science Center at Houston (the Center) to aid in the establishment of the database. Insurance Code §38.409 requires the Commissioner, in consultation with the Center, to adopt rules that specify the types of data a payor is required to provide; detail the schedule, frequency, and manner of data submission; and establish oversight and enforcement mechanisms.

Section 21.5401. New §21.5401 identifies the types of health plans that are subject to the requirements to produce all-payor claims data files. As proposed, the list of plans subject to these requirements includes county employee health benefit plans established

under Local Government Code Chapter 157 and group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172. The department invited comments on whether these plans qualify as a "payor" under Texas Insurance Code §38.402(7) and can be subject to the requirements of this rulemaking. The department received one comment on this subject that was in support of including these types of plans within the scope of the rules. New §21.5401 also specifies that the data required by new Subchapter TT is limited to Texas resident members.

In response to other comments, §21.5401(b)(9) is changed to permit, but not require, payors to submit data with respect to Medicare Supplement plans.

Section 21.5402. New §21.5402 provides definitions of terms used throughout the new rules, including various types of data files. The department changes "The Center for Healthcare Data" to "The Center for Health Care Data" in paragraph (2) of this section.

Section 21.5403. New §21.5403 describes the database's common data layout (CDL) and permits the Center to provide flexibility for payors submitting data by issuing a submission guide or other technical guidance for existing requirements. It also specifies that any inconsistencies in the Center's submission guide and these rules will be controlled by the text of the rules. The Texas All-Payor Claims Database (APCD) CDL is modified in response to comments. As a result, the version number and date of the Texas APCD CDL is updated. Changes made to the Texas APCD CDL include:

- Threshold values are removed for several data fields where they are inapplicable because the fields are required only if available.

- The Unassigned field is clarified to indicate that it is not a required field.

- The Employment Status field is changed to be required only if available, and the threshold is removed in response to a comment.

- The description of the Allowed Amount field is modified to clarify the instruction for capitated claims in response to a comment.

- Threshold values are clarified for certain data fields in the medical claims data file that previously indicated, "Not required if Provider ID can be linked to provider file." The threshold values now match the values for the corresponding fields in the provider data file.

- Threshold values are clarified for certain data fields in the medical and pharmacy claims data files that previously indicated, "May be left blank if Member ID links to eligibility file." The threshold values now match the values for the corresponding fields in the eligibility data file.

- Data fields are added to the dental claims file. The data fields are consistent with the All-Payer Claims Database Common Data Layout established by the National Association of Health Data Organizations. Added data fields are either optional or required only if available.

Section 21.5404. New §21.5404 provides technical requirements concerning the formatting, encryption, and transmission of data. It instructs payors or their designees to register with the Center to obtain their credentials and unique member identification (ID) numbers to be used with the submission and naming of data. It also prohibits the submission of duplicate data submitted by a third party. In response to comments, subsection (a) is modified to permit, rather than require, certain payors to ask sponsors of health benefit plans referenced in Insurance Code §38.407 whether they will voluntarily submit plan data. In response to comments, the adopted rule clarifies that the Texas

Health and Human Services Commission may submit data on behalf of all payors participating in applicable plans and programs overseen by the Commission. Also in response to comments, the adopted rule now permits, but does not require, payors to submit data with respect to Medicare Supplement plans.

Section 21.5404 also lists the data files that must be submitted consistent with the requirements of the APCD CDL, including standardized values and code sources. It requires files to include information that enables the data to be separated on the basis of the types of plans. It clarifies certain requirements for claims data files, including specifying that all claims data must be submitted for a given reporting period based on the claim adjudication date. In response to comments, the adopted rule permits files to be submitted within multiple zip files, and clarifies the types of denied claims that must be reported.

This new section also sets forth requirements related to reporting members' social security numbers or unique member IDs, requires enrollment and eligibility data to be reported at the individual member level, and requires header and trailer records for file submissions. In response to comments, the adopted rule relaxes requirements about when a unique member ID may change.

The department also changes "USB disk" to "USB drive" in paragraph (d)(1) and "transmit the filing" to "transmit the files" in paragraph (d)(4) of this section.

Section 21.5405. New §21.5405 describes the timing and frequency of the required data submissions. It also directs payors to submit test data, historical data, and monthly data on the basis of notice provided by the Center. As proposed, the initial date for submission of monthly data would be no sooner than January 1, 2023. In response to comments, that date is changed to March 1, 2023, and additional time is provided for the

submission of test and historical data files. This new section also provides an extension for certain small payors; allows other payors an opportunity to request an extension or a temporary exception from some requirements related to the submission of data; and outlines the Center's role in assessing, receiving, requesting corrections to, and rejecting data. In response to comments, the adopted rule adds a requirement that the Center communicate receipt of data and respond to a request for an extension or temporary exception within 14 calendar days.

Section 21.5406. New §21.5406 prescribes the fixed terms to be served by members of the stakeholder advisory group, as directed by statute. It provides dates for the initial terms of the stakeholder advisory group as well as the staggered terms. This new section outlines the obligations of members with respect to required disclosures, conflicts of interest, standards of conduct, and removal for good cause.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received comments from five commenters on the proposed rule. Commenters in support of the proposal with changes were America's Health Insurance Plans, the Center for Health Care Data at The University of Texas Health Science Center at Houston, Texas Association of Health Plans, Texas Association of Life & Health Insurers, and USAA Life Insurance Company.

Comments on the proposed rule generally

Comment. A commenter requests careful consideration of appropriately funding any data collection program to maintain it and avoid collection of low-quality data after it is

developed. The commenter asserts that submitting data quarterly can be challenging and costly.

Agency Response. The department appreciates the input but is unable to address funding in the rules. HB 2090 does not provide a mechanism to fund the database through the adoption of rules. Further, the proposed rules provide for monthly submission of data, not quarterly as the commenter asserts.

Comment. A commenter requests that the rule clarify that payors are not required to submit any data on performance-based contracting arrangements. The commenter asserts that the APCD is a claims database, "so requiring data on items that are not claims related, such as drug rebates or performance-based provider contract data . . . should be expressly prohibited by the rules."

Agency Response. The department agrees that the focus of the rule is on claims but declines to make changes to the rule because the department does not believe adding clarifying language is necessary. The rule text and the common data layout reflect the nature of the claims that are to be submitted to the APCD.

Comments on §21.5401

Comment. Four commenters request striking Medicare Supplement plans from the list of plans subject to the rules, and two commenters request an explicit exclusion of Medicare Supplement plans from the rules. Two of the four commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts that the Legislature did not intend HB 2090 to apply to a policy where Medicare is the primary payor.

One commenter asserts that smaller carriers will be burdened by the reporting and the additional cost will increase rates and discourage new carriers offering Medicare Supplement plans from entering the market. Two commenters assert that inclusion of Medicare Supplement plan data does not enhance transparency, while another commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan.

Three of the four commenters assert that because federal law dictates provider charges and benefits of Medicare Supplement plans, the value of that data is limited. Three commenters assert that because Medicare Supplement plans are fixed indemnity products, they have no relation to the cost of services rendered, and the inclusion of this data would skew reporting. Two commenters assert that the data is not useful and will require extensive resources to produce.

On the other hand, one commenter asserts that Medicare Supplement plan data is valuable and, for example, could provide insight into the affordability of medical care and how access to medical care differs between seniors who have traditional Medicare alone and those with both Medicare and a Medicare Supplement plan. The commenter encourages inclusion of Medicare Supplement plan data and asserts that both federal and state law define Medicare Supplement plans as a type of benefit plan or health benefit plan, and that HB 2090 was not intended to exclude Medicare Supplement plans.

Agency Response. The department disagrees with the assertion that HB 2090's reporting requirements do not extend to payors providing Medicare Supplement benefit plans. Insurance Code §38.402(7)(A) defines "payor" broadly, including in the definition, "an insurance company providing health or dental insurance" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services,

supplies, or devices to a patient. . . ." Insurance Code §1652.002 defines a Medicare supplement benefit plan as a "policy of accident and health insurance." And insurance companies providing Medicare Supplement benefit plans either pay, reimburse, or otherwise contract with providers. In addition, Insurance Code §38.404(c)(4)(A) requires certain information to be collected and submitted to the database, including whether health services, supplies, or devices were provided to an individual through a Medicaid *or Medicare program*.

Still, the department understands the commenters' concerns regarding costs to produce this data. As a result, and in the interest of maximizing cost effectiveness, particularly in the early phases of the database's implementation, the department makes reporting Medicare Supplement plan data voluntary by revising §21.5401(b)(9) and §21.5404(a). If the cost-benefit analysis for this data changes, the department may consider future amendments to the rules to require reporting of certain Medicare Supplement plan data.

Comment. A commenter supports the applicability of the rule to group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program, contained in §21.5401(b)(16). The commenter suggests keeping the direct reference to Chapter 172 entities to ensure the inclusion of their data.

Agency Response. The department agrees and believes retaining the language accomplishes the goal of the statute.

Comment. Three commenters request striking Medicare Advantage Plans from the list of plans subject to the rules. Two of the three commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts that the Legislature did not intend HB 2090 to apply to a policy where Medicare is the primary payor. The third commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan. Three commenters assert that because federal law dictates provider charges and benefits of Medicare Advantage Plans, the value of that data is limited. Two commenters assert that the data is not useful and will require extensive resources to produce. One commenter asserts that federal law precludes the department from requiring the submission of data, and another commenter expresses support for this assertion.

On the other hand, a fourth commenter indicates that a majority of other states' APCDs require Medicare Advantage Plan data while noting that, to the commenter's knowledge, there has been no litigation challenging the submission of claims from Medicare Advantage Plans. The commenter also asserts that the Legislature is aware of the principles of statutory construction and chose to exclude only "fully self-funded ERISA plans." The commenter says that if the Legislature had wanted to exclude a particular plan type from having to submit data to the APCD, it would have done so.

Agency Response. The department disagrees with the assertion that HB 2090's reporting requirements do not extend to payors providing Medicare Advantage Plans and that federal law precludes the state from requiring payors to submit data related to Medicare Advantage Plans. The department also believes Medicare Advantage Plan data is valuable. Thus, the department declines to make a change.

An entity defined as a "payor" by HB 2090 is required to submit claims data in accordance with that law. In Insurance Code §38.402(7), the Legislature defines "payor" broadly, including in the definition "an insurance company providing health . . . insurance" or "a health maintenance organization" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services, supplies, or devices to a patient. . . ." An entity providing a Medicare Advantage Plan meets that definition and thus is required to submit claims data as required by HB 2090 and these rules.

The department also does not believe that federal law precludes the mandatory submission of data for Medicare Advantage Plans. Standards established under 42 CFR part 422 generally govern Medicare Advantage Plans, and those standards supersede conflicting state laws and regulations. *See* 42 CFR §422.402 (Federal Preemption of State Law). But the proposed rules do not impact or change Medicare Advantage Plans' eligibility, enrollment, benefits, the payment of claims, or any other area governed by the federal standards in part 422. Also, under 42 USC §1395w-25, an organization providing Medicare Advantage Plans must be "organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage. . . ." Medicare Advantage Plans provide hospital and medical coverage similar to other major medical plans that are subject to reporting, and pay, reimburse, or otherwise contract with providers. The department also finds it noteworthy that other states' APCDs collect Medicare Advantage Plan data, and to date no parties have brought legal challenges against those states based on federal preemption arguments.

The department also believes that the collection of Medicare Advantage plan data is valuable, and the absence of such data would prevent the database from meeting the goals of the statute. The database aims to collect information on health care utilization,

access, outcomes, and quality across the Texas population--not just information on covered benefits and costs, and not just information on the commercial health insurance market.

Comment. Three commenters request striking Medicare Part D prescription drug benefit plans from the list of plans subject to the rules. Two commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts the Legislature did not intend to apply HB 2090 to a policy where Medicare is the primary payor. One commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan. Three commenters assert that because federal law dictates provider charges and benefits of Part D plans, the value of that data is limited. Two commenters assert that the data is not useful and will require extensive resources to produce. One commenter asserts that federal law precludes the department from requiring the submission of data. Another commenter expresses support for this federal preemption comment.

Agency Response. The department disagrees that HB 2090's reporting requirements do not extend to payors providing Medicare Part D prescription drug benefit plans and that federal law precludes the state from requiring payors to submit data related to Medicare Part D prescription drug benefit plans. The department also believes Medicare Part D prescription drug benefit plan data is valuable. Thus, the department declines to make a change.

An entity defined as a "payor" by HB 2090 is required to submit claims data in accordance with that law. In Insurance Code §38.402(7), the Legislature defines "payor"

broadly, including in the definition, "an insurance company providing health . . . insurance" or "a health maintenance organization" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services, supplies, or devices to a patient. . . ." An entity providing a Medicare Part D prescription drug plan meets that definition and thus is required to submit claims data as required by HB 2090 and these rules.

The department also does not believe that federal law precludes the mandatory submission of data for Medicare Part D plans. Standards established under 42 CFR part 423 generally govern Medicare Part D plans, and those standards supersede conflicting state laws and regulations. *See* 42 CFR §423.440(a) (Federal Preemption of State Law). But the proposed rules do not impact or change Medicare Part D plans' eligibility, enrollment, benefits, the payment of claims, or any other area governed by the standards in part 423. Also, under 42 USC §1395w-112, a sponsor of a Medicare Part D prescription drug plan must be "organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage. . . ."

The department also believes that the collection of Medicare Part D plan data is valuable, and the absence of such data would prevent the database from meeting the goals of the statute. Medicare Part D plans provide prescription drug coverage similar to other major medical plans that are subject to reporting. The database aims to collect information on health care utilization, access, outcomes, and quality across the Texas population--not just information on covered benefits and costs, and not just information on the commercial health insurance market.

Comment. A commenter requests changing the "or" to "and" in §21.5401(b)(23).

Agency Response. The department declines to make changes to the proposed rule in response to the comment. The language contained in §21.5401(b)(23) is consistent with the definition of "payor" in Insurance Code §38.402(7)(B).

Comment. Two commenters thank the department for specifying in §21.5401(c) that the rules apply only to the reporting of claims for applicable policies issued to Texas resident members.

Agency Response. The department thanks the commenters for the support and agrees that this clarification accomplishes the goal of the statute.

Comments on §21.5403

Comment. A commenter objects to the requirement in §21.5403(a) for payors to comply with a particular version of the Texas APCD CDL. The commenter asks the department to remove the specificity and allow the Center to select the version of the CDL with stakeholder input, asserting that "it is important for Texas to have the flexibility to change the version type without having to go through the entire rulemaking process."

Another commenter suggests limiting changes to the data submission guide and other sub-regulatory guidance to no more than once per year. The commenter also suggests making significant updates through statutory changes instead of rulemaking.

Agency Response. The department declines to make a change in response to either commenter. The department believes the level of specificity included in the Texas APCD CDL as adopted is currently appropriate, and that it was the Legislature's intent that any changes to it should be made through the rulemaking process under the Administrative Procedure Act to allow the public an opportunity to participate. *See* Tex. Ins. Code

§38.409(a). The Legislature delegated the responsibility to determine APCD data submission requirements to the department and the Center. *See id.* §38.404 and §38.409. Further, the adoption of the Texas APCD CDL by rule allows for more flexibility than relying only on statutory changes by the Legislature.

Comment. A commenter objects to the following required fields contained in the APCD CDL described in §21.5403:

- Employment Status (CDLME059)
- Payor Claim Control Number (CLDMC005, CDLPC005) and Claim Version Number (CDLM007, CDLPC007, CDLDC007)
- Sequence Number (CDLME015)
- Other Coverage Under This Plan (CDLME036, CDLME0387, CDLME039)

Agency Response. With respect to the Employment Status field, the department recognizes that the field is not relevant to dependents; however, the employment status of the subscriber provides important information. The Texas APCD CDL is modified to make this field required only if available and remove the threshold.

With respect to the Payor Claim Control Number fields and Claim Version Number fields, the department understands that some payors may have claims systems limitations that prevent the claims reported from fully meeting the requirements of the Texas APCD CDL. Nevertheless, the department believes that data files should contain a Payor Claim Control Number (PCCN) that applies to the entire claim and is unique within a payor's system. The PCCN should be consistent across claim versions and not used as a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. If possible, it is also

imperative that a reversal uses the same PCCN as the original paid claim. Payors that are unable to provide PCCNs that fully meet the requirements of the Texas APCD CDL should request a temporary exception as provided by §21.5405(d).

With respect to the Sequence Number field, the department understands that the sequence number representing the subscriber and dependents may change over time. The submission guide is modified to acknowledge this.

With respect to the Other Coverage Under This Plan field, the department makes no change in response to the comment. To clarify what information is sought, the three codes referenced are defined as indicators requiring "yes" or "no" as a response as to whether medical coverage, pharmacy coverage, or dental coverage is provided as part of the plan. The responses are expected to be from the perspective of the plan submitting the data. These fields do not seek information concerning other coverage provided by other payors.

Comments on §21.5404

Comment. A commenter recommends that the rules clarify in §21.5404(a) that the Texas Health and Human Services Commission (HHSC) may submit data to the APCD for CHIP, the STAR+PLUS Medicare-Medicaid Pilot program, and Medicaid managed care plans on behalf of all applicable payors.

Agency Response. The department agrees that submitting HHSC data for applicable payors who participate in these various plans or programs is appropriate and changes the relevant proposed language in §21.5404(a) from "may submit data on Medicaid managed care plans on behalf of all applicable payors" to "may submit data on behalf of all

applicable payors participating in a plan or program identified in §21.5401(b)(17) - (b)(20) of this title (relating to Applicability)."

Comment. Two commenters object to the written election in §21.5404(a) with respect to plans for which reporting is optional per Insurance Code §38.407. One commenter asserts that "the written opt-out election and response requirements" are in violation of federal law and U.S. Supreme Court decisions and would be subject to preemption, and the commenter urges the department to remove them. The second commenter asserts that the mandatory ask is in violation of state law by depriving the administrator of the ability to decide whether to submit data and suggests replacing "must ask the plan sponsor" with "may ask the plan sponsor."

A third commenter is grateful for the rules' inclusion of informing voluntary data reporters in §21.5404 but is understanding that this component may eventually be deleted.

Agency Response. The department disagrees with the first commenter's characterization of the proposed language as an "opt-out election" and notes that the statute provides otherwise-exempt payors the ability to opt in to submitting data to the APCD. The proposed language permitted, but did not require, a payor to submit data on behalf of a plan that is exempt from state regulation under ERISA. However, the department agrees that the language proposed by the second commenter is appropriate and adopts this revised language.

Comment. A commenter requests clarification that a payor may submit multiple zip files for its large data files instead of a single zip file as proposed in §21.5404(d).

Agency Response. The department agrees and changes the proposed language to accommodate this request.

Comment. A commenter objects to the inclusion of capitated claims data in §21.5404(h). The commenter asserts that "many claims processing systems are unable to provide useful data for claims subject to a capitation payment arrangement" and do not provide a "fee-for-service equivalent" for these capitated claims to be submitted with APCD data. The commenter requests the department to clarify that capitated claims are required only when estimates are available.

Agency Response. The department understands that reporting for claims subject to a capitation payment arrangement will look different from claims paid under a fee-for-service arrangement. Under the Texas APCD CDL, claims that are paid under capitation are identified under the Payment Arrangement Type fields. Within the Plan Paid Amount fields, the amount may be set to "0" for capitated claims. Under the Allowed Amount fields, the payor may also report "0." The description in the Texas APCD CDL is modified to remove the statement instructing payors to report the maximum amount contractually allowed.

Comment. Three commenters address the inclusion of denied claims as a data element described in §21.5404(i)(3), stating that collecting and submitting such data is burdensome, of low value, incomplete, or inaccurate. One of these commenters asserts that the requirement is not consistent with "the plain meaning of the intent of the reporting data base . . . to report paid claims" and says it should be deleted. Another commenter also says submission of data on denied claims should not be required, but

suggests using Claim Adjustment Reason Codes (CARCs) to clarify which types of "administrative denials" are to be included in the data reporting if any data is required for denied claims, and the commenter lists four CARCs that should be excluded.

One commenter asserts that "*some* denied claim information" contains valuable information worthy of inclusion in a payor's submission of data to the APCD. The commenter points out that the submission guide anticipates the exclusion of some fully denied claims, such as for a duplicate claim, but also that claims denied because the service or procedure is an uncovered benefit would be useful information for researchers.

Agency Response. The department understands the commenters' concerns and adopts changes to alleviate them. Section 21.2405(i)(3) is modified to clarify that denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. However, denied claims are required when they provide information that supports the objectives of the statute. For example, when a denied claim accurately reflects care that was provided, but that was not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. The submission guide is modified to identify the particular CARCs that must be submitted to the APCD. A claim or claim line may be omitted if it is denied using a CARC that has not been identified as required within the submission guide.

Comment. A commenter objects to the provision in §21.5404(l) requiring a payor to use the same unique qualifier for the member's entire period of coverage, even if the member's name, plan type, or other enrollment information changes, when the payor does not have that member's social security number. The commenter says this is not

feasible because of the variety of changes that might apply to a member, including name changes or movement between employers and plans. The commenter recommends that the rules require payors to use a unique member ID for a member's entire period of coverage under a particular plan.

Agency Response. The department agrees and makes the change requested to clarify that the requirement for a payor to provide documentation linking member IDs when the unique member ID changes is required only when such documentation is available.

Comments on §21.5405

Comment. A commenter suggests that the first monthly data collection described in §21.5405 not be due until June 1, 2023, to provide "more flexibility to ensure that this process is done correctly." Another commenter says the timeline is aggressive and suggests using the standard submission schedule of other states but does not explain what the standard schedule entails.

Agency Response. The department does not agree it is necessary to delay data reporting an additional 150 days. However, the department understands concerns regarding payors having sufficient time to submit the claims data required by the rule and adjusts the dates of the data collection as follows:

- the Center will provide notice of the timeline to submit registration and test data no later than 90 days before the data is due, and test data will be due no sooner than October 1, 2022;

- the Center will provide notice of the timeline for submitting historical data from January 1, 2019, to the most recent reporting period no later than 120 days before the data is due, and the historical data will be due no sooner than January 1, 2023; and

- the Center will provide notice of the timeline for submitting monthly data no later than 180 days before the commencement of the monthly data submission, and the initial monthly data submission will be due no sooner than March 1, 2023.

Comment. A commenter emphasizes the importance of obtaining historical data, as described in §21.5405(b)(2), to create a baseline of pre-COVID information. Another commenter notes that data older than three years may require additional work to access from payors' systems.

Agency Response. The department agrees that January 1, 2019, is appropriate and makes no changes to the language. In recognition of the time that will be needed for issuers to assemble the historical data reports, the department extends the timeline for submitting historical data, so that it will be required no sooner than January 1, 2023.

Comment. A commenter states appreciation for the submission extension for smaller carriers under §21.5405(c), but requests and recommends an exemption for smaller benefit plans from the rules instead. The commenter asserts that "requiring plans with less than 1,000 covered residents to submit data would be extremely burdensome and provide very little useful data." The commenter asserts that with such a small sample size, "the likelihood of them begin able to meet the CDL reporting thresholds drops significantly." A different commenter asserts that the exemption and modified timeline for small carrier submission in the proposed rules are workable solutions.

Agency Response. The department declines to make the first commenter's change. Reporting is required at the payor level, not at the plan level. HB 2090 does not exempt smaller plans from its data submission requirements. Further, the department believes the

data submission deadline extension in §21.5405(c) provides an adequate accommodation for small issuers.

Comment. A commenter requests the rules establish a presumption for the granting of a temporary exception or extension when requested by a payor under §21.5405(d) or (e), respectively.

Agency Response. The department understands the commenter's concerns and changes the language in proposed §21.5405(d) and (e) to address those concerns and provide details concerning when a request is deemed accepted or withdrawn and to provide a 14-day timeline for the Center to respond or request additional information.

Comment. A commenter recommends the rules require the Center to respond within 14 calendar days notifying a payor of acceptance, rejection, or other issues to allow the payor to correct any system issues going forward rather than having to spend limited resources recreating old submissions.

Agency Response. The department agrees and changes the language in proposed §21.5405(g) to provide a 14-day timeline for the Center to inform the payor of the data quality assessments and specify any required data corrections and resubmissions.

Comment on §21.5406

Comment. A commenter expresses appreciation for the inclusion of health insurance providers in the stakeholder advisory group established in §21.5406.

Agency Response. The department thanks the commenter and believes this accomplishes the goal of the statute.

SUBCHAPTER TT. ALL-PAYOR CLAIMS DATABASE
28 TAC §§21.5401 - 21.5406

STATUTORY AUTHORITY. The Commissioner adopts new §§21.5401 - 21.5406 under Insurance Code §§38.403, 38.404, 38.409, and 36.001.

Insurance Code §38.403 provides that members of the stakeholder advisory group serve fixed terms as prescribed by rules adopted by the Commissioner.

Insurance Code §38.404 provides that payors must submit the required data at a schedule and frequency determined by the Center and adopted by the Commissioner by rule.

Insurance Code §38.409 provides that the Commissioner adopt rules specifying the types of data a payor is required to provide to the Center and also specifying the schedule, frequency, and manner in which a payor must provide data to the Center.

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

TEXT.

§21.5401. Applicability.

(a) This subchapter applies to a payor that issues, sponsors, or administers a plan subject to reporting under subsection (b) of this section.

(b) Payors must submit data files as required by this subchapter with respect to each of the following types of health benefit plans or dental benefit plans issued in Texas:

(1) a health benefit plan as defined by Insurance Code §1501.002, concerning Definitions;

(2) an individual health care plan that is subject to Insurance Code §1271.004, concerning Individual Health Care Plan;

(3) an individual health insurance policy providing major medical expense coverage that is subject to Insurance Code Chapter 1201, concerning Accident and Health Insurance;

(4) a health benefit plan as defined by §21.2702 of this title (relating to Definitions);

(5) a student health plan that provides major medical coverage, consistent with the definition of student health insurance coverage in 45 CFR §147.145, concerning Student Health Insurance Coverage;

(6) short-term limited-duration insurance as defined by Insurance Code §1509.001, concerning Definition;

(7) individual or group dental insurance coverage that is subject to Insurance Code Chapter 1201 or Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance;

(8) dental coverage provided through a single service HMO that is subject to Chapter 11, Subchapter W, of this title (relating to Single Service HMOs);

(9) a Medicare supplement benefit plan under Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, if the payor elects to submit such data;

(10) a health benefit plan as defined by Insurance Code Chapter 846, concerning Multiple Employer Welfare Arrangements;

(11) basic coverage under Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act;

(12) a basic plan under Insurance Code Chapter 1575, concerning Texas Public School Employees Group Benefits Program;

(13) a health coverage plan under Insurance Code Chapter 1579, concerning Texas School Employees Uniform Group Health Coverage;

(14) basic coverage under Insurance Code Chapter 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System;

(15) a county employee health benefit plan established under Local Government Code Chapter 157, concerning Assistance, Benefits, and Working Conditions of County Officers and Employees;

(16) group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program;

(17) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program;

(18) a Medicaid managed care plan operated under Government Code Chapter 533, concerning Medicaid Managed Care Program;

(19) the child health plan program operated under Health and Safety Code Chapter 62;

(20) the health benefits plan for children operated under Health and Safety Code Chapter 63;

(21) a Medicare Advantage Plan providing health benefits under Medicare Part C as defined in 42 USC §1395w-21, *et seq*.;

(22) a Medicare Part D voluntary prescription drug benefit plan providing benefits as defined in 42 USC §1395w-101, *et seq*.; and

(23) a health benefit plan or dental plan subject to the Employee Retirement Income Security Act of 1974 (29 USC §1001 *et seq*.) if the plan sponsor or administrator elects to submit such data.

(c) Data files required by this subchapter must include information with respect to all Texas resident members, as defined in §21.5402(16) of this title. Information on persons who are not Texas resident members is not required.

§21.5402. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Allowed amount--Has the meaning assigned by Insurance Code §38.402, concerning Definitions.

(2) Center--The Center for Health Care Data at The University of Texas Health Science Center at Houston.

(3) Data--Has the meaning assigned by Insurance Code §38.402.

(4) Data files--Files submitted under this subchapter, including dental claims data files, enrollment and eligibility data files, medical claims data files, pharmacy claims data files, and provider files.

(5) Database--Has the meaning assigned by Insurance Code §38.402.

(6) Dental claims data file--A file that includes data as specified in the Texas APCD CDL about any dental claim or encounter for which some action has been taken on the claim during the reporting period, including payment, denial, adjustment, or other modification.

(7) Enrollment and eligibility data file--A file that provides identifying data as specified in the Texas APCD CDL about a person who is enrolled and eligible to receive health care coverage from a payor, whether or not the member used services during the reporting period, with one record per member, per month, per plan.

(8) Medical claims data file--A file that includes data as specified in the Texas APCD CDL about medical claims and other encounter information for which some action has been taken on the claim during the reporting period, including payment, denial, adjustment, or other modification.

(9) Payor--Has the meaning assigned by Insurance Code §38.402.

(10) Pharmacy claims data file--A file that includes data as specified in the Texas APCD CDL about all claims filed by pharmacies, including mail order and retail dispensaries, for prescriptions that were dispensed, processed, and paid during the reporting period.

(11) Provider file--A file that includes information as specified in the Texas APCD CDL about all providers (regardless of network status) that submitted claims that are included in the medical claims data file, dental claims data file, or pharmacy claims data file, with a separate record provided for each unique physical location for a provider who practices in multiple locations.

(12) Qualified research entity--Has the meaning assigned by Insurance Code §38.402.

(13) Stakeholder advisory group--Has the meaning assigned by Insurance Code §38.402.

(14) Submission guide--The document entitled "The Texas All-Payor Claims Database Data Submission Guide," created by the Center, that outlines administrative procedures and provides technical guidance for submitting data files.

(15) Texas APCD CDL--The standardized format, or common data layout (CDL), for All-Payor Claims Database (APCD) data files published by the Center and based on the "All-Payer Claims Database Common Data Layout" established by the National Association of Health Data Organizations and used with permission.

(16) Texas resident member--Any policyholder or certificate holder (subscriber) of a plan issued in Texas whose residence is within the state of Texas and all covered dependents, regardless of where the dependent resides.

§21.5403. Texas APCD Common Data Layout and Submission Guide.

(a) Payors must submit complete and accurate data files for all applicable plans as required by this subchapter and consistent with the Texas APCD CDL v1.09, released May 20, 2022. The Texas APCD CDL is available on the Center's website and:

(1) is modeled on the "All-Payer Claims Database Common Data Layout" published by the National Association of Health Data Organizations and used with permission;

(2) identifies which data elements payors are required to submit in each data file and which data elements are optional, consistent with Insurance Code §38.404(c), concerning Establishment and Administration of Database; and

(3) identifies the record specifications, definitions, code tables, and threshold levels for each required data element.

(b) The Center may issue technical guidance that provides flexibility regarding the existing requirements contained in the Texas APCD CDL, such as removing required data elements, clarifying specifications, increasing the maximum length, or decreasing the minimum threshold. However, such guidance may not modify statutory requirements, impose more stringent requirements, or increase the scope of the data being collected.

(c) The Center will establish, evaluate, and update data collection procedures within a submission guide, consistent with Insurance Code §38.404(f), concerning Establishment and Administration of Database. Notwithstanding subsection (b) of this section, in the event of an inconsistency between this subchapter and the submission guide, this subchapter controls.

§21.5404. Data Submission Requirements.

(a) Payors must submit the data files required by subsection (c) of this section to the Center according to the schedule provided in §21.5405 of this title (relating to Timing and Frequency of Data Submissions). Payors are responsible for submitting or arranging to submit all applicable data under this subchapter, including data with respect to benefits that are administered or adjudicated by another contracted or delegated entity, such as carved-out behavioral health benefits or pharmacy benefits administered by a pharmacy benefit manager. Payors may arrange for a third-party administrator or delegated or contracted entity to submit data on behalf of the payor, but may not submit data that duplicates data submitted by a third party.

(1) The Texas Health and Human Services Commission may submit data on behalf of all applicable payors participating in a plan or program identified in §21.5401(b)(17) - (b)(20) of this title (relating to Applicability).

(2) A payor that acts as an administrator on behalf of a health benefit plan or dental plan for which reporting is optional per Insurance Code §38.407, concerning Certain Entities Not Required to Submit Data, may ask the plan sponsor whether it elects or declines to participate in or submit data to the Center and may include data for such plans within the payor's data submission. Both the inquiry to and response from the plan sponsor should be in writing.

(3) A payor providing Medicare Supplement benefit plans may elect to submit Medicare Supplement benefit plan data to the Center.

(b) Payors or their designees must register with the Center each year to submit data, consistent with the instructions and procedures contained in the submission guide. Payors must communicate any changes to registration information by contacting the Center within 30 days using the contact information provided in the submission guide. Upon registration, the Center will assign a unique payor code and submitter code to be used in naming the data files and provide the credentials and information required to submit data files.

(c) Payors must submit the following files, consistent with the requirements of the Texas APCD CDL:

(1) enrollment and eligibility data files;

(2) medical claims data files;

(3) pharmacy claims data files;

(4) dental claims data files; and

(5) provider files.

(d) Payors must package all files being submitted into zip files that are encrypted according to the standard provided in the submission guide. Payors must submit the encrypted zip files to the Center using one of the following file submission methods:

(1) save the files on a Universal Serial Bus (USB) flash drive and use a secure courier to deliver the USB drive to the database according to delivery instructions provided in the submission guide;

(2) transmit the files to the Center's Managed File Transfer servers using the Secure File Transport Protocol (SFTP) and the credentials and transmittal information provided upon registration;

(3) upload files from an internet browser using the Hypertext Transfer Protocol Secure (HTTPS) protocol and the credentials and transmittal information provided upon registration; or

(4) transmit the files using a subsequent electronic method as provided in the data submission guide.

(e) Payors must name data files and zip files consistent with the file naming conventions specified by the Center in the submission guide.

(f) Payors must format all data files as standard 8-bit UCS Transformation Format (UTF-8) encoded text files with a ".txt" file extension and adhere to the following standards:

(1) use a single line per record and do not include carriage returns or line feed characters within the record;

(2) records must be delimited by the carriage return and line feed character combination;

(3) all data fields are variable field length, subject to the constraints identified in the Texas APCD CDL, and must be delimited using the pipe (|) character (ASCII=124), which must not appear in the data itself;

(4) text fields must not be demarcated or enclosed in single or double quotes;

(5) the first row of each data file must contain the names of data columns as specified by the Texas APCD CDL;

(6) numerical fields (e.g., ID numbers, account numbers, etc.) must not contain spaces, hyphens, or other punctuation marks, or be padded with leading or trailing zeroes;

(7) currency and unit fields must contain decimal points when appropriate;

(8) if a data field is not to be populated, a null value must be used, consisting of an empty set of consecutive pipe delimiters (||) with no content between them.

(g) Data files must include information consistent with the Texas APCD CDL that enables the data to be analyzed based on the market category, product category, coverage type, and other factors relevant for distinguishing types of plans.

(h) Payors must include data in medical, pharmacy, and dental claims data files for a given reporting period based on the date the claim is adjudicated, not the date of service associated with the claim. For example, a service provided in March, but adjudicated in April, would be included in the April data report. Likewise, any claim adjustments must be included in the appropriate data file based on the date the adjustment was made and include a reference that links the original claim to all subsequent actions associated with that claim. Payors must report medical, pharmacy, and dental claims data at the visit,

service, or prescription level. Payors must also include claims for capitated services with all medical, pharmacy, and dental claims data file submissions.

(i) Payors must include all payment fields specified as required in the Texas APCD CDL. With respect to medical, pharmacy, and dental claims data file submissions, payors must also:

(1) include coinsurance and copayment data in two separate fields;

(2) clearly identify claims where multiple parties have financial responsibility by including a Coordination of Benefits, or COB, notation; and

(3) include specified types of denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. The data submission guide will specify the types of denied claims that must be included on the basis of the claim adjustment reason code associated with the denial. In general, denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. Denied claims are required when they accurately reflect care that was delivered to an eligible member but not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. Payors are not required to include data for rejected claims or claims that are denied because the patient was not an eligible member.

(j) Every data file submission must include a control report that specifies the count of records and, as applicable, the total allowed amount and total paid amount.

(k) Unless otherwise specified, payors must use the code sources listed and described in the Texas APCD CDL within the member eligibility and enrollment data file and medical, pharmacy, and dental claims data file and provider file submissions. When

standardized values for data fields are available and stated within the Texas APCD CDL, a payor may not submit data that uses a unique coding system.

(l) Payors must use the member's social security number as a unique member identifier (ID) or assign an alternative unique member ID as provided in this subsection.

(1) If a payor collects the social security number for the subscriber only, the payor must assign a discrete two-digit suffix for each member under the subscriber's contract.

(2) If a payor does not collect the subscriber's social security number, the payor must assign a unique member ID to the subscriber and the member in its place. The payor must also use a discrete two-digit suffix with the unique member ID to associate members under the same contract with the subscriber.

(3) A payor must use the same unique member ID for the member's entire period of coverage under a particular plan. If a change in the unique member ID or the use of two different unique member IDs for the same individual is unavoidable, the payor must provide documentation, if available, linking the member IDs in the form and method provided by the Center.

(m) When standardized values for data variables are available and stated within the Texas APCD CDL, no specific or unique coding systems will be permitted as part of the health care claims data set submission.

(n) Within the enrollment and eligibility data files, payors must report member enrollment and eligibility information at the individual member level. If a member is covered as both a subscriber and a dependent on two different policies during the same month, the payor must submit two member enrollment and eligibility records. If a

member has two different policies for two different coverage types, the payor must submit two member enrollment and eligibility records.

(o) Payors must include a header and trailer record in each data file submission according to the formats described in the Texas APCD CDL. The header record is the first record of each separate file submission, and the trailer record is the last.

§21.5405. Timing and Frequency of Data Submissions.

(a) Payors must submit monthly data files according to the following schedule:

(1) January data must be submitted no later than May 7 of that year;

(2) February data must be submitted no later than June 7 of that year;

(3) March data must be submitted no later than July 7 of that year;

(4) April data must be submitted no later than August 7 of that year;

(5) May data must be submitted no later than September 7 of that year;

(6) June data must be submitted no later than October 7 of that year;

(7) July data must be submitted no later than November 7 of that year;

(8) August data must be submitted no later than December 7 of that year;

(9) September data must be submitted no later than January 7 of the following year;

(10) October data must be submitted no later than February 7 of the following year;

(11) November data must be submitted no later than March 7 of the following year; and

(12) December data must be submitted no later than April 7 of the following year;

(b) Except as provided in subsections (c) and (d) of this section, payors must submit test data files, historical data files, and monthly data files according to the dates specified by the Center, subject to the following requirements:

(1) the Center will provide notice of the timeline for payors to submit registration and test data no later than 90 days before the data is due, and test data will be due no sooner than October 1, 2022;

(2) the Center will provide notice of the timeline for submitting historical data, which must include data for reporting periods spanning from January 1, 2019, to the most recent monthly reporting period, no later than 120 days before the data is due, and historical data will be due no sooner than January 1, 2023; and

(3) the Center will provide notice of the timeline for submitting monthly data no later than 180 days before the commencement of the monthly data submission, and the first monthly data submission date will be no sooner than March 1, 2023.

(c) A payor with fewer than 10,000 covered lives in plans that are subject to reporting under this subchapter as of December 31 of the previous year must begin reporting no later than 12 months after the dates otherwise required, as specified by the Center, consistent with subsection (a) of this section. The payor must register with the Center to document the payor's eligibility for this extension.

(d) A payor may request a temporary exception from one or more requirements of this subchapter or the Texas APCD CDL by submitting a request to the Center no less than 30 calendar days before the date the payor is otherwise required to comply with the requirement. Except as provided in paragraph (2) of this subsection, the Center may grant an exception if the payor demonstrates that compliance would impose an unreasonable cost or burden relative to the public value that would be gained from full compliance.

(1) An exception may not last more than 12 consecutive months.

(2) An exception may not be granted from any requirement contained in Insurance Code Chapter 38, Subchapter I.

(3) The Center may request additional information from a payor in order to make a determination on an exception request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received.

(4) A request for an exception that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (3) of this subsection, the 14-day timeline begins the day after the payor submits such information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an exception may be deemed withdrawn by the Center at the end of the 14-day period.

(e) A payor that is unable to meet the reporting schedule provided by this section may submit a request for an extension to the Center before the reporting due date. The Center may grant a request for good cause at its discretion.

(1) The Center may request additional information from a payor in order to make a determination on an extension request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received.

(2) A request for an extension that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under

paragraph (1) of this subsection, the 14-day timeline begins the day after the payor submits such information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an extension may be deemed withdrawn by the Center at the end of the 14-day period.

(f) The Center will assess each data submission to ensure the data files are complete, accurate, and correctly formatted.

(g) The Center will communicate receipt of data within 14 calendar days, inform the payor of the data quality assessments, and specify any required data corrections and resubmissions.

(h) Upon receipt of a resubmission request, the payor must respond within 14 calendar days with either a revised and corrected data file or an extension request.

(i) If a payor fails to submit required data or fails to correct submissions rejected due to errors or omissions, the Center will provide written notice to the payor. If the payor fails to provide the required information within 30 calendar days following receipt of said written notice, the Center will notify the department of the failure to report. The department may pursue compliance with this subchapter via any appropriate corrective action, sanction, or penalty that is within the authority of the department.

§21.5406. Stakeholder Advisory Group Terms.

(a) Except as provided by subsections (b) and (c) of this section, members of the stakeholder advisory group designated under Insurance Code §38.403(b)(2) - (4), concerning Stakeholder Advisory Group, serve fixed terms of three years.

(b) Initial terms of the stakeholder advisory group will end December 31, 2024.

(c) Subsequent designations of the stakeholder advisory group will begin January 1, 2025, and will be staggered as follows:

(1) two members representing the business community, as provided by Insurance Code §38.403(b)(4)(A), and two members representing consumers, as provided by Insurance Code §38.403(b)(4)(B), with terms to expire December 31, 2026;

(2) the member designated by the Teacher Retirement System of Texas; two members representing hospitals, as provided by Insurance Code §38.403(b)(4)(C); and two members representing health benefit plan issuers, as provided by Insurance Code §38.403(b)(4)(D), with terms to expire December 31, 2027; and

(3) the member designated by the Employees Retirement System; two members representing physicians, as provided by Insurance Code §38.403(b)(4)(E); and two members not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices, or health benefit plans, as provided by Insurance Code §38.403(b)(4)(F), with terms to expire December 31, 2028.

(d) If a member does not complete the member's three-year term, a replacement member must be designated to complete the remainder of the term. A member designated by the Center to serve a partial term of less than two years will not be prevented from serving for an additional two consecutive terms.

(e) Except as provided by subsection (d) of this section, members designated by the Center under Insurance Code §38.403(b)(4) may not serve more than two consecutive terms.

(f) Members and prospective members of the stakeholder advisory group are subject to the conflicts of interest and standards of conduct provisions in paragraphs (1) - (4) of this subsection.

(1) A prospective member of the stakeholder advisory group must disclose to the designating entity any conflict of interest before being designated to the group.

(2) A member of the stakeholder advisory group must immediately disclose to the Center and the member's designating entity any conflict of interest that arises or is discovered while serving on the group.

(3) A conflict of interest means a personal or financial interest that would lead a reasonable person to question the member's objectivity or impartiality. An example of a conflict of interest is employment by or financial interest in an organization with a financial interest in work before the stakeholder advisory group, such as evaluating data requests from qualified research entities under Insurance Code §38.404(e)(2), concerning Establishment and Administration of Database.

(4) A member of the stakeholder advisory group must comply with Government Code §572.051(a), concerning Standards of Conduct; State Agency Ethics Policy, to the same extent as a state officer or employee.

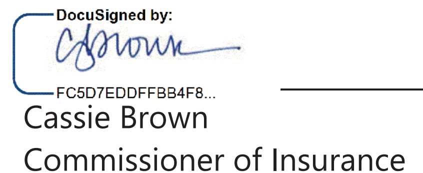
(g) A member may be removed from the stakeholder advisory group for good cause by the member's designating entity.

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 26, 2022.

Allison Eberhart, Deputy General Counsel
Texas Department of Insurance

The Commissioner adopts new 28 TAC §§21.5401 - 21.5406.



Cassie Brown
Commissioner of Insurance

Commissioner's Order No. **2022-7331**