SUBCHAPTER Z
DATA COLLECTING AND REPORTING RELATING TO
MANDATED HEALTH BENEFITS AND MANDATED OFFERS OF COVERAGE
28 TAC §§21.3401 – 21.3409

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC §§21.3401 – 21.3409, relating to the collecting and reporting of data relating to certain mandated health benefits and mandated offers of coverage, with changes to the proposed text published in the March 31, 2017, issue of the *Texas Register* (42 TexReg 1722). TDI adopts the amendments to §§21.3401, 21.3403, 21.3405, and 21.3407 – 21.3409 without changes to the proposed text. TDI adopts §§21.3402, §21.3404, and §21.3406 with nonsubstantive changes to the text as proposed.

TDI has revised the text as proposed to correct nonsubstantive typographical errors. In §21.3402(4), the word "be" in the phrase "Mandates for Which Data Must be Reported" has been capitalized, and the semicolon and the words "Mandated Benefits" have been deleted for consistency with TDI style for citation to Administrative Code sections. In §21.3402(5), the word "be" in the phrase "Mandates for Which Data Must be Reported" has been capitalized, and the semicolon and the words "Mandated Offers" have been deleted for consistency with TDI style for citation to Administrative Code sections. In §21.3404(b), the word "reports" is changed to "report."

REASONED JUSTIFICATION. The amendments are necessary because the list of mandated benefits and offers, and the types of information for which the rule requires data submission, has not been updated since TDI first adopted the rule in 2002. In addition, over time, it has become clear that the data collection process under the original rules has not yielded consistent and accurate information. The amendments require data on mandates that the agency believes are now useful; and the revised collection process will improve the accuracy and standardization of the data collected. The amendments are necessary to determine the impact of mandated benefits and mandated offers of coverage for which data collection and reporting is now required. The amendments also revise the reporting period to match the calendar year.

Section 21.3401 states the purpose of the rule and identifies the entities to which the rule applies. The amendments are necessary because of changes in the healthcare market and in the state's health insurance laws since the rule was initially adopted. The amendments require reporting entities to

report information separately for small group and large group coverages that meet the threshold of $10 million in reported direct premiums earned. Entities should report data on individual plans separately, and the reporting threshold for these plans is $10 million in reported direct premiums earned.

Section 21.3402 defines certain words and terms used in Subchapter Z. The amendments to §21.3402 are necessary to: clarify that TDI requires information on claims incurred and premiums earned; enable the reporting of additional and more uniform data that will be more useful to TDI and to the legislature; remove items that will no longer be reported; and to revise the reporting period to match the calendar year.

Section 21.3403 directs reporting entities to collect and report the information required by the rule. The amendments to this section conform the text of the section to TDI's current writing style and improve the rule's clarity.

Section 21.3404 establishes the rule's reporting periods and due dates. The amendments to this section allow reporting entities, after a conversion period, to report data one calendar year at a time, and to require the data be reported on June 1 of the following year.

Section 21.3405 lists certain exceptions to reporting requirements, and it requires reporting entities to provide justification for excluding otherwise required information. The amendments to this section conform the text of the section to TDI's current writing style to improve its clarity.

Section 21.3406 identifies the mandated benefits and mandated offers for which data must be reported. As amended, reporting entities must report data separately for small and large group plans. The mandates are listed in separate subsections, based on whether they are mandated benefits or mandated offers. Subsection (b) lists the mandated benefits for which data must be reported. Subsection (c) lists the mandated offers for which data must be reported.

Section 21.3407 requires that a reporting entity submit its report using the Mandated Benefits and Mandated Offers Reporting Form found on TDI's website. It also requires the reporting entity to use medical billing codes to identify applicable claims for each mandated benefit and mandated offer of coverage. As amended, the section requires the report to show, for all plans on which it is reporting, the total direct premiums earned instead of the total premiums written; the total claims incurred instead of the total claims paid; and the total member months. As amended, the section also requires that similar information to be reported for the mandated benefits and mandated offers. For example, the data

requirements include the number of individual claims incurred instead of the number of claims paid; and the total number of member months instead of the number of certificates, policies, or lives covered.

Section 21.3408 provides notice of possible penalties for noncompliance with the rule. The section is amended to conform the text of the section to TDI's current writing style to improve its clarity.

Section 21.3409 addresses severability of a section of the rule found invalid by a court of law. Amendments to this section conform the text of the section to TDI's current writing style to improve the rule's clarity.

SUMMARY OF COMMENTS. TDI did not receive any comments on the proposed amendments.

STATUTORY AUTHORITY. TDI adopts the amendments to 28 TAC §§21.3401 – 21.3409 under Insurance Code §38.252 and §36.001.

Insurance Code §38.252 directs the commissioner to require a health benefit plan issuer to collect and report cost and utilization data for mandated benefits and mandated offers designated by the commissioner; to adopt rules specifying which issuers must report data based on dollar amounts of premiums collected in Texas; and to specify the data to be collected, the dates of the reporting period and the report's submission, the detail and form of the report, and any other reasonable requirements necessary to determine the impact of those mandated benefits and mandated offers of coverage.

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.

SUBCHAPTER Z. DATA COLLECTING AND REPORTING RELATING TO MANDATED HEALTH BENEFITS AND MANDATED OFFERS OF COVERAGE

§21.3401. Purpose and Scope.

(a) Purpose of subchapter. The purpose of this subchapter is to require certain health benefit plan issuers to collect and report to the commissioner data on certain mandated health benefits and mandated offers of coverage.

(b) Scope of subchapter. This subchapter applies to a health benefit plan issuer that is subject to Insurance Code §38.251 (concerning Applicability), and that reports on its submission to the National Association of Insurance Commissioners (NAIC), for the year for which it is reporting data, a total of $10 million or more in direct premiums earned in Texas for individual comprehensive health coverage, small group comprehensive health coverage, or large group comprehensive health coverage.

(c) This subchapter does not apply to a governmental plan as defined by 29 U.S.C. § 1002(32).

§21.3402. Definitions.

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

(1) Claims incurred--Paid claims plus amounts held in reserve for claims that have been incurred but have not yet been paid.

(2) Direct premium--The amount of health premiums earned for comprehensive health coverage as reported on an issuer's submission to the NAIC for the year for which it is reporting data.

(3) Health benefit plan--A health benefit plan regulated under Insurance Code Title 8 (concerning Health Insurance and Other Health Coverages), Subtitles A (concerning Health Coverage in General), B (concerning Group Health Coverage), C (concerning Managed Care), D (concerning Provider Plans), and G (concerning Health Coverage Availability).

(4) Mandated benefit--A health benefit listed in §21.3406(b) of this title (relating to Mandates for Which Data Must Be Reported) that must be included in a health benefit plan.

(5) Mandated offer--An offer of coverage listed in §21.3406(c) of this title (relating to Mandates for Which Data Must Be Reported) that must be offered and made available to the holder or sponsor of an individual or group health benefit plan.

(6) Medical billing codes--Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and diagnosis-related group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the Current Procedural Terminology (CPT) code set maintained by the American Medical Association, and the International

Classification of Diseases (ICD) code sets developed by the World Health Organization. TDI's list of suggested mandated benefit codes is shown on its website, www.tdi.texas.gov.

(7) Member months--The cumulative number of months that all enrollees were covered during the reporting year.

(8) Reporting entity--A health benefit plan issuer or a third-party administrator that performs claims payment services for a health benefit plan issuer to which this subchapter applies.

(9) Reporting year--A one-year period, beginning each January 1 and ending the following December 31, for which health benefit plan issuers must collect the data required by §21.3407 of this title (relating to Reporting of Required Information).

(10) Third-party administrator--An administrator holding a certificate of authority under Insurance Code Chapter 4151 (concerning Third-Party Administrators).

§21.3403. Collection of Data Necessary to Provide Report.

A reporting entity must collect the data required by this subchapter for each mandated benefit and mandated offer listed in §21.3406 of this title (relating to Mandates for Which Data Must Be Reported) and must prepare and submit a report as required by §21.3407 of this title (relating to Reporting of Required Information).

§21.3404. Deadline for Submission of Reports.

(a) First reporting date. The first reporting date for the rule will be June 1, 2018, for data collected from January 1, 2017, through December 31, 2017. Subsequent annual reporting will follow this schedule.

(b) Submission of annual reports. A reporting entity must submit the report required by this subchapter no later than June 1 following the reporting year.

§21.3405. Exceptions to Required Reporting and Justification for Exceptions.

(a) Exceptions for confidential information. A reporting entity is not required to report data that:

(1) could reasonably be used to identify a specific enrollee; or

(2) violates confidentiality requirements of state or federal law or regulations applicable to an enrollee.

(b) Exceptions for certain HMOs. A reporting entity that is an HMO is not required to report data for a particular benefit or coverage if:

(1) the HMO does not directly process the claim because the services are prepaid under a capitated payment arrangement; or

(2) the HMO does not receive complete and accurate encounter data.

(c) Justification for exceptions. A reporting entity that does not report data for a reason listed in subsection (a) of this section must submit, in addition to the report required by this subchapter, an addendum containing:

(1) a general description of the type of data that has been omitted;

(2) the specific provision of each state or federal law or regulation that is the basis for its omission; and

(3) a certification that the data could not be identified in a way that would allow it to be included in the report without violating subsection (a) of this section.

(d) Addendum required. A reporting entity that omits data for a reason listed in subsection (b) of this section must submit, in addition to the report required by this subchapter, an addendum describing the arrangements or circumstances that except the reporting entity from reporting the data as required.

§21.3406. Mandates for Which Data Must Be Reported.

(a) Data to be reported separately. For all mandated benefits and mandated offers to be reported, a reporting entity must report separately its data for individual, small group, and large group health benefit plans.

(b) Mandated benefits. The following is a list of mandated benefits about which data relating to a health benefit plan must be filed under §21.3403 of this title (relating to Collection of Data Necessary to Provide Report):

(1) Certain Benefits Related to Acquired Brain Injury, Insurance Code §1352.003 and §1352.0035;

(2) Serious Mental Illness, Insurance Code §1355.004;

(3) Autism Spectrum Disorder, Insurance Code §1355.015;

(4) Low-Dose Mammography, Insurance Code §1356.005;

(5) Reconstructive Surgery Following Mastectomy, Insurance Code §1357.004;

(6) Diabetes Equipment, Supplies, and Self-Management Training, Insurance Code §1358.054;

(7) Formulas for Phenylketonuria (PKU) or Other Heritable Diseases, Insurance Code §1359.003;

(8) Temporomandibular Joint (TMJ) Diagnosis and Treatment, Insurance Code §1360.004;

(9) Osteoporosis, Detection and Prevention, Insurance Code §1361.003;

(10) Certain Tests for Detection of Prostate Cancer, Insurance Code §1362.003;

(11) Certain Tests for Detection of Colorectal Cancer, Insurance Code §1363.003;

(12) Childhood Immunizations, Insurance Code §1367.053;

(13) Hearing Screening for Children, Insurance Code §1367.103;

(14) Chemical Dependency Coverage, Insurance Code §§1368.004, 1368.005, and 1368.007;

(15) Prescription Contraceptive Drugs and Devices and Related Services, Insurance Code §1369.104;

(16) Certain Tests for Detection of Human Papillomavirus and Cervical Cancer, Insurance Code §1370.003;

(17) Certain Tests for Detection of Ovarian Cancer, Insurance Code §1370.003;

(18) Certain Tests for Early Detection of Cardiovascular Disease, Insurance Code §1376.003; and

(19) Certain Amino Acid-Based Elemental Formulas, Insurance Code §1377.051.

(c) Mandated offers. The following is a list of mandated offers about which data relating to a health benefit plan must be filed under §21.3403 of this title:

(1) Loss or Impairment of Speech or Hearing, Insurance Code §1365.003;

(2) In Vitro Fertilization Procedures, Insurance Code §1366.003; and

(3) Developmental Delays, Insurance Code §1367.204.

(d) Suggested procedure and diagnosis codes. TDI will provide on its website, www.tdi.texas.gov, suggested procedure and diagnosis codes that may be used in capturing the required data for the report. Regardless of whether a reporting entity uses the suggested codes or some other method of capturing the required information, each reporting entity must maintain information

and documentation supporting the accuracy and completeness of its data and the report, including, but not limited to, a list of all procedural and diagnosis codes used in collecting data for the report for five years following the submission of the report on which the information was based. On receiving a request from TDI, a reporting entity must make available the supporting information described in this subsection.

§21.3407. Reporting of Required Information.

(a) Reporting data. A reporting entity must submit the data required by this section electronically by completing the Mandated Benefits and Mandated Offers Reporting Form found on TDI's website, www.tdi.texas.gov. A reporting entity must use medical billing codes to identify applicable claims for each mandated benefit and mandated offer of coverage.

(b) Issuer's information. For each reporting year, a reporting entity must provide the following information:

(1) the year for which the data is being reported;

(2) the health benefit plan issuer's NAIC Number;

(3) the health benefit plan issuer's name;

(4) the health benefit plan issuer's mailing address;

(5) the issuer type (insurance or HMO);

(6) whether a third-party administrator is submitting the report;

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

(8) whether the contact person's email address can be released;

(9) the submission date; and

(10) whether the health benefit plan issuer meets the reporting threshold for each reporting category (individual, small group, and large group).

(c) Reporting for all covered benefits. For each reporting year, a reporting entity must provide, for all covered comprehensive health benefit plans subject to mandated benefits and mandated offers, the following aggregated data:

(1) the total direct premiums earned;

(2) the total dollar amount of the claims incurred; and

(3) the total member months.

(d) Reporting for all mandated benefits and mandated offers. For each reporting year, a reporting entity must provide the following information for each of the mandated benefits and mandated offers listed in §21.3406 of this title (relating to Mandates for Which Data Must Be Reported), aggregated separately by individual, small group, and large group health benefit plans:

(1) the total dollar amount of the claims incurred;

(2) the total number of individual claims incurred; and

(3) the total member months.

(e) Additional reporting data. A reporting entity must provide the following information:

(1) the medical billing codes used to capture the required data for the report;

(2) any additional information the reporting entity believes is pertinent to the data being reported, if applicable; and

(3) the certification on the data collection form.

§21.3408. Compliance.

A reporting entity that fails to comply with this subchapter will be subject to the sanctions and penalties provided in Insurance Code Chapters 82 (concerning Sanctions), 83 (concerning Emergency Cease and Desist Orders), 84 (concerning Administrative Penalties), 601 (concerning Privacy), and 602 (concerning Privacy of Health Information).

§21.3409. Severability.

If a court holds invalid any section or portion of a section of this subchapter or holds invalid its applicability to any person or circumstance, the remainder of the subchapter or the applicability of the provision to other persons or circumstances will not be affected.

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 June 15, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance

The Texas Department of Insurance adopts amendments to §§21.3401 – 21.3409.

Kevin Brady
Deputy Commissioner of Agency Affairs
Texas Department of Insurance
Delegation Order 4506

COMMISSIONER'S ORDER NO. **2017-5113**