SUBCHAPTER OO. DISCLOSURES BY OUT-OF-NETWORK PROVIDERS
28 TAC §21.4901 and §21.4903

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
DIVISION 1. GENERAL PROVISIONS
28 TAC §21.5002 and §21.5003

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC §21.4901 and §21.4903, concerning disclosures by out-of-network providers, and 28 TAC §21.5002 and §21.5003, concerning out-of-network claim dispute resolution. The amendments to §21.4901 and §21.4903 are adopted without changes to the proposed text published in the October 22, 2021, issue of the *Texas Register* (46 TexReg 7191). The amendments to §21.5002 and §21.5003 are adopted with nonsubstantive changes to the proposed text.

REASONED JUSTIFICATION. The amendments to §§21.4901, 21.4903, 21.5002, and 21.5003 are necessary to implement House Bill 3924, 87th Legislature, 2021, and Insurance Code Chapter 1275. HB 3924 allows a nonprofit agricultural organization under Chapter 1682 to offer a health benefit plan. These health benefit plans are subject to the requirements of Insurance Code Chapter 1275, which creates similar requirements for out-of-network billing that already exist for Health Maintenance Organization (HMO) and Preferred Provider Benefit (PPO) plans, as well as for health benefit plans administered by Employees Retirement System of Texas (ERS) and Teacher Retirement System of Texas (TRS) plans under Insurance Code Chapters 1551, 1575, and 1579.

The amendments to the sections are described in the following paragraphs.

Section 21.4901. The amendment to §21.4901 adds citations to Insurance Code §1275.052 and §1275.053 to the list of Insurance Code sections interpreted and implemented by 28 TAC Chapter 21, Subchapter OO. These Insurance Code sections, which address out-of-network facility-based provider payments and out-of-network diagnostic imaging provider or laboratory service provider payments, respectively, are similar to the parallel sections in the rule that refer to requirements for HMO, PPO, TRS, and ERS plans.

Section 21.4903. The amendment to §21.4903 adds citations to Insurance Code §1275.052 and §1275.053 to the list of sections addressed in the explanation of the meaning of "balance bill" for the purposes of the section.

Section 21.5002. The amendment to §21.5002 adds new Insurance Code Chapter 1682 to the scope of the subchapter. Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Chapter 1275 applies, and the administrator of a health benefit plan to which this chapter applies is an administrator for purposes of Chapter 1467. Nonsubstantive changes are made to conform to current TDI language preferences and drafting practices. The changes replace parentheses with commas for Insurance Code "concerning" information text, and replace some commas with semicolons to separate that information where lists occur.

Section 21.5003. The amendments to §21.5003 modify the definition of "administrator" and "health benefit plan" to include plans offered under Chapter 1682, to conform with HB 3924. Nonsubstantive changes are made to conform to current TDI language preferences and drafting practices. The changes replace parentheses with commas for Insurance Code "concerning" information text, and replace some commas with semicolons to separate that information where lists occur.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenter: One commenter, the Texas Medical Association, states its support of the proposal with changes.

Comment on §21.4902

Comment. A commenter suggests adding definitions of "administrator" and "health benefit plan" to Subchapter OO, §21.4902. The commenter states that the addition will clarify the application of the rules.

Agency Response. The department declines to make the suggested amendments to §21.4902. The rule proposal did not include amendments to §21.4902, thus the suggested changes are outside the scope of this rule adoption.

Comment on §21.5001 and §21.5040

Comment. The commenter suggests incorporating the balance billing prohibition notice under Insurance Code §1275.003 into §21.5001 and §21.5040.

Agency Response. The department declines to make the suggested amendments to §21.5001 and §21.5040. The rule proposal did not include amendments to §21.5001 and §21.5040, thus the suggested changes are outside the scope of this rule adoption.

Comment on §21.5002

Comment. A commenter suggests amending §21.5002(c) to reflect that HB 3924 became effective September 1, 2021.

Agency Response. The department declines to make the suggested change. Since the health benefits offered by certain nonprofit agricultural organizations were not available in Texas until HB 3924 went into effect, there would be no applicable claims for the period before the 2019 amendments to the subchapter. Therefore, the proposed change is unnecessary.

STATUTORY AUTHORITY. The Commissioner of Insurance adopts amendments to §21.4901 and §21.4903 under Insurance Code §§1275.004, 1467.003, and 36.001.

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

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

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

SUBCHAPTER OO. DISCLOSURES BY OUT-OF-NETWORK PROVIDERS
28 TAC §21.4901 and §21.4903

TEXT.

§21.4901. Purpose and Applicability.

(a) The purpose of this subchapter is to interpret and implement Insurance Code §§1271.157, 1271.158, 1275.052, 1275.053, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111; and Insurance Code Chapter 1467.

(b) Section 21.4903 of this title is only applicable to a covered nonemergency health care or medical service or supply provided by:

(1) a facility-based provider that is not a participating provider for a health benefit plan, if the service or supply is provided at a health care facility that is a participating provider; or

(2) a diagnostic imaging provider or laboratory service provider that is not a participating provider for a health benefit plan, if the service or supply is provided in connection with a health care or medical service or supply provided by a participating provider.

§21.4903. Out-of-Network Notice and Disclosure Requirements.

(a) For purposes of this section a "balance bill" is a bill for an amount greater than an applicable copayment, coinsurance, and deductible under an enrollee's health benefit plan, as specified in Insurance Code §§1271.157(c), 1271.158(c), 1275.052(c), 1275.053(c), 1301.164(c), 1301.165(c), 1551.229(c), 1551.230(c), 1575.172(c), 1575.173(c), 1579.110(c), or 1579.111(c).

(b) An out-of-network provider may not balance bill an enrollee receiving a nonemergency health care or medical service or supply, and the enrollee does not have financial responsibility for a balance bill, unless the enrollee elects to obtain the service or supply from the out-of-network provider knowing that the provider is out-of-network and the enrollee may be financially responsible for a balance bill. An enrollee's legal

representative or guardian may elect on behalf of an enrollee. For purposes of this subsection, an enrollee elects to obtain a service or supply only if:

(1) the enrollee has a meaningful choice between a participating provider for a health benefit plan issuer or administrator and an out-of-network provider. No meaningful choice exists if an out-of-network provider was selected for or assigned to an enrollee by another provider or health benefit plan issuer or administrator;

(2) the enrollee is not coerced by a provider or health benefit plan issuer or administrator when making the election. A provider engages in coercion if the provider charges or attempts to charge a nonrefundable fee, deposit, or cancellation fee for the service or supply prior to the enrollee's election; and

(3) the out-of-network provider or the agent or assignee of the provider provides written notice and disclosure to the enrollee and obtains the enrollee's written consent, as specified in subsection (c) of this section.

(c) If an out-of-network provider elects to balance bill an enrollee, rather than participate in claim dispute resolution under Insurance Code Chapter 1467 and Subchapter PP of this title, the out-of-network provider or agent or assignee of the provider must provide the enrollee with the notice and disclosure statement specified in subsection (e) of this section prior to scheduling the nonemergency health care or medical service or supply. To be effective, the notice and disclosure statement must be signed and dated by the enrollee no less than 10 business days before the date the service or supply is performed or provided. The enrollee may rescind acceptance within five business days from the date the notice and disclosure statement was signed, as explained in the notice and disclosure statement form.

(d) Each out-of-network provider, or the provider's agent or assignee, must maintain a copy of the notice and disclosure statement, signed and dated by the enrollee, for four years if the medical service or supply is provided and a balance bill is sent to the enrollee. The provider must provide the enrollee with a copy of the signed notice and disclosure statement on the same date the statement is received by the provider.

(e) The department adopts by reference Form AH025 as the notice and disclosure statement to be used under this section. The notice and disclosure statement may not be modified, including its format or font size, and must be presented to an enrollee as a stand-alone document and not incorporated into any other document. The form is available from the department by accessing its website at www.tdi.texas.gov/forms.

(f) A provider who seeks and obtains an enrollee's signature on a notice and disclosure statement under this section is not eligible to participate in claim dispute resolution under Insurance Code Chapter 1467 and Subchapter PP of this title. This subsection does not apply if the election is defective as described by subsection (b) of this section or rescinded by the enrollee under subsection (c) of this section.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
DIVISION 1. GENERAL PROVISIONS
28 TAC §21.5002 and §21.5003

STATUTORY AUTHORITY. The Commissioner of Insurance adopts amendments to §21.5002 and §21.5003 under Insurance Code §§1275.003, 1275.004, 1467.003, and 36.001.

Insurance Code §1275.003 provides that the Commissioner adopt rules advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

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

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

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

TEXT.

§21.5002. Scope.

(a) This subchapter applies to a qualified mediation claim or qualified arbitration claim filed under health benefit plan coverage:

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

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations; or

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

(b) This subchapter does not apply to a claim for health benefits that is not a covered claim under the terms of the health benefit plan coverage.

(c) Except as provided in §21.5050 of this title (relating to Submission of Information), this subchapter applies to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2020. A claim for health care or medical services or supplies provided before January 1, 2020, is governed by the rules in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose.

§21.5003. Definitions.

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

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes a nonprofit agricultural organization under Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, offering a health benefit plan.

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

(3) Claim--A request to a health benefit plan for payment for health benefits under the terms of the health benefit plan's coverage, including emergency care, or a health care or medical service or supply, or any combination of emergency care and health care or medical services and supplies, provided that the care, services, or supplies:

(A) are furnished for a single date of service; or

(B) if furnished for more than one date of service, are provided as a continuing or related course of treatment over a period of time for a specific medical problem or condition, or in response to the same initial patient complaint.

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

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

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

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

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

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

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

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

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

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

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

(12) Insurer--A life, health, and accident insurance company; health insurance company; or other company operating under: Insurance Code Chapters 841, concerning Life, Health, or Accident Insurance Companies; 842, concerning Group Hospital Service Corporations; 884, concerning Stipulated Premium Insurance Companies; 885, concerning Fraternal Benefit Societies; 982, concerning Foreign and Alien Insurance Companies; or 1501, concerning Health Insurance Portability and Availability Act, that is authorized to issue, deliver, or issue for delivery in this state a preferred provider benefit plan, including an exclusive provider benefit plan, under Insurance Code Chapter 1301.

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

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

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

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

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

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 January 31, 2022.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 TAC §§21.4901, 21.4903, 21.5002, and 21.5003.

DocuSigned by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. **2022-7198**