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 Texas Department of Insurance proposes 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 implement House Bill 3924, 87th Legislature, 2021.

EXPLANATION. The amendments to §§21.4901, 21.4903, 21.5002, and 21.5003 are necessary to implement HB 3924 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 create similar requirements for out-of-network billing that already exist for Health Maintenance Organizations (HMOs) and Preferred Provider Benefit Plans (PPOs), 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 proposed 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 HMOs and PPOs, and 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 that chapter.

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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Cindy Wright, director of Consumer Protection and Services, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections other than that imposed by the statute. Ms. Wright made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Wright does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Wright expects that administering the proposed amendments will have the public benefit of ensuring that the department's rules conform to HB 3924 and Insurance Code Chapter 1275, allowing for the mediation and arbitration of certain out-of-network health claims.

Ms. Wright expects that the proposed amendments will not increase the costs of compliance with Insurance Code Chapter 1275 or 1467 because they do not impose requirements beyond those in the statute. Insurance Code Chapter 1275 requires out-of-network claim dispute resolution for plans offered by nonprofit agricultural organizations under Insurance Code Chapter 1682. As a result, the costs associated with complying with the process do not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. Because the proposed amendments are designed to implement Insurance Code §§1275.003, 1275.004, 1275.051, 1275.052, and 1275.053, any economic impact results from the statute itself. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does not impose possible costs on regulated persons. No additional rule amendments are required under Government Code §2001.0045 because all possible costs would result from the statute, and these amendments are

necessary to implement legislation. The proposed amendments implement Insurance Code §§1275.003, 1275.004, 1275.051, 1275.052, and 1275.053.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed amendments are in effect, the proposed amendments:

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will not create a new regulation;
- will expand, limit, or repeal an existing regulation;
- will increase the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., central time, on November 22, 2021. Send your comments to ChiefClerk@tdi.texas.gov or to the

Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on November 22, 2021. If the department holds a public hearing, the department will consider written comments received and those presented at the hearing.

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

STATUTORY AUTHORITY. The department proposes 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.

CROSS-REFERENCE TO STATUTE. Section 21.4901 and §21.4903 implement Insurance Code §§1275.004, 1275.052 and 1275.053.

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) - (f) No change.

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STATUTORY AUTHORITY. The department proposes 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 this chapter applies is an administrator for purposes of that chapter.

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.

CROSS-REFERENCE TO STATUTE. Section 21.5002 and §21.5003 implement Insurance Code §1275.004.

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), [~~or~~] 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 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;

(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, 1575, [~~or~~] 1579, 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 proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas, on October 8, 2021.

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Allison Eberhart
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Allison Eberhart
Deputy General Counsel
Texas Department of Insurance