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

INTRODUCTION. The Texas Department of Insurance proposes new 28 TAC Chapter 21, Subchapter TT, consisting of §§21.5401 - 21.5406, concerning the all-payor claims database. These sections implement House Bill 2090, 87th Legislature, 2021, which amended the Texas Insurance Code by adding Chapter 38, Subchapter I, concerning Texas All Payor Claims Database.

EXPLANATION. 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 department to collaborate with the Center for Healthcare 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 specifying the types of data a payor is required to provide; detailing the schedule, frequency, and manner of data submission; and establishing oversight and enforcement mechanisms.

The department received comments on an informal draft posted on the department's website on November 12, 2021. The department considered those comments when drafting this proposal.

The proposed new sections are described in the following paragraphs.

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 invites 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 notwithstanding language in Texas Local Government Code §§157.008(2) and 172.014 limiting the applicability of the Insurance Code to and the department's authority over such plans. *See* Tex. Att'y Gen. Op. No. GA-0047 (2003) at 1 (A "risk pool [under Chapter 172 of the Local Government Code] is subject to an Insurance Code provision that expressly encompasses a risk pool."). The department received a comment on this subject on the informal draft which noted that the filed version of HB 2090 expressly referenced those types of plans, but that reference was removed by the author in a floor amendment. The commenter believed that action indicated a legislative intent not to extend the applicability of HB 2090 to those types of plans. However, the portion of the bill from which those references were deleted did not concern the All Payor Claims Database. *See* H.J. of Tex., 87th Leg., R.S., 1056 (2021). Therefore, it is not relevant in determining the proper scope of this rulemaking, so the department seeks additional comments on this issue.

New §21.5401 also specifies that the data required by new Subchapter TT is limited to Texas resident members.

Section 21.5402. New §21.5402 provides definitions of terms used throughout the new rules, including various types of data files.

Section 21.5403. New §21.5403 describes the database's common data layout 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.

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 identification numbers to be used with the submission and naming of data. It also prohibits the submission of duplicate data submitted by a third party and requires certain payors to ask sponsors of health benefit plans referenced in Insurance Code §38.407 whether they will voluntarily submit plan data.

The new section lists the data files that must be submitted consistent with the requirements of the Texas All-Payor Claims Database (APCD) common data layout (CDL), including standardized values and code sources. It requires files to include information that enables the data to be separated based on 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.

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.

Section 21.5405. New §21.5405 describes the timing and frequency of the required data submissions, with schedules provided for each month. It also directs payors to submit test data, historical data, and monthly data based on notice provided by the Center and no sooner than January 1, 2023, for monthly data. 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.

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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the proposed new sections are in effect, there may be a fiscal impact on state and local governments that administer health benefit plans that are subject to reporting data to the APCD as directed by the statute. Based on the definition of "payor" in Insurance Code §38.402(7)(E), health benefit plans offered or administered by or on behalf of the state or a political subdivision are subject to requirements in Insurance Code Chapter 38, Subchapter I, and these proposed rules. The proposal clarifies in §21.5401(b)(11)-(20) the types of state and local governmental plans that are subject to reporting. Ms. Bowden has determined that state and political subdivisions will face the same potential costs as other payors. Those costs are explained in the Public Benefit and Cost Note. Most state agencies and political subdivisions offer plans that are administered by an insurance company or other third-party administrator. The costs for complying with the rules will vary depending on the technology and data systems of the administrator, and their experience reporting to APCDs in other states. While much of the costs are attributable directly to the statute, the specific data elements and reporting standards proposed in the Texas APCD CDL may create additional costs.

Ms. Bowden 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 new sections are in effect, Ms. Bowden expects that administering and enforcing the proposed sections will have the public benefit of ensuring that the department's rules properly implement new Insurance Code Chapter 38, Subchapter I, which increases public transparency of health care information and enables research aimed at improving the quality of health care provided in this state.

Ms. Bowden expects that the proposed new sections will impose an economic cost on persons required to comply. The cost will vary based on each payor's data systems, staffing strategies, whether the payor offers medical or dental coverage, and whether a payor has experience reporting to an all-payor claims database in one or more other states.

Ms. Bowden expects there will be no costs added by new proposed §§21.5401 - 21.5402, which describe the applicability of the rules and definitions, respectively.

Costs may result from requirements to collect and submit data as required in proposed new §§21.5403 - 21.5405, which describe the common data layout, establish data submission requirements, and set the timing and frequency of data submissions, respectively. The statute specifies a particular set of information that must be collected at a minimum. To meet that minimum standard and achieve the legislation's desired result espoused in Insurance Code §38.404(c), the proposed rules define and identify more detailed data elements payors must submit. As the work needed to gather and report these data elements occurs simultaneously, TDI is unable to separate the costs for reporting data elements required by the rules from data elements required by the statute. Therefore, the summary below reflects TDI's estimate of the initial costs to assemble data files containing all required data elements.

Cost of personnel associated with programming information systems for data collection. The United States Department of Labor, Bureau of Labor Statistics May 2020

State Occupational Employment and Wage Estimates for Texas indicates that the hourly mean wage for computer programmers is $49.35 (www.bls.gov/oes/current/oes_tx.htm#15-0000). TDI recognizes that costs will vary depending on each payor's data systems and staffing strategies. For large carriers that are already delivering APCD data to other states and have existing operational monitoring in place, costs are expected to be minimal. Ms. Bowden estimates a one-time requirement of between 16 and 36 hours to complete the programming needed to assemble the required data files and conduct testing. Small carriers that have no APCD experience may have limited infrastructure for creating data extracts and will require a thorough testing program to validate the initial data submission. Ms. Bowden estimates that for these carriers, it will require between 112 and 240 hours to complete the programming and testing needed for the initial data submission. There is not expected to be a cost impact for payors offering Medicaid managed care plans or child health plans, as they already submit data to the Texas Health and Human Services Commission (HHSC). HHSC has indicated that they will report APCD data on behalf of those payors.

Proposed §21.5405(b)(2) requires payors to submit historical data files dating back to January 1, 2019. To the extent that payors' systems archive older data, such as data older than three years, additional work may be required to access those historical data files. Ms. Bowden estimates a one-time requirement of between 8 and 40 hours for a computer programmer to extract the historical data files.

Costs related to the frequency of data submission. Insurance Code §38.409(a)(2) requires the submission of data not less frequently than quarterly, but the proposed rules require monthly data submissions. Any costs associated with more frequent submissions is expected to be offset by decreased costs associated with transmitting smaller data files.

Ms. Bowden expects there will be no cost added by proposed §21.5406, which outlines appointment standards for the stakeholder advisory committee.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed new sections will not have an adverse economic effect on rural communities, but it may have an adverse economic effect on small or micro businesses, to the extent that they are subject to reporting data to the APCD. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to these small and micro businesses. The department estimates that between 3 and 15 payors that are small or micro businesses may be required to report data to the APCD.

The primary objective of this proposal is to support the establishment of an APCD that increases transparency of health care costs, utilization, and access across all payors in Texas and includes information useful for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. TDI considered the following options to minimize any adverse effect on small and micro businesses while accomplishing the proposal's objectives: (1) exempting payors from reporting if they are small or micro businesses or based on a minimum threshold of covered lives; (2) requiring payors that are small or micro businesses to report fewer data elements; and (3) providing additional time to comply with the rules for payors that are small or micro businesses or based on a minimum threshold of covered lives.

In considering Option 1, TDI declined to provide an exemption for payors that are small or micro businesses because such an exemption is not supported by the statute. As stated in the cost note, the statute specifies a particular set of information that must be collected at a minimum. TDI does not have authority to exempt small or micro businesses from the collection of some of the data, and without the guidance provided by these rules, small or micro businesses would have a more difficult time complying with the requirements of the statute and might not provide usable data.

In regard to Option 2, the department believes an incomplete dataset would provide little value to researchers and would not have satisfied the purpose of the statute. However, the proposal does authorize the Center to grant temporary exceptions for issuers that are unable to comply with certain reporting requirements. Such exceptions may be granted if compliance would impose an unreasonable cost relative to the public value that would be gained from full compliance. This will provide flexibility, particularly for smaller issuers, if any element of the common data layout not required by statute or other rule requirement imposes undue costs, or if a small or micro business needs more time to fully comply with the rule.

After considering Option 3, TDI opted to provide additional implementation time based on the number of lives covered by the payor in plans subject to reporting. This will mitigate the costs required to implement the rule by allowing eligible payors to spread those costs over a longer timeframe. This may further reduce costs by enabling payors to implement the requirements without hiring additional staff. This flexibility will be available to all payors with fewer than 10,000 covered lives in plans that are subject to reporting, including small and micro businesses. This is a metric that can be validated by the department and ensures that high-value datasets are not delayed.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does impose a possible cost on regulated persons. However, no additional rule amendments are required under Government Code §2001.0045 because the proposed new sections are necessary to implement legislation. The proposed rules implement Insurance Code Chapter 38, Subchapter I, as added by HB 2090.

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

- 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 create a new regulation;
- will not expand, limit, or repeal an existing regulation;
- will increase the number of individuals subject to the rules' 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 May 9, 2022. 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.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2830 at 9:30 a.m., central time, on Wednesday, May 4, 2022, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

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STATUTORY AUTHORITY. The department proposes §§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.

CROSS-REFERENCE TO STATUTE. Section 21.5401 implements Insurance Code §38.402 and §38.407. Section 21.5406 implements Insurance Code §38.403. Sections 21.5403 - 21.5405 implement Insurance Code §38.404 and §38.409.

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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;

(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 Healthcare 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 v1.08, released January 21, 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. The Texas Health and Human Services Commission may submit data on Medicaid managed care plans on behalf of all applicable payors. 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, must ask the plan sponsor in writing 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. A response from the plan sponsor should be in writing.

(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 a single zip file that is encrypted according to the standard provided in the submission guide. Payors must submit the encrypted zip file to the Center using one of the following file submission methods:

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

(2) transmit the file 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 filing 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 denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. When a claim contains both fully processed or paid service lines and partially processed or denied service lines, the payor must include all service lines as part of the claims data file. 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 members' 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 with that payor. A payor must use the same unique member ID, even if the member's name, plan type, or other enrollment information changes. 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 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;

(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

(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 January 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.

(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.

(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, 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 proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas, on March 25, 2022.

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