SUBCHAPTER B. ADVERTISING, CERTAIN TRADE PRACTICES, AND SOLICITATION

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INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§21.113, 21.2505, 21.4902, 21.5001, 21.5002, 21.5010, 21.5011, 21.5020, 21.5021, and 21.5040. The amendments to these sections remove or update outdated TDI contact information and implement Senate Bill 1264, 86th Legislature, 2019; House Bill 3924, 87th Legislature, 2021; and Insurance Code Chapters 1275 and 1467. TDI also proposes to repeal Chapter 21, Subchapter QQ, because the Insurance Code provision this subchapter implemented expired in 2012.

EXPLANATION. The proposed amendments to §§21.4902, 21.5001, 21.5002, and 21.5040 are necessary to implement HB 3924 and Insurance Code Chapter 1275. HB 3924 permits a nonprofit agricultural organization under Insurance Code 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 HMOs and Preferred Provider Benefit Plans, as well as for health benefit plans administered by Employees Retirement Systems of Texas and Teacher Retirement System of Texas plans under Insurance Code Chapters 1551, 1575, and 1579. The proposed amendments clarify the applicability of Subchapters OO and PP to health benefit plans offered by nonprofit agricultural organizations.

The proposed amendments to §§21.5010, 21.5011, 21.5020, and 21.5021 are necessary to implement SB 1264 and Insurance Code Chapter 1467. SB 1264 prohibits balance billing for certain health benefit claims under certain health benefit plans, provides exceptions to balance billing prohibitions, and authorizes an independent dispute resolution process for claim disputes between certain out-of-network providers and health benefit plan issuers and administrators. The proposed amendments clarify the independent dispute resolution requirements to ensure efficient processing of mediation and arbitration of claims.

The proposed amendments to §21.113 and §21.2505 are necessary to remove outdated TDI mailing addresses.

The proposed amendments also make nonsubstantive changes throughout the amended sections to reflect current agency drafting style and plain language preferences.

The proposed repeal of Subchapter QQ is necessary because the information technology waiver previously granted under Insurance Code Chapter 1661 to certain health benefit plan issuers expired in 2012. Before January 1, 2012, a health benefit plan

issuer could apply for a waiver from the information technology requirements under Chapter 1661. All waivers previously approved by the Commissioner under §21.5103 expired September 1, 2013. Subchapter QQ implemented Insurance Code §1661.008, which has since expired.

The proposed amendments to specific sections and the repeal are described in the following paragraphs, organized by subchapter.

Subchapter B. Advertising, Certain Trade Practices, and Solicitation.

Section 21.113. Proposed amendments replace inaccurate references to "Figure: 28 TAC §21.113(1)(5)" with "Figure: 28 TAC §21.113(l)(5)" for accuracy and consistency. The proposed amendments also remove reference to TDI's mailing address in §21.113(l)(2) because the address is no longer accurate and TDI no longer keeps physical copies of the referenced form in hard copy format. The referenced form is available in Figure: 28 TAC §21.113(l)(5) for ease of access.

Nonsubstantive amendments update references to the titles of 28 TAC Chapter 3, Subchapters S and Y, and add references to the titles of Insurance Code Chapter 1214; Chapter 541, Subchapter B; and Chapter 541 to ensure consistency and accuracy in Administrative Code and Insurance Code references.

Nonsubstantive amendments also include amendments to conform with current agency drafting style and plain language preferences. The amendments include correcting the punctuation and changing the capitalization of policy types listed in §21.113(d)(19). These amendments do not change the policy types.

Other amendments include corrections to punctuation and capitalization and, where appropriate, replacing "shall" and "shall be" with alternative words as appropriate in the context of the provision, "prior to" and "prior to such" with "before," "which" with "that" or "the," "conjunction therewith of" with "proximity to," "or" with "of," "division" with "title," "pre-existing" with "preexisting," "utilizes" with "uses," "low cost" with "low-

cost," "consummate" with "complete," "such" with "the" or "these," "in order to" with "to," "who" with "that," and "acknowledgement" with " acknowledgment"; inserting the word "the"; and deleting "that," "as such," "such time as," "and," and "which is." Also, a nonsubstantive amendment to Figure: 28 TAC §21.113(l)(5) restructures it so that Item (6) is shown before Item (7).

Subchapter Q. Complaint Records to Be Maintained.

Section 21.2505. The proposed amendments to §21.2505 remove reference to TDI's former mailing address where insurers were able to request the recommended complaint record maintenance form. TDI no longer provides physical copies of the referenced form. The proposed amendments provide TDI's website where insurers may access the form.

Subchapter OO. Disclosures by Out-of-Network Providers.

Section 21.4902. Proposed amendments to §21.4902 add the defined terms "administrator" and "health benefit plan" to the section. The addition of these defined terms clarifies the applicability of Insurance Code Chapter 1682 and ensures consistency of the language used in Chapter 21, Subchapters OO and PP.

Subchapter PP. Out-of-Network Claim Dispute Resolution.

Section 21.5001. The proposed amendments to §21.5001 expressly incorporate a reference to Insurance Code §1275.003 into the purpose statement of §21.5001 to clarify that administrators operating under Chapter 1275 must comply with the requirements in the subchapter. Amendments also remove unnecessary punctuation.

Section 21.5002. The proposed amendment to §21.5002 clarifies that the subchapter applies to a claim filed for certain care or services by the administrator of a health benefit plan under Insurance Code Chapter 1682.

Section 21.5010. The proposed amendments to §21.5010 clarify that an out-of-network health benefit claim for an out-of-network laboratory or out-of-network

diagnostic imaging service must be in connection with a health care or medical service or supply provided by a participating provider.

Section 21.5011. The proposed amendments clarify that TDI may remove a mediator from the list of qualified mediators in certain circumstances, including failure to comply with any requirement under Chapter 1467 or rules adopted under Chapter 1467.003.

The proposed amendments also make nonsubstantive grammatical changes to §21.5011(e)(1) by adding "the" and "the date" for clarity.

Section 21.5020. The proposed amendments to §21.5020 clarify that an out-of-network health benefit claim for an out-of-network laboratory or out-of-network diagnostic imaging service must be in connection with a health care or medical service or supply provided by a participating provider.

Section 21.5021. The proposed amendments to §21.5021 clarify that TDI may remove an arbitrator from the list of qualified arbitrators in certain circumstances, including failure to comply with any requirement under Chapter 1467 or rules adopted under Chapter 1467.003.

The proposed amendments also specify that an arbitrator must evaluate only the factors found in Insurance Code §1467.083. Finally, the proposed amendments remove unnecessary punctuation and add "the" and "the date" to §21.5021(e)(1) for clarity.

Section 21.5040. The proposed amendments to §21.5040 expressly incorporate a reference to Insurance Code §1275.003 into the list of cited Insurance Code provisions under which health benefit plan issuers or administrators must provide the explanation of benefits according to the section. The proposal also clarifies that the written notice required under the section must specify that the itemization of copayments, coinsurance, deductibles, and other amounts required under §21.5040(1)(B) is at an in-network cost-sharing level.

A proposed nonsubstantive amendment adds the word "and" to the end of subparagraph (B) to clarify that a health benefit plan issuer or administrator subject to §21.5040 must provide the physician or provider with a written notice in an explanation of benefits that includes the requirements in paragraphs (1) and (2). Proposed amendments also correct capitalization and delete unnecessary punctuation in the section.

Subchapter QQ. Health Information Technology.

Sections 21.5101 - 21.5103. These sections make up the entirety of Subchapter QQ and are proposed for repeal. Subchapter QQ is no longer necessary because the statutory provision it implemented expired.

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

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 repeal and amendments are in effect, Ms. Wright expects that administering them will have the public benefits of ensuring that TDI's rules conform to Insurance Code

§§1271.157, 1271.158, 1275.003, 1275.004, 1275.052, 1275.053, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, 1579.111, and Chapter 1467.

The proposed amendments to Subchapters OO and PP clarify the independent dispute resolution requirements and their applicability to health benefit plans offered by nonprofit agricultural organizations as required under Insurance Code Chapters 1275 and 1682. The proposed amendments will have the public benefit of promoting efficient processing of mediation and arbitration claims. The amendments will not require additional actions from regulated persons under Subchapters OO and PP.

The proposed amendments removing TDI's mailing address and providing TDI's forms website will have the public benefit of ensuring that consumers, policyholders, and other interested parties can locate the necessary forms in the most efficient way.

The proposed repeal of Subchapter QQ will have the public benefit of conforming to Insurance Code Chapter 1661, which previously granted an information technology waiver to certain health benefit plan issuers. The waiver provision in Insurance Code §1661.008 expired in 2012. The waivers previously approved by the Commissioner under Subchapter QQ and Insurance Code §1661.008 expired September 1, 2013.

Ms. Wright expects that the proposed repeal and amendments will not increase the cost of compliance because they do not impose requirements beyond those in the statutes. The amendments as proposed clarify the statutory requirements, but they do not add any new requirements. As a result, the cost associated with complying with the independent dispute resolution process does not result from the enforcement or administration of the proposed repeal and amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed repeal and amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. Because the proposal

implements Insurance Code §§1271.157, 1271.158, 1275.003, 1275.004, 1275.052, 1275.053, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, 1579.111, and Chapter 1467, any economic impacts are attributable to the statutes and not the proposed rule. The repeal and amendments do not impose requirements beyond those in statute and will not create an increase in cost of compliance with statute. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. However, even if the proposal did impose a possible cost on regulated persons, Insurance Code §1467.003(b) exempts a rule adopted under Chapter 1467 from Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed repeal and amendments are in effect, the proposed repeal and 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 not expand or limit an existing regulation, but will repeal existing regulations;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI 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. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on March 13, 2023. 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 TDI no later than 5:00 p.m., central time, on March 13, 2023. If TDI holds a public hearing, TDI will consider written and oral comments presented at the hearing.

SUBCHAPTER B. ADVERTISING, CERTAIN TRADE PRACTICES, AND SOLICITATION.
DIVISION 1. INSURANCE ADVERTISING.
28 TAC §21.113

STATUTORY AUTHORITY. TDI proposes amendments to §21.113 under Insurance Code §§541.401(a), 1201.101, and 36.001.

Insurance Code §541.401(a) authorizes the Commissioner to adopt and enforce reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1201.101 authorizes the Commissioner to adopt reasonable rules under the section establishing specific standards, including standards that address the nonduplication 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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.113 affect Insurance Code §1201.101 and Insurance Code Chapters 541 and 1214.

TEXT.

§21.113. Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising.

(a) Coverage details. An invitation to inquire that specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable must [~~shall~~] contain a provision in effect as follows: "For specific costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

(b) Illustration of rates. Subject to [~~the~~] Insurance Code Chapter 1214, concerning Advertising for Certain Health Benefits, and [~~the~~] Insurance Code Chapter 541, Subchapter B, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined, an invitation to inquire concerning a health benefit plan may include rate information without including information about all benefit exclusions and limitations so long as any rate mentioned in any advertisement disseminated under this subsection

indicates the age, gender, and geographic location on which that rate is based and so long as the advertisement includes prominent disclaimers clearly indicating that:

(1) the rates are illustrative only;

(2) a person should not send money to the issuer of the health benefit plan in response to the advertisement;

(3) a person cannot obtain coverage under the health benefit plan until the person completes an application for coverage; and

(4) benefit exclusions and limitations may apply to the health benefit plan.

(c) Identification of policy.

(1) The form number or numbers of the policy advertised must [~~shall~~] be clearly identified in an invitation to contract.

(2) If an advertisement refers to various benefits that are contained in two or more policies or riders, but excepting group master policies, the advertisement must [~~shall~~] disclose that such benefits are provided only through a combination of such policies or riders.

(3) An advertisement may not use the word "plan" without first identifying the subject as an "insurance plan" or an "HMO plan," as appropriate.

(d) Description of benefits.

(1) An invitation to contract referring to a dollar amount, a period of time for which a benefit is payable, the cost of the policy, or a specific policy benefit or the loss for which such benefit is payable must [~~shall~~] also disclose those exclusions, reductions, and limitations affecting the basic provisions of the policy, without which the advertisement would have the capacity and tendency to mislead or deceive.

(2) If a policy pays varying amounts of benefits for the same loss occurring under different conditions or [~~that~~] pays benefits only when a loss occurs under certain

conditions, any reference to these benefits in an invitation to contract must [~~shall~~] be accompanied by a clear and conspicuous disclosure of the different or limited conditions.

(3) No advertisement may refer to a benefit payable under a "family group" policy if the full amount of the benefit is not payable upon the occurrence of the contingency insured against to each member of the family, unless clear and conspicuous disclosure of such fact is made in the advertisement.

(4) No advertisement may be used that represents or implies:

(A) that the condition of the applicant's or insured's health before [~~prior to~~], or at the time of issuance of a policy, or thereafter, will not be considered by the insurer in issuing the policy or in determining its liability or benefits to be furnished for or in the settlement of a claim if such is not a fact;

(B) if [~~If~~] an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, must [~~shall~~] disclose that a medical examination is required.

(5) An invitation to contract for a policy that [~~which~~] provides coverage for loss due to accident only for a specified period of time from its effective date must [~~shall~~] state this fact clearly and conspicuously.

(6) If any covered benefits are, by the terms of the policy, limited to a certain age group or are reduced at a certain age, an invitation to contract must [~~shall~~] clearly and conspicuously disclose such fact.

(7) An advertisement may not contain representations of an aggregate amount payable without clear and conspicuous disclosure in close proximity to [~~conjunction therewith of~~] any maximum daily benefit and maximum time limit.

(8) No advertisement of a policy providing benefits for which payment is conditioned upon confinement in a hospital, extended care facility, or at home may advertise that the amount of the benefit is payable on a monthly or weekly basis if, in fact,

the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless such statements of monthly or weekly benefit amounts are followed immediately by equally prominent statements of the benefit payable on a daily basis. For example, either of the following statements is acceptable: "$1,000 a Month ($33.33 a Day)" or "$33.33 a Day ($1,000 a Month)." If the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(9) An advertisement offering assistance or information concerning Medicare may not state or imply that an obligation is imposed by the receipt of such information.

(10) An advertisement of benefits payable in conjunction with Medicare must [~~shall~~] disclose the Medicare benefits (Part A or B) they are designed to supplement.

(11) A Medicare-related advertisement must [~~shall~~] state in a prominent place the following or similar words: "Not connected with or endorsed by the United States government or the federal Medicare program."

(12) References to Medicare may not be used in such a manner in an advertisement so as to be misleading or deceptive.

(13) Advertisements referenced as being "Important Notices" or similar language and directed primarily to Medicare recipients or senior citizens are presumed to be misleading or having the capacity or tendency to mislead unless shown otherwise.

(14) The words, numerals, and phrases "all," "100%," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills," or "this policy will replace your income," or similar words, numerals, and phrases may not be used to exaggerate any benefit beyond the terms of the policy, but may be used only in a manner as fairly and accurately describes the benefit.

(15) An advertisement may not contain descriptions of a policy limitation, exclusion, or reduction, worded or stated in a manner to imply that it is a benefit, for example, describing a waiting period as a "benefit builder," or stating "even preexisting [~~pre-existing~~] conditions are covered after two years." Words and phrases used in an advertisement to describe policy limitations, exclusions, and reductions must [~~shall~~] accurately describe the negative features of such limitations, exclusions, and reductions of the policy offered.

(16) No advertisement of a benefit, if payment of the benefit is conditioned upon confinement in a hospital or similar extended care facility, or at home, may use words or phrases such as "tax free," "extra cash," "extra income," "extra pay," or similar words or phrases. In those cases such words and phrases have the capacity, tendency, or effect of misleading the public and cause the belief that the policy advertised enables a profit to be made from being hospitalized. This section prohibits the misleading use of the phrase "tax free," but it does not prohibit the use of complete and accurate terminology explaining the Internal Revenue Service rules applicable to the taxation of accident and sickness benefits. Prominence either by caption, lead-in, boldface, or large type must [~~shall~~] not be given in any manner to any statements relating to the tax status of such benefits.

(17) Except as permitted under §21.109(a) of this title [~~division~~] (relating to Unlawful Inducement), an advertisement may not list goods and services other than those set out in the policy as possible benefits.

(18) A policy covering only one disease or a list of specific diseases or accidents may not be advertised so as to imply coverage beyond the terms of the policy. Synonymous terms may not be used to refer to any disease to imply broader coverage than that provided.

(19) An advertisement that is an invitation to contract for a limited benefit policy, a supplemental coverage policy, or a nonconventional coverage policy, as defined in Chapter 3, Subchapter S of this title (relating to Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies), must [~~shall~~] clearly and conspicuously, in prominent type, state in language identical to or substantially similar to whichever of the following is applicable: "This is a limited benefit policy," "This is a cancer-only policy," "This is a supplemental policy," or "This is an automobile-accident-only policy." [~~"THIS IS A LIMITED BENEFIT POLICY," "THIS IS A CANCER ONLY POLICY," "THIS IS A SUPPLEMENTAL POLICY," or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."~~] The insurer or agent must [~~shall~~] use the foregoing statement to clearly advise the public of the nature of the policy.

(e) Exceptions, reductions, and limitations.

(1) If a policy contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy, or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an invitation to contract must [~~shall~~] disclose the existence of such periods.

(2) An advertisement may not use the words "only," "just," "merely," "minimum," or similar words or phrases to unfairly describe the applicability of [~~or~~] any exclusions, limitations, or reductions, such as "This policy is subject to the following minimum exclusions and reductions."

(f) Preexisting [~~Pre-existing~~] condition.

(1) An advertisement that states or implies that preexisting [~~pre-existing~~] conditions may apply must define the applicable preexisting [~~pre-existing~~] condition provisions.

(2) An advertisement that is an invitation to contract must, [~~shall,~~] in accurate terms, disclose the extent to which a loss is not covered if the cause of the loss is traceable to a condition existing before [~~prior to~~] the effective date of the policy.

(g) Disclosure of policy provisions relating to renewability, cancellability, and termination.

(1) An advertisement that is an invitation to contract must [~~shall~~] disclose the provisions in respect of renewability, cancellability, and termination, and each modification of benefits, covered losses or premiums either because of age or for other reasons, in a manner that does not minimize or render obscure the qualifying conditions.

(2) An advertisement for a policy stating or implying that the policy is "guaranteed renewable" must: [~~shall:~~]

(A) have a clear and conspicuous statement that coverage may terminate at certain ages, if such is a fact; and

(B) include, in a prominent place, a statement indicating that rates for the policy may change if the advertisement suggests or implies that rates for the product will not change. Such statement must generally identify the manner in which rates may change, such as by age, by health status, by class, or through application of other general criteria.

(3) No advertisement may represent or imply that an insurance policy may be continued in effect indefinitely or for any period of time, if the policy provides that it may not be renewed or may be cancelled by the insurer, or terminated under any circumstances over which the insured has no control, during the period of time represented.

(4) The term "noncancellable" or derivation thereof may not be used by an insurer or agent to describe a policy if the insurer has a right to periodically, by individual or class, revise rates or premiums.

(5) An invitation to contract must [~~shall~~] contain a notice stating that the person to whom the policy is issued is permitted to return the policy within 10 days (or more as stated in the policy) of its delivery to that person and to have the premium paid refunded.

(h) Description of premiums, cost, and interest.

(1) Consideration paid or to be paid for individual insurance, including policy fees, must [~~shall~~] be in all instances described as premium, consideration, cost, or payments.

(2) Consideration paid or to be paid for group insurance, including enrollment fees, dues, administrative fees, membership fees, service fees, and other similar charges paid by the employees, must [~~shall~~] be disclosed in an invitation to contract advertisement as a part of the cost and consideration.

(3) An advertisement may not offer a policy that uses [~~utilizes~~] a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. If an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable, the advertisement may not display the amount of the reduced initial premium more prominently than the renewal premium.

(4) A reduced initial or first-year premium may not be described by an insurer or agent as constituting free insurance for a period of time.

(5) An advertisement of an insurance product may not imply that it is "a low-cost [~~low-cost~~] plan" or use other similar words or phrases without a substantial present or past cost record for the policy advertised or similar policy, demonstrating a composite of lower production, administrative, and claim cost resulting in a low premium rate to the public.

(6) The words "deposits," "savings," "investment," and other phrases used to describe premiums may not be used by an insurer or agent to hide or untruthfully minimize the cost of the hazards insured against.

(7) An insurer or agent may not make a billing of a premium for increased coverage or include the cost of increased coverage in the premium for which a billing is made without first disclosing the premium and details of the increased coverage and obtaining the consent of the insured to such increase in coverage. This does not apply to policies that contain provisions providing for automatic increases in benefits or increases in coverages required by law.

(8) If the cost of home collection results in a higher premium an advertisement must [~~shall~~] state that fact.

(i) Dividends.

(1) An advertisement may not use [~~utilize~~] or describe dividends in a manner that is misleading or has the capacity or tendency to mislead.

(2) An advertisement may not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, the dividends must be based on the insurer's current dividend scale and the illustration must contain a statement to the effect that the dividends are not to be construed as guarantees or estimates of dividends to be paid in the future.

(3) An insurer or agent may not, as an inducement to purchase insurance, circulate, publish, or otherwise exhibit to any person who is an insured, or prospective insured, any form of director resolution, stockholders resolution, or form of company action stating or implying the action an insurer will take on a declaration of dividend or other matter in the future if the insurer, its directors, or its stockholders are not bound to take the action stated or implied, or if the insurer does not presently have the earnings or

other funds or assets to make the payments, or to complete [~~consummate~~] the transaction in accordance with the appropriate statutes.

(j) Compliance with statutes or rules as grounds for changing policy. [~~Statutes or Rules as Grounds for Changing Policy.~~] In consideration of the comprehensive content of this division and, among other reasons, the division being applicable to substantially all insurers, an insurer or agent may not, particularly if used as a "twisting" device, inform any policyholder or prospective policyholder that an insurer or agent was required to change a policy or contract form or related material to comply with the provisions of this division or other rules or statutes.

(k) Deception or deceptive method as to introductory, initial, or special offers.

(1) An advertisement of a particular policy may not state or imply that prospective policyholders become group or quasi-group members that [~~, as such,~~] enjoy special rates or underwriting privileges ordinarily associated with group insurance as recognized in the industry unless such is the fact.

(2) If an insured or prospective insured is provided a policy or coverage of insurance and the first premium has not been paid, or an application has not been returned to the insurer or its agents or representatives, the insurer, its agents, or representatives may not make any billing or attempt to collect a premium on such policy until [~~such time as~~] an application or acknowledgment of acceptance is received. If coverage is issued before [~~prior to such~~] acceptance, it must [~~shall~~] be accompanied by a written statement describing it as follows:

(A) giving the facts concerning the delivery of the policy and whether or not the policy was requested by the insured; [~~and~~]

(B) stating that the insured is under no obligation to pay the insurer if the insured does not want to continue or initiate the coverage; and

(C) clearly stating when coverage will be effective.

(3) An advertisement may not state or imply that a policy or combination of policies is an introductory, initial, special, or limited offer and that applicants will receive advantages by accepting the offer or that the [~~such~~] advantages will not be available at a later date unless it is a fact. An advertisement may not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases if the insurer uses these [~~such~~] enrollment periods as the usual method of advertising insurance.

(A) An enrollment period during which "a particular insurance product" may be purchased may not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement must [~~shall~~] indicate the date by which the applicant must mail the application. The [~~which~~] date may not be less than 10 days and not more than 40 days from the date that the [~~such~~] enrollment period is advertised for the first time. (It is emphasized that this section is applicable to all advertisements as defined in §21.102(1) of this title [~~division~~] (relating to Scope)). This subparagraph is inapplicable to solicitation of employees or members of a particular group, except that this subparagraph does [~~shall~~] apply to the solicitation of members of an association group that [~~, which~~] otherwise would be eligible under specific provisions of the Insurance Code for group, blanket, or franchise insurance. This section applies to all affiliated companies under common management or control. The phrase "a particular insurance product" is used here to describe an insurance policy that [~~which~~] provides substantially different benefits than those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy are not sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

(B) There may be no statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(C) An invitation to contract Medicare supplement advertisement must describe complete information regarding all available "open enrollment" opportunities or prominently disclose a means of obtaining complete information regarding such opportunities.

(l) Acknowledgment of nonduplication; notice to consumer.

(1) Acknowledgment of nonduplication; notice to consumer.

(A) Acknowledgment of nonduplication--The document that [~~which~~] contains and is limited to the language [~~which is~~] set forth in item (6) of Figure: 28 TAC §21.113(l)(5) [~~Figure: 28 TAC §21.113(1)(5)~~].

(B) Duplication--Policies of the same coverage type according to minimum standard classifications outlined in Chapter 3, Subchapter S and Subchapter Y of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy [~~Minimum Standards and Benefits and Readability for Accident and Health Insurance Policies and Minimum Standards for Benefits for Long-term Coverage under Individual and Group Policies~~]). For example, two cancer insurance policies or two long-term care policies would be duplicative. Duplication is also present when two policy coverages overlap to the extent that a reasonable person would not consider the ownership of two such policies to be cost efficient in light of the consumer's needs and income level. Group health coverage obtained through an employer-sponsored plan, conversion from a group employer-sponsored health plan, short-term travel accident

coverage, short-term nonrenewable coverage, Medicare risk contracts, and retired-employee group plans will not be considered duplication of other coverage.

(C) Notice to consumer--The document that [~~which~~] contains and is limited to the language [~~which is~~] set forth in item (7) of Figure: 28 TAC §21.113(l)(5) [~~Figure: 28 TAC §21.113(1)(5)~~].

(2) All insurers, other than direct response insurers, or their agents or other intermediaries, must [~~shall~~] obtain an acknowledgment of nonduplication with all applications for health insurance sold to an individual who is 65 years of age or older, other than group health coverage obtained through an employer-sponsored plan, conversion from a group employer-sponsored health plan, short-term travel accident coverage, short-term nonrenewable coverage, Medicare risk contracts, and retired-employee group plans. This acknowledgment must [~~shall~~] be obtained at the same time as the application and must [~~shall~~] be submitted to the insurer with the application. One copy of the acknowledgment must [~~shall~~] be left with the insured and one copy kept on file with the company. The form of the [~~such~~] acknowledgment or notice must be printed on a separate piece of paper and must contain the specific language and must be in the format set forth in item (6) of Figure: 28 TAC §21.113(l)(5) [~~Figure: 28 TAC §21.113(1)(5). This form is published by the Texas Department of Insurance, and copies of the form are available from and on file at the Texas Department of Insurance, Market Conduct Division, Mail Code 305-2E, P.O. Box 149104, Austin, Texas 78714-9104~~].

(3) To [~~In order to~~] obtain this acknowledgment, all insurers or their agents or other intermediaries must [~~shall~~] offer to examine all health insurance policies and health care coverage owned by a prospective insured and advise the insured as to whether the purchase of the proposed policy will result in any duplication of benefits.

(4) Direct response insurers that [~~who~~] market to the consumer without agents or other intermediaries are exempt from the requirement to deliver the

acknowledgment [~~acknowledgement~~] contained in item (6) of Figure: 28 TAC §21.113(l)(5) [~~Figure: 28 TAC §21.113(1)(5)~~], but must deliver the notice to consumers set forth in item (7) of Figure: 28 TAC §21.113(l)(5) [~~Figure: 28 TAC §21.113(1)(5)~~].

(5) Failure to comply with paragraphs (1) - (4) of this subsection is [~~shall be~~] an unfair business practice as defined by [~~the~~] Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices.

Figure: 28 TAC §21.113(l)(5)

Item (6)

ACKNOWLEDGEMENT OF NONDUPLICATION

PLEASE READ CAREFULLY BEFORE SIGNING

I _____, certify that I
(Agent's Name)

have done the following:

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of this policy.

2. Reviewed the policies listed below and have found that duplication WILL or WILL NOT (circle one) occur with the issuance of the applied for policy.

_____
(Form Number)

COMPANY POLICY TYPE OF

NUMBER (#) POLICY

_____

_____

_____

_____

Check one:

a.____ Duplication will not occur because the above listed policy(ies) #_____ will be replaced by the applied-for policy _____ (*form number*). Justification for the replacement is (*explain benefit to consumer*)

_____

_____

b.____ No health policies in force at this time.

c.____ Applicant has elected not to have the policy(ies) reviewed.

_____ _____
DATE AGENT/COMPANY REPRESENTATIVE

NOTICE TO CONSUMERS

Age 65 and Older

This Notice is required by the Texas Department of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:

☐ SPECIFIED DISEASE (CANCER, STROKE, ETC.)

☐ HOSPITAL INDEMNITY

☐ BASIC HOSPITAL EXPENSE OR BASIC MEDICAL/SURGICAL

☐ EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)

☐ LONG-TERM CARE

THE TEXAS DEPARTMENT OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE TEXAS DEPARTMENT OF INSURANCE STRONGLY URGES YOU TO GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.

3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.

4. THE TEXAS DEPARTMENT OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE AGENT OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the agent named above.

____ I have been informed that the policy for which I am applying WILL OR WILL NOT (*circle one*) result in duplicate coverage.
____ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.
I have read the attached notice. Dated this ____ day of _____ , 20 ___.

_____
APPLICANT

Item (7)

NOTICE TO CONSUMERS
AGE 65 AND OLDER

The Texas Department of Insurance requires that this Notice be given to you at the time you receive a policy.

State law gives you the right to review this policy and return it for a full premium refund if you are not satisfied. By law you have a minimum 10 days if you buy any individual

accident and health insurance policy. The Texas Department of Insurance urges you to use this time to verify that this coverage is needed.

The Department is concerned that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:

- SPECIFIED DISEASE (CANCER, STROKE, ETC.)
- HOSPITAL INDEMNITY
- BASIC HOSPITAL EXPENSE OR BASIC MEDICAL/SURGICAL
- EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
- LONG-TERM CARE

THE TEXAS DEPARTMENT OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE TEXAS DEPARTMENT OF INSURANCE STRONGLY URGES YOU TO GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.

3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.

[~~Figure: 28 TAC §21.113(l)(5)~~]

SUBCHAPTER Q. COMPLAINT RECORDS TO BE MAINTAINED.
28 TAC §21.2505

STATUTORY AUTHORITY. TDI proposes amendments to §21.2505 under Insurance Code §§541.401, 542.014, and 36.001.

Insurance Code §541.401 authorizes the Commissioner to adopt and enforce reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.014 authorizes the Commissioner to adopt reasonable rules as necessary to implement and augment the purposes and provisions of Chapter 542, Subchapter A.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendment to §21.2505 affects §541.060 and §542.005.

TEXT.

§21.2505. Complaint Record Form.

(a) Recommended maintenance form. The recommended form for complaint record maintenance is available on TDI's website at www.tdi.texas.gov/forms. [~~is included in subsection (b) of this section in its entirety and has been filed with the Office of the Secretary of State. The form is available from the Texas Department of Insurance, Consumer Protection Division (111-1A), P.O. Box 149104, Austin, Texas 78714-9104.~~]

(b) Texas Department of Insurance Complaint Record Form.

Figure: 28 TAC 28 TAC §21.2505(b)

(No change.)

SUBCHAPTER OO. DISCLOSURES BY OUT-OF-NETWORK PROVIDERS. 28 TAC §21.4902

STATUTORY AUTHORITY. TDI proposes amendments to §21.4902 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 requires the Commissioner to 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 TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.4902 affect Insurance Code Chapters 1275, 1467, 1551, 1575, 1579, and 1682.

TEXT.

§21.4902. Definitions.

Words and terms defined in Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, have the same meaning 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) 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.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION.
DIVISION 1. GENERAL PROVISIONS.
28 TAC §21.5001 AND §21.5002

STATUTORY AUTHORITY. TDI proposes amendments to §21.5001 and §21.5002 under Insurance Code §§1275.004, 1301.007, 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 §1301.007 authorizes the Commissioner to adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1467.003 requires the Commissioner to 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 TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.5001 and §21.5002 affect Insurance Code Chapters 1275, 1467, and 1682.

TEXT.

§21.5001. Purpose.

The purpose of this subchapter is to:

(1) prescribe the process for requesting, initiating, and conducting mandatory mediation and mandatory binding arbitration of claims as authorized in Insurance Code Chapter 1467, [~~(~~]concerning Out-of-Network Claim Dispute Resolution[~~)~~];

(2) facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under Insurance Code Chapter 1467;

(3) prescribe the contents of the explanation of benefits as required by Insurance Code §1271.008, [~~(~~]concerning Balance Billing Prohibition Notice; §1275.003, concerning Balance Billing Prohibition Notice;[~~),~~] §1301.010, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] §1551.015, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] §1575.009, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] and §1579.009, [~~(~~]concerning Balance Billing Prohibition Notice[~~)~~]; and

(4) facilitate the collection of data as authorized in Insurance Code §1467.006, [~~(~~]concerning Benchmarking Database[~~)~~].

§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. <u>This subchapter applies to a claim filed for emergency care or health care or medical services or supplies by the administrator of a health benefit plan under Chapter 1682.</u>

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION.
DIVISION 2. MEDIATION PROCESS.
28 TAC §21.5010 AND §21.5011

STATUTORY AUTHORITY. TDI proposes amendments to §21.5010 and §21.5011 under Insurance Code §§1467.003, 1467.0505, and 36.001.

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

Insurance Code §1467.0505 authorizes the Commissioner to adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.5010 and §21.5011 affect Insurance Code Chapters 1271, 1275, 1301, 1467, 1551, 1575, 1579, and 1682.

TEXT.

§21.5010. Qualified Mediation Claim Criteria.

(a) Required criteria. An out-of-network provider that is a facility or a health benefit plan issuer or administrator may request mandatory mediation of an out-of-network claim under §21.5011 of this title (relating to Mediation Request Procedure) if the claim complies with the criteria specified in this subsection. An out-of-network claim that complies with those criteria is referred to as a "qualified mediation claim" in this subchapter.

(1) The out-of-network health benefit claim must be for:

(A) emergency care;

(B) an out-of-network laboratory service provided in connection with a health care or medical service or supply provided by a participating provider; or

(C) an out-of-network diagnostic imaging service provided in connection with a health care or medical service or supply provided by a participating provider.

(2) There is an amount billed by the provider and unpaid by the health benefit plan issuer or administrator after copayments, deductibles, and coinsurance, for which an enrollee may not be billed.

(b) Submission of multiple claim forms. The use of more than one form in the submission of a claim, as defined in §21.5003 of this title (relating to Definitions), does not prevent eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible claims. This division does not require a health benefit plan issuer or administrator to pay for an uncovered service or supply.

§21.5011. Mediation Request Procedure.

(a) Mediation request and notice.

(1) An out-of-network provider that is a facility or a health benefit plan issuer or administrator may request mediation. To be eligible for mediation, the party requesting mediation must complete the mediation request information required on the department's website at www.tdi.texas.gov, as specified in subsection (b) of this section.

(2) The party who requests the mediation must provide written notice to each other party on the date the mediation is requested. The notification must contain the information as specified on the department's website, including the necessary claim information and contact information of the parties. A health benefit plan issuer or administrator requesting mediation must send the mediation notification to the mailing

address or email address specified in the claim submitted by the provider. If a provider does not specify an address to receive notice requesting mediation in the claim, a health benefit plan issuer or administrator may provide notice to the provider at the provider's last known address the issuer or administrator has on file for the provider. A provider requesting mediation must send the mediation notification to the email address specified in the explanation of benefits by the health benefit plan issuer or administrator.

(b) Submission of request. The requesting party must submit information necessary to complete the initial mediation request, including:

(1) facility details, including identifying the facility type, facility contact information, and facility representative information;

(2) claim information, including the claim number, type of service or supply provided, date of service, billed amount, amount paid, and balance; and

(3) relevant information from the enrollee's health benefit plan identification card or other similar document, including plan number and group number.

(c) Notice of teleconference outcome. Parties must submit additional information on the department's website at the completion of the informal settlement teleconference period, including the date the teleconference request was received and the date of the teleconference.

(d) Mediator selection.

(1) The parties must notify the department through the department's website on or before 30 days from the date the mediation is requested if:

(A) the parties agree to a settlement;

(B) the parties agree to the selection of a mediator; or

(C) the parties agree to extend the deadline to have the department select a mediator and notify the department of new deadlines.

(2) If the department is not given notification under paragraph (1) of this subsection, the department will assign a mediator after the 30th day from the date the mediation is requested. The parties must pay the nonrefundable mediator's fee to the mediator when the mediator is assigned. Failure to pay the mediator when the mediator is assigned constitutes bad faith participation.

(e) Submission of information. Parties must submit information, as specified on the department's website, to the department at the completion of the mediation or informal settlement, including:

(1) the name of the mediator, the date when the mediator was selected, the date when the mediation was held, the date of the agreement, the date of the mediator report, and when payment was made; and

(2) the agreement, including the original billed amount, payment amount, and the total agreed amount.

(f) Mediator approval and removal.

(1) Mediators may apply to the department using a method as determined by the Commissioner, including through an application on the department's website or through the department's procurement process. An individual or entities that employ mediators may apply for approval.

(2) A list of qualified mediators will be maintained on the department's website. [~~A mediator who no longer meets the qualification requirements in Insurance Code §1467.052 (concerning Mediator Qualifications) will be terminated.~~] A mediator must notify the department immediately if the mediator wants to voluntarily withdraw from the list.

(3) At the discretion of the department, a mediator may be removed from the list of qualified mediators in certain circumstances, including failure to comply with

any requirement under Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, or rules adopted under §1467.003, concerning Rules.

(g) Mediation process.

(1) A party may request mediation after 20 days from the date an out-of-network provider receives the initial payment for a health benefit claim, during which time the out-of-network provider may attempt to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process.

(2) The parties may submit written information to a mediator concerning the amount charged by the out-of-network provider for the health care or medical service or supply and the amount paid by the health benefit plan issuer or administrator.

(3) The parties must evaluate the factors specified in Insurance Code §1467.056, [{]concerning Matters Considered in Mediation; Agreed Resolution[}].

(4) Each party is responsible for reviewing the list of mediators and notifying the department within 10 days of the request for mediation whether there is a conflict of interest with any of the mediators on the list to avoid the department assigning a mediator with a conflict of interest.

(5) The parties may agree to aggregate claims between the same facility and same health benefit plan issuer or administrator for mediation.

(h) Assistance. Assistance with submitting a request for mediation is available on the department's website at www.tdi.texas.gov.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION.
DIVISION 3. ARBITRATION PROCESS.
28 TAC §21.5020 AND §21.5021

STATUTORY AUTHORITY. TDI proposes amendments to §21.5020 and §21.5021 under Insurance Code §§1467.003, 1467.082, and 36.001.

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

Insurance Code §1467.082 states that the Commissioner may adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.5020 and §21.5021 affect Insurance Code Chapters 1271, 1275, 1301, 1467, 1551, 1575, 1579, and 1682.

TEXT.

§21.5020. Qualified Arbitration Claim Criteria.

(a) Required criteria. An out-of-network provider that is not a facility or a health benefit plan issuer or administrator may request mandatory binding arbitration of an out-of-network claim under §21.5021 of this title (relating to Arbitration Request Procedure) if the claim complies with the criteria specified in this section. An out-of-network claim that complies with those criteria is referred to as a "qualified arbitration claim" in this subchapter.

(1) The health benefit claim must be for:

(A) emergency care;

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider;

(C) an out-of-network laboratory service <u>provided in connection with a health care or medical service or supply provided by a participating provider</u>; or

(D) an out-of-network diagnostic imaging service provided in connection with a health care or medical service or supply provided by a participating provider; and

(2) The health benefit claim must be for a charge billed by the provider and unpaid by the health benefit plan issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee may not be billed.

(b) Availability. Not later than the 90th day after the date an out-of-network provider receives the initial payment for a health care or medical service or supply, the out-of-network provider or the health benefit plan issuer or administrator may request arbitration of a settlement of an out-of-network health benefit claim. The initial payment could be zero dollars if the allowable amount was applied to an enrollee's deductible.

(c) Ineligible claims. Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

§21.5021. Arbitration Request Procedure.

(a) Arbitration request and notice.

(1) An out-of-network provider or a health benefit plan issuer or administrator may request arbitration. To be eligible for arbitration, the party requesting arbitration must complete the arbitration request information required on the department's website at www.tdi.texas.gov, as specified in subsection (b) of this section.

(2) The party who requests the arbitration must provide written notice to each other party on the date the arbitration is requested. The notification must contain the information as specified on the department's website, including the necessary claim information and contact information of the parties. A health benefit plan issuer or administrator requesting arbitration must send the arbitration notification to the mailing

address or email address specified in the claim submitted by the provider. If a provider does not specify an address to receive notice requesting arbitration in the claim, the health benefit plan issuer or administrator may provide notice to the provider at the provider's last known address the issuer or administrator has on file for the provider. A provider requesting arbitration must send the arbitration notification to the email address specified in the explanation of benefits by the health benefit plan issuer or administrator.

(b) Submission of request. The requesting party must submit information necessary to complete the initial arbitration request, including:

(1) provider details, including identifying the provider type, provider contact information, and provider representative information;

(2) claim information, including the claim number, type of service or supply provided, date of service, billed amount, amount paid, and balance; and

(3) relevant information from the enrollee's health benefit plan identification card or a similar document, including plan number and group number.

(c) Notice of teleconference outcome. Parties must submit additional information on the department's website at the completion of the informal settlement teleconference period, including the date the teleconference request was received, the date of the teleconference, and settlement offer amounts.

(d) Arbitrator selection.

(1) The parties must notify the department, through the department's website, on or before 30 days from the date arbitration was requested if:

(A) the parties agree to a settlement;

(B) the parties agree to the selection of an arbitrator; or

(C) the parties agree to extend the deadline to have the department select an arbitrator and notify the department of new deadlines.

(2) If the department is not given notification under paragraph (1) of this subsection, the department will assign an arbitrator after the 30th day from the date the arbitration is requested. The parties must pay the nonrefundable arbitrator's fee to the arbitrator when the arbitrator is assigned. Failure to pay the arbitrator when the arbitrator is assigned constitutes bad faith participation, and the arbitrator may award the binding amount to the other party.

(e) Submission of information.

(1) The arbitrator must submit information, as specified on the department's website, to the department at the completion of the arbitration, including:

(A) the name of the arbitrator, the date when the arbitrator was selected, the date of the decision, the date of the arbitrator report, and when payment was made; and

(B) the written decision, including any final offers made during the health benefit plan issuer's or administrator's internal appeal process or informal settlement, reasonable amount for the services or supplies, and the binding award amount.

(2) If the parties settle the dispute before the arbitrator's decision, the parties must submit information, as specified on the department's website, to the department, including:

(A) the date of the settlement; and

(B) the amount of the settlement.

(f) Arbitrator approval and removal.

(1) Arbitrators may apply to the department using a method as determined by the Commissioner, including through an application on the department's website or the department's procurement process. An individual or entities that employ arbitrators may apply for approval.

(2) A list of qualified arbitrators will be maintained on the department's website. [~~An arbitrator who no longer meets the qualification requirements in Insurance Code §1467.086 (concerning Selection and Approval of Arbitrator) will be terminated.~~] An arbitrator must notify the department immediately if the arbitrator wants to voluntarily withdraw from the list.

(3) At the discretion of the department, an arbitrator may be removed from the list of qualified arbitrators in certain circumstances, including failure to comply with any requirement under Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, or rules adopted under §1467.003, concerning Rules.

(g) Arbitration process.

(1) A party may request arbitration after 20 days from the date an out-of-network provider receives the initial payment for a health benefit claim, during which time the out-of-network provider may attempt to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process.

(2) The parties must submit written information to an arbitrator concerning the amount charged by the out-of-network provider for the health care or medical service or supply, and the amount paid by the health benefit plan issuer or administrator.

(3) The arbitrator must evaluate only the factors specified in Insurance Code §1467.083, [~~{~~]concerning Issue to Be Addressed; Basis for Determination[~~}~~].

(4) The arbitrator must provide the parties an opportunity to review the written information submitted by the other party, submit additional written information, and respond in writing to the arbitrator on the time line set by the arbitrator.

(5) Each party is responsible for reviewing the list of arbitrators and notifying the department within 10 days of the request for arbitration if there is a conflict of interest with any of the arbitrators on the list to avoid the department assigning an arbitrator with a conflict of interest.

(6) If a party does not respond to the arbitrator's request for information, the dispute will be decided based on the available information received by the arbitrator without an opportunity for reconsideration.

(7) The submission of multiple claims to arbitration in one proceeding must be for the same provider and the same health benefit plan issuer or administrator and the total amount in controversy may not exceed $5,000.

(h) Assistance. Assistance with submitting a request for arbitration is available on the department's website at www.tdi.texas.gov.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION.
DIVISION 5. EXPLANATION OF BENEFITS.
28 TAC §21.5040

STATUTORY AUTHORITY. TDI proposes amendments to §21.5040 under Insurance Code §§1275.003, 1275.004, 1301.007, 1467.003, and 36.001.

Insurance Code §1275.003 requires an explanation of benefits to contain information required by Commissioner rule 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 §1301.007 authorizes the Commissioner to adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1467.003 requires the Commissioner to 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 TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.5040 affect Insurance Code §§1271.008, 1301.010, 1551.015, 1575.009, and 1579.009, and Chapters 1275 and 1467.

TEXT.

§21.5040. Required Explanation of Benefits.

A health benefit plan issuer or administrator subject to Insurance Code §1271.008, [~~(~~]concerning Balance Billing Prohibition Notice; §1275.003, concerning Balance Billing Prohibition Notice;[~~),~~] §1301.010, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] §1551.015, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] §1575.009, [~~(~~]concerning Balance Billing Prohibition Notice;[~~),~~] or §1579.009, [~~(~~]concerning Balance Billing Prohibition Notice,[~~)~~] must provide written notice in accordance with this section in an explanation of benefits in connection with a health care or medical service or supply provided by a non-network provider or an out-of-network provider:

(1) to [~~To~~] the enrollee and physician or provider, which must include:

(A) a statement of the billing prohibition, as applicable; and

(B) the total amount the physician or provider may bill the enrollee under the health benefit plan and an itemization of in-network copayments, coinsurance, deductibles, and other amounts included in that total; and

(2) to [~~To~~] the physician or provider, a conspicuous statement in not less than 10-point boldface type that is substantially similar to the following: "If you disagree with the payment amount, you can request mediation or arbitration. To learn more and

submit a request, go to www.tdi.texas.gov. After you submit a complete request, you must notify [HEALTH BENEFIT PLAN ISSUER OR ADMINISTRATOR NAME] at [EMAIL]."

SUBCHAPTER QQ. HEALTH INFORMATION TECHNOLOGY.
28 TAC §§21.5101 - 21.5103

STATUTORY AUTHORITY. The repeal of §§21.5101 - 21.5103 is proposed under Insurance Code §1661.009(a) and §36.001.

Insurance Code §1661.009(a) authorizes the Commissioner to adopt rules as necessary to implement Chapter 1661.

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.

CROSS-REFERENCE TO STATUTE. The proposed repeal of §§21.5101 - 21.5103 affects Insurance Code Chapter 1661.

TEXT.

§21.5101. Purpose.

§21.5102. Applicability.

§21.5103. Waiver.

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 30, 2023.

DocuSigned by:
Allison Eberhart
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Allison Eberhart
Deputy General Counsel
Texas Department of Insurance