

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION**DIVISION 1. GENERAL PROVISIONS
28 TAC §§21.5001 – 21.5003****DIVISION 2. MEDIATION PROCESS
28 TAC §§21.5010 – 21.5013****DIVISION 3. ARBITRATION PROCESS
28 TAC §§21.5020 – 21.5023****DIVISION 4. COMPLAINT RESOLUTION
28 TAC §21.5030****DIVISION 5. EXPLANATION OF BENEFITS
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28 TAC §21.5050**

INTRODUCTION. The Commissioner of Insurance adopts amended 28 TAC §§21.5001 – 21.5003, 21.5010 – 21.5013, and 21.5030; repeals §21.5020 and §21.5031; and adopts new §§21.5020 – 21.5023, 21.5040, and 21.5050, concerning out-of-network claim dispute resolution. Sections 21.5011, 21.5021, and 21.5030 are adopted with changes to the proposed text as published in the September 27, 2019, issue of the *Texas Register* (44 TexReg 5551). The department revised §21.5011 and §21.5021 in response to public comments. Additional revisions were made to correct grammar in §21.5030. The department adopts §§21.5001 - 21.5003, 21.5010, 21.5012, 21.5013, 21.5020, 21.5022, 21.5023, 21.5031, 21.5040, and 21.5050 without changes to the proposed text. These rules will not be republished.

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REASONED JUSTIFICATION. The new sections, amendments, and repeals are necessary to implement Senate Bill 1264, 86th Legislature, Regular Session (2019), which prohibits balance billing for certain health benefit claims under certain plans; amends the current mediation process set out in the Insurance Code, and provides for health benefit plan issuers and administrators to mediate disputes with out-of-network providers that are facilities; and provides for health benefit plan issuers and administrators to resolve disputes through binding arbitration with out-of-network providers that are not facilities.

SB 1264 applies to health benefit plans offered by insurers and health maintenance organizations (HMOs), and to plans other than those offered by insurers or HMOs that the department regulates, and it also applies to the Texas Employees Group, the Texas Public School Employees Group, and the Texas School Employees Uniform Group. The changes to law made by the bill apply to health care and medical services or supplies provided on or after January 1, 2020. SB 1264 addresses dispute resolution in cases involving emergency medical services, services provided by out-of-network providers at in-network facilities, and out-of-network laboratory and imaging services in connection with services performed by network physicians and providers. SB 1264 requires the department to establish a portal on its website to handle mediation and arbitration requests.

The amendments included in this adoption implement provisions that are required by SB 1264, including conforming amendments in 28 TAC Subchapter PP, and new divisions to implement the new mandatory arbitration procedures, required explanation of benefit notices created by the bill, and the benchmarking database. The department will propose and adopt conforming amendments under SB 1264 for other rule chapters separately, and those changes are outside the scope of this rule adoption. As provided by

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SB 1264, the Commissioner will conduct a study on the impacts of the bill, which is not part of this rule adoption.

The department encourages parties to settle payment disputes before engaging in mandatory mediation or mandatory binding arbitration.

Division 1. General Provisions.

Section 21.5001. Purpose. Amendments to this section clarify the purpose of the subchapter. The amendments reflect that the subchapter also addresses requesting, initiating, and conducting mandatory binding arbitration, as added by SB 1264. The rules no longer include preliminary procedures for mandatory mediation, because SB 1264 removed the State Office of Administrative Hearings from the out-of-network mediation dispute resolution process. Section 21.5001 is also amended to clarify that the subchapter now includes implementation of additional Insurance Code provisions outside of Chapter 1467 that relate to the new explanation of benefits required by Insurance Code Chapters 1271, 1301, 1551, 1575, and 1579 as adopted in new Division 5. Section 21.5001 is also amended to clarify that the subchapter now includes implementation for the submission of information for the benchmarking database in Insurance Code §1467.006.

Section 21.5002. Scope. Amendments to this section clarify the scope of the subchapter. Amending §21.5002 implements SB 1264, including changes to the applicability of health benefit plans offered by HMOs and for exclusive provider benefit plans. The amendments include notice that the adopted changes are prospective and apply to a health care or medical service or supply provided on or after January 1, 2020. The existing rule remains in effect for services provided before January 1, 2020.

Section 21.5003. Definitions. Amendments to this section update the definitions for the subchapter. Amending §21.5003 implements SB 1264, including removing

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definitions no longer necessary and to reflect new definitions in amended Insurance Code Chapter 1467. The adopted amendments refer to Insurance Code §1467.001 or other code citations found in that section. Some of the definitions in Insurance Code §1467.001, including "enrollee" and "party," were amended by SB 1264. Amendments to the definition of "out-of-network claim" refer to claims for payment by an out-of-network provider. SB 1264 expanded Insurance Code Chapter 1467 to include HMOs and exclusive provider benefit plans. The defined term "preferred provider" is removed because the term is no longer used in the text.

Division 2. Mediation Process.

Section 21.5010. Qualified Mediation Claim Criteria. This section clarifies what constitutes a claim eligible for mediation. Amending §21.5010 implements SB 1264 and Insurance Code Chapter 1467, Subchapter B, relating to mandatory mediation for out-of-network facilities. Section 21.5010(a) is amended to be consistent with Insurance Code §1467.050 and §1467.051. The mediation process no longer involves enrollees and only applies to a health benefit claim submitted by an out-of-network provider that is a facility or a health benefit plan issuer or administrator. Existing §21.5010(c) is amended because Insurance Code §1467.051(c) and (d) were repealed by SB 1264, and §21.5010(c) was based on those provisions. The amended §21.5010(c) states for clarity that uncovered claims are not eligible for mediation under the subchapter. Existing §21.5010(d) is removed because a threshold amount, as provided by that provision, no longer applies to mediation claims.

Section 21.5011. Mediation Request Procedure. This section is amended to require the use of the department's online portal to request mediation, instead of the form currently required by the section. Amending §21.5011 implements SB 1264 and

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Insurance Code Chapter 1467, Subchapter B, relating to mandatory mediation for out-of-network facilities. Insurance Code §1467.0505 calls for the Commissioner to establish and administer a mediation program and to establish a portal on the department's website through which mediation requests may be submitted.

Section 21.5011(a) is revised to update mediation request requirements and address notice requirements. Subsection (a)(1) requires an out-of-network provider that is a facility or a health benefit plan issuer or administrator to request mediation on the department's website at www.tdi.texas.gov, and it provides that the party requesting mediation must complete the mediation request information required on the department's website to be eligible for mediation. Subsection (a)(2) provides that the party who requests a mediation must send the notice of mediation to the other party, consistent with Insurance Code §1467.054(b-1). The department will receive the required notice when the party requesting mediation completes the request through the department's website. Subsection (a)(2) also clarifies that the proper address for a provider to send written notice is in the explanation of benefits, as specified in new §21.5040. A health benefit plan issuer or administrator requesting mediation is required to send the notice to the address the provider designates in the claim, or to the last known address that the health benefit plan issuer or administrator has on file for the provider if no address for mediation notice is provided in the claim.

The data elements listed in current subsection (a) and required in the existing form to request mediation are deleted, because SB 1264 repealed Insurance Code §1467.054(b). Insurance Code §1467.054(b) addressed the meditation request form, but meditation must now be requested through the department's online portal.

Amendments to §21.5011(b) prescribe the required information that must be included in an initial mediation request, which is similar to the content of the existing

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mediation request form. The request entered through the department's website must be complete, and incomplete requests may be rejected. Information from the enrollee's health benefit plan identification card is required. This information will help the parties and the department determine if the health benefit plan is one regulated by the department. Insurance Code §1467.054(b-1) requires the person who requests mediation to provide written notice on the date the mediation is requested in the form and manner provided by Commissioner rule.

Adopted §21.5011(c) addresses notice of teleconference outcome. The subsection specifies additional information the parties must submit to the department at the completion of the informal settlement teleconference period. The department needs this information to implement and administer the mediation program as required by Insurance Code §1467.0505. The proposed text in §21.5011(c) was changed in the adoption order in response to comments to clarify that parties will not have to submit "settlement offer amounts" to the department's website at the completion of the informal settlement teleconference period for mediation.

Adopted §21.5011(d) provides mediator selection procedures. Insurance Code §1467.053 requires that the department be notified if a mediator has not been selected by mutual agreement on or before the 30th day after the date mediation is requested. Subsection (d)(1) requires that the parties notify the department through the department's website if the parties agree to settle, agree on selection of a mediator, or agree to extend the deadline to have the department select a mediator and notify the department of new deadlines. In order to efficiently implement and administer the mediator program, mediation fees must be paid to the mediator if the Commissioner is required to select a mediator. The proposed text in §21.5011(d)(2) was changed in

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response to comment to clarify that the mediation fees are due when the department assigns a mediator, and the word "promptly" was removed.

Adopted §21.5011(e) requires the parties notify the department through the department's website of a mediation agreement or informal teleconference settlement. The submission of information will help the department efficiently implement and administer the mediation program.

Adopted §21.5011(f) specifies the procedures for mediator approval and removal. Insurance Code §1467.0505 requires the Commissioner to maintain a list of qualified mediators. The adopted rules allow for flexibility in how mediators will be added to the list, subject to the statutory qualification standards in Insurance Code §1467.052.

Adopted §21.5011(g) provides specific guidance on certain elements of the mediation process. Subsection (g)(1) gives the parties an opportunity to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process before requesting mediation. Resolving disputes in the internal appeal process will make for more efficient administration of the mediation process. The department removes the "best efforts" requirement in §21.5011(g)(1) in response to comment and replaces the language in the adoption order. The adopted language clarifies that 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.

Adopted §21.5011(g)(2) and (3) clarify that written submission of information to a mediator is acceptable and reminds parties that Insurance Code §1467.056 establishes the factors to be considered in mediation.

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Adopted §21.5011(g)(4) requires parties to check the list of qualified mediators and notify the department if there are conflicts. The parties are in the best position to know if there is a conflict of interest, as contemplated by Insurance Code §1467.052(c). The specified timeline will allow for timely selection of a mediator and will help the department efficiently administer the mediator program. The proposed text in §21.5011(g)(4) was changed in response to comment to clarify that each party has 10 days, instead of five days, within the request for mediation to notify the department of a conflict of interest with the mediator.

Adopted §21.5011(g)(5) allows parties to aggregate claims between the same facility and same health benefit plan issuer or administrator. This provision is based on Insurance Code §1467.056(c), which allows for the mediation of more than one claim between the parties during a mediation.

Existing §21.5011(c) is redesignated as new §21.5011(h). Reference to the toll-free telephone number is removed and instead the department's website is provided. This is consistent with SB 1264 changing the process to focus on requests being submitted through a portal on the department's website.

Section 21.5012. Informal Settlement Teleconference. This section is revised to specify that all parties must participate in an informal settlement teleconference under Insurance Code §1467.054(d). Amending §21.5012 implements SB 1264 and Insurance Code Chapter 1467, Subchapter B, relating to mandatory mediation for out-of-network facilities. In contrast to Insurance Code §1467.084(d) and new §21.5022, which require a health benefit plan issuer or administrator to make reasonable efforts to arrange a teleconference for a requested arbitration, Insurance Code §1467.054(d) and adopted §21.5012 provide that all parties arrange a workable date and time. An additional amendment is adopted to clarify that the deadline to have an informal telephone

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conference can be extended by agreement of the parties, consistent with Insurance Code §1467.055(k). The requirement to provide a toll-free telephone number is removed. This requirement is no longer necessary, because SB 1264 has removed enrollees from the process. The department assumes that providers and health benefit plan issuers and administrators have more experience with claims, and technological solutions exist beyond toll-free phone conferences that may be used by the parties for the informal settlement.

Section 21.5013. Mediation Participation. This section is revised for consistency with Insurance Code §1467.101, as amended by SB 1264. Subsection §21.5013(a) is deleted, because SB 1264 removed the State Office of Administrative Hearings from the out-of-network mediation dispute resolution process. Amending §21.5013 implements SB 1264 and Insurance Code Chapter 1467, Subchapter B, relating to mandatory mediation for out-of-network facilities.

Repeal of Current Division 3. Required Notice of Claims Dispute Resolution Notice.

Section 21.5020. Required Notice of Claims Dispute Resolution. Current Division 3 and §21.5020 are repealed to implement SB 1264. SB 1264 repealed Insurance Code §1467.0511, which required notice and information to the enrollee. Because enrollees are no longer party to the out-of-network claims dispute resolution process, current Division 3 and §21.5020 are no longer necessary.

New Division 3. Arbitration Process.

New Division 3 contains rules for required arbitration of certain out-of-network claims. The division is structured to be similar to the existing mediation rules in Division 2, but applies to nonfacility claims, as provided by SB 1264. As also provided in SB 1264,

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certain out-of-network facility claims are eligible for mandatory mediation under Insurance Code Chapter 1467, Subchapter B, and certain out-of-network claims not made by facilities are eligible for mandatory binding arbitration under Insurance Code Chapter 1467, subchapter B-1.

Section 21.5020. Qualified Arbitration Claim Criteria. This section provides the criteria established by statute for a claim to be eligible for mandatory binding arbitration under the subchapter. New §21.5020 implements SB 1264 and Insurance Code Chapter 1467, subchapter B-1, relating to mandatory arbitration for certain out-of-network claims. The criteria specified in the section are consistent with Insurance Code §1467.081 and §1467.084. Adopted §21.5020(a)(1) is consistent with Insurance Code §1467.084(a)(2). Adopted §21.5020(a)(2) is consistent with Insurance Code §1467.084(a)(1). Adopted §21.5020(b) is consistent with Insurance Code §1467.084(a) and clarifies that mandatory binding arbitration under the subchapter is intended to apply to claims where the health benefit plan issuer or administrator makes a payment and there is no dispute as to whether the claim is covered. However, the parties may agree to have the arbitrator decide the issue of coverage. Adopted §21.5020(c) is consistent with Insurance Code §1467.087(d).

Section 21.5021. Arbitration Request Procedure. This section provides for the use of the arbitration request portal and its requirements, and the procedures for arbitrator selection and the arbitration process. New §21.5021 implements SB 1264 and Insurance Code Chapter 1467, subchapter B-1, relating to mandatory arbitration for certain out-of-network claims.

Subsection (a)(1) of the adopted section specifies that an arbitration request must be made by completing the information required on the department's website. Insurance Code §1467.082 requires the Commissioner to establish and administer an arbitration

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program to resolve disputes over out-of-network provider charges, and to establish a portal on the department's website. Adopted §21.5021(a)(2) provides that the notice of arbitration must be sent to the other party, consistent with Insurance Code §1467.084(c). The department will receive the required notice when the party who requests an arbitration completes the request through the department's website. Subsection (a)(2) also clarifies that the proper address for a provider to send written notice is in the explanation of benefits. A health benefit plan issuer or administrator requesting arbitration is required to send notice to the address the provider designates in the claim, or to the last known address that health benefit plan issuer or administrator has on file for the provider if no address for arbitration notice is provided in the claim.

Adopted §21.5021(b) prescribes the required information that must be included in the initial arbitration request. The subsection specifies the types of information that are required, including basic provider and claim information. The request entered through the department's website must be complete, and incomplete requests may be rejected. Information from the enrollee's health benefit plan identification card is required. This information will help parties and the department determine if the benefit plan is one regulated by the department.

The notice of teleconference outcome is described in adopted new §21.5021(c). The subsection specifies the information the parties must submit to the department. The department needs this information to implement and administer the arbitration program, as required by Insurance Code §1467.082.

Adopted §21.5021(d) provides for arbitrator selection procedures. Insurance Code §1467.086 requires the department be notified if an arbitrator has not been selected by mutual agreement on or before the 30th day after the date the arbitration is requested. The adopted rule requires parties to notify the department if the parties have settled,

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agreed to their own arbitrator, or have extended the deadlines as provided by Insurance Code §1467.087(c). In order to efficiently implement and administer the arbitration program, arbitrator fees must be paid to the arbitrator if the Commissioner is required to select the arbitrator. Payment at the time the arbitrator is assigned may encourage qualified arbitrators to seek placement on the list. The proposed text in §21.5021(d)(2) was changed in the adoption order in response to comment to clarify that the arbitration fees are due when the department assigns an arbitrator, and the word "promptly" was removed.

Adopted §21.5021(e) requires certain information be sent to the department. Section 21.5021(e)(1) prescribes the process for arbitrators to send these notices. Insurance Code §1467.088(c) requires that an arbitrator must provide written notice in the form and manner prescribed by the Commissioner. Under adopted §21.5021(e)(2), the parties must notify the department when a settlement occurs before a decision. The statute also requires that parties provide written notice to the department if the parties settle before a decision. The submission of information will help the department efficiently implement and administer the arbitration program. Part of the proposed text in §21.5021(e)(1)(A) was removed in the adoption order in response to comment to clarify that the arbitrator is not required to submit information about when the arbitration was held. The arbitration process is a document review process and there is not a hearing or other in-person proceeding.

Adopted §21.5021(f) specifies the procedures for arbitrator approval and removal. Insurance Code §1467.082 requires the Commissioner to maintain a list of qualified arbitrators. The adopted rules allow for flexibility in how the Commissioner will add arbitrators to the list, subject to the statutory qualification standards in Insurance Code §1467.086.

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Adopted §21.5021(g) provides specific guidance on certain elements of the arbitration process. Adopted §21.5021(g)(1) provides the parties an opportunity to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process before a party requests arbitration. The department believes that resolving disputes in the internal appeal process will make for more efficient administration of the arbitration process. The department removes the "best efforts" requirement in §21.5021(g)(1) in response to comment and replaces the language in the adoption order. The adopted language clarifies that 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.

Adopted §21.5021(g)(2) clarifies that written submission of information to an arbitrator is required. Insurance Code §1467.087(a) states that the arbitrator will provide the date for submission of all considered information.

Adopted §21.5021(g)(3) requires the arbitrator to consider all the factors required by the statute, in accordance with Insurance Code §1467.083.

Adopted §21.5021(g)(4) is intended to provide procedural protections of all parties during the arbitration process. Consistent with Insurance Code §1467.083 and §1467.087, the arbitrator must provide each party 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 arbitrator's specified timeline.

Adopted §21.5021(g)(5) requires parties to check the list of qualified arbitrators and notify the department of any conflicts. The parties are in the best position to know if there is a conflict of interest, as contemplated by Insurance Code §1467.086. The proposed

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text in §21.5021(g)(5) was changed in the adoption order in response to comment to clarify that each party has 10 days, instead of five days, within the request for arbitration to notify the department of a conflict of interest with the arbitrator.

Adopted §21.5021(g)(6) states the consequences in the arbitration decision for parties that do not participate in good faith. Without enough information, the arbitrator will be limited to basing their decision on the information received. An arbitrator can make a decision even if a party fails to participate.

Adopted §21.5021(g)(7) provides for the submission of multiple claims between the same provider and same health benefit plan issuer or administrator. Insurance Code §1467.084(e) allows for the submission of multiple claims to arbitration in one proceeding, with certain limitations.

Adopted §21.5021(h) provides the department's website address for assistance. This is consistent with SB 1264 changing the process to focus on requests being submitted through a portal on the department's website.

Section 21.5022. Informal Settlement Teleconference. This section describes which parties must participate in an informal settlement teleconference under Insurance Code §1467.084(d). New §21.5022 implements SB 1264 and Insurance Code Chapter 1467, subchapter B-1, relating to mandatory arbitration for certain out-of-network claims. Insurance Code §1467.084(d) requires the health benefit plan issuer or administrator make a reasonable effort to arrange the teleconference. The adopted section permits extension of the deadline, in accordance with Insurance Code §1467.087(c).

Section 21.5023. Arbitration Participation. This section requires that arbitration participants not engage in bad faith conduct. New §21.5023 implements SB 1264 and Insurance Code Chapter 1467, subchapter B-1, relating to mandatory arbitration for certain out-of-network claims. New §21.5023 is like existing §21.5013, as Insurance Code

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§1467.101 prohibits bad faith conduct for both the mediation and arbitration process. The statutorily prohibited conduct is restated for emphasis.

Division 4. Complaint Resolution.

Section 21.5030. Complaint Resolution. This section is amended to reflect changes to Insurance Code §1467.151 made by SB 1264. The adopted amendments clarify that the complaint process applies to both the revised mediation process and the new mandatory binding arbitration process under SB 1264. Subsection §21.5030(a) is amended to simplify the language and reflects the increased experience with claims among parties who may request mediation or arbitration under the subchapter, reducing the information required to file a complaint. Because SB 1264 requires providers and health benefit plan issuers or administrators to use the department's website, amending the complaint instructions in §21.5030 allows for more efficient administration of the statute. Other amendments are adopted to make the section apply to both the mediation and arbitration procedures.

Section 21.5031. Department Outreach. This section is repealed. Repealing §21.5031 is necessary to implement amendments made by SB 1264 to Insurance Code §1467.151(a)(2). Repealing the section removes outreach efforts to enrollees from the rules because enrollees are no longer part of the out-of-network claims dispute resolution process.

New Division 5. Explanation of Benefits.

New Division 5, relating to explanation of benefits, is adopted to provide requirements for the mandatory explanation of benefits required by certain health benefit plan issuers and administrators.

Section 21.5040. Required Explanation of Benefits. This section implements requirements established by Insurance Code §§1271.008, 1301.010, 1551.015, 1575.009, and 1579.009. The section requires a statement of the applicable billing prohibition and a disclosure of the total amount the provider may bill the enrollee under the health benefit plan, and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total. The health benefit plan issuer or administrator must provide the statement by the date the health benefit plan issuer or administrator makes a payment, as applicable. The section requires the health benefit plan issuer or administrator to provide a specific statement related to the availability of mediation or arbitration. The statement requires the health benefit plan issuer or administrator to provide contact information for where the mediation or arbitration request notice must be sent, as required by amended §21.5011 and new §21.5021.

New Division 6. Benchmarking.

New Division 6, relating to benchmarking, is adopted to provide requirements on data submission by health benefit plan issuers and administrators to the organization selected by the Commissioner to maintain a benchmarking database.

Section 21.5050. Submission of Information. This section implements new requirements in Insurance Code §1467.006, created by SB 1264. Data reporting is needed for the mandatory binding arbitration process. Data in the benchmarking database must be obtained so that arbitrators can consider billed charges for services provided in the same geozip area, in accordance with Insurance Code §1467.083; however, the data collection must be consistent with Insurance Code §1467.006 and §1467.083. Health benefit plan issuers and administrators must submit their 2019 plan-year data to the benchmarking database organization by February 1, 2020. After February 1, 2020, health

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benefit plan issuers and administrators must submit data monthly to the benchmarking database organization, or as required by the selected benchmarking organization.

In addition to the amendments to specific sections previously noted, the adopted amendments include nonsubstantive editorial and formatting changes to conform the sections to the department's current style and to improve the rule's clarity.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received 43 written comments and 15 people spoke at the public hearing on October 23, 2019. Some people who spoke at the hearing also submitted written comments. One individual supported the proposal. Commenters in support of the proposal with changes were: nine individuals, AARP Texas, American College of Obstetricians and Gynecologists District XI, American Surgical Professionals, Blue Cross Blue Shield of Texas, Center for Public Policy Priorities, Emergency Department Practice Management Association, FAIR Health, National Association of Independent Review Organizations, National Federation of Independent Business, Office of Dispute Resolution, Patient Choice Coalition, PPO Check, ProPeer, RNFA Surgical Specialists, Surgeons Advantage PLLC, Surgery Studio LLC, Texas Ambulatory Surgery Center Society, Texas Assistant Surgical Association, Texas Association of Business, Texas Association of Freestanding Emergency Centers, Texas Association of Health Plans, Texas Association of Health Underwriters, Texas Association of Life and Health Insurers, Texas Chapter of the American College of Cardiology, Texas College of Emergency Physicians, Texas Conservative Coalition Research Institute, Texas Emergency Medicine Practice Alliance, Texas Hospital Association, Texas Medical Association, Texas Orthopedic Association, Texas Radiological Society, Texas Society for Gastroenterology and Endoscopy, Texas Society of Anesthesiologists, Texas Society of Pathologists, Texas Society of Plastic

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Surgeons, Texas Urological Society, TexAssist Surgical Staffing, University of Texas Health Science Center at Houston, and Utilization Review Accreditation Commission. One individual opposed the proposal.

General Comment.

Comment: Many commenters support implementation of SB 1264.

Agency Response: The department thanks the commenters for the support of the proposed rules.

Comments on Division 1. General Provisions

Comment on §21.5002

Comment: Several commenters shared concerns over SB 1264. One commenter requests that the department exempt or provide a safe harbor for certain providers, such as surgical assistants, from the regulations. In the alternative, the commenter asks for an extension from the applicability of the bill. One commenter states that they feel that legislators did not have adequate information to make informed decisions, because not all affected parties have had input.

Agency Response: The department declines to make a change. These concerns are outside the scope of the proposed rules because the proposed rules implement what is required by SB 1264. The department must implement enrolled legislation, and the changes in law made by SB 1264 apply to a health care or medical service or supply provided on or after January 1, 2020.

Comments on §21.5003

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Comment: Two commenters suggest that the definition of "emergency care" in §21.5003(6) be limited to Subsection (a) of Insurance Code §1301.155.

Agency Response: The department disagrees with the comments and declines to make the change. While Insurance Code §1301.155(a) does describe the meaning of "emergency care," the definition in §21.5003 of the rule comes directly from Insurance Code §1467.001. Section 1467.001 says that "emergency care" has the meaning assigned by Insurance Code §1301.155, which does not limit the definition to just a part of that section.

Comment: One commenter requests clarification on why the definition of "out-of-network claim" in §21.5003(15) includes services provided by an out-of-network provider or a non-network provider. The commenter suggests deletion of the term "non-network provider" from the definition of out-of-network claim and where it is used in §21.5040.

Agency Response: The department disagrees with the commenter and declines to make a change. The term "non-network" is sometimes used with respect to HMO plan networks, and SB 1264 added HMOs to the dispute resolution process. The department added the non-network language to address possible concerns that the existing definitions in the subchapter did not adequately address HMO network contracting practices.

Comments on Division 2. Mediation Process

Comment on Mediation Procedures

Comment: One commenter expressed dissatisfaction with the mediation procedures prior to SB 1264. The commenter asks how the department plans to manage the new mediation process going forward.

Agency Response: The amendments to the mediation rules implement SB 1264. Under SB 1264 many billing situations formerly eligible for mediation will be eligible for

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arbitration. The adopted mediation procedures remove the enrollee from the process, which is only between health plan issuers or administrators and facilities. SB 1264 has made other changes to the mediation process that the department believes will improve the mediation experience for participating parties.

Comments on §21.5010(a)

Comment: One commenter requests the department amend §21.5010(a)(1) to clarify that only out-of-network claims are eligible for mediation. Another commenter states that the rules do not clarify whether emergency care services are covered. The commenter suggests alternative language for §21.5010(a)(1).

Agency Response: The department agrees with the first commenter that only out-of-network claims are eligible for mediation; however, it declines to make a change. The department does not agree with the second commenter and declines to make the requested change to the proposed rule text. As adopted, §21.5010(a)(1)(A)-(C) is consistent with Insurance Code §1467.051(a)(2)(A)-(C). Both statute and rule state that the "claim must be for...emergency care[.]" The term "emergency care" is defined in Insurance Code §1301.155(a) as a health care service.

Comment: One commenter recommends the rule be changed to clarify that in-network and not out-of-network copayments, coinsurance, and deductibles apply in §21.5010(a)(2).

Agency Response: The department disagrees with the commenter that further clarification is needed and declines to make a change. As adopted, §21.5010(a)(2) is consistent with Insurance Code §1467.051(a)(1). The request is outside the scope of this rulemaking and is also already addressed by statute and rule.

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Comment: One commenter states that there should be a 90-day deadline to request mediation, similar to the requirement for requesting arbitration. The commenter states that mediation is a statutory prerequisite for accessing civil courts and payment delays may create financial hardship. Another commenter requests clarification if there is a deadline for requesting mediation.

Agency Response: The department declines to make a change. The Legislature did not provide a deadline to request mediation like it did for arbitration. See *Liberty Mut. Ins. Co. v. Adcock*, 412 S.W.3d 492, 497 (Tex. 2013) ("When the Legislature expresses its intent regarding a subject in one setting, but . . . remains silent on that subject in another, we generally abide by the rule that such silence is intentional."). However, in Insurance Code §1467.055(g), the Legislature created a 180-day period within which a mediation must be held. Under Insurance Code §1467.0575, a party may not bring a civil action before the conclusion of the mediation process.

Comment on §21.5010(c)

Comment: Several commenters support proposed §21.5010(c) and agree that the issue of whether a service or supply is covered by a health benefit plan is not subject to mediation unless the parties agree. A commenter suggests that the rules clarify that mediation is not available for coverage disputes.

One commenter states that there appears to be no limits in the statute regarding what portion of a dispute can be mediated, including questions of coverage, down-coding, levels of care, prudent layperson standard, and reimbursement rates. The commenter states that if the intent is to exclude everything a health benefit plan classifies as uncovered, then it creates an exception that swallows the rule.

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Agency Response: The department appreciates the supportive comments, but it disagrees with the commenters who request further clarification and the commenter who says the rule creates an exception that swallows the rule and declines to make a change. Insurance Code §1467.055(i) states that "A health care or medical service or supply provided by an out-of-network provider may not be summarily disallowed. This subsection does not require a health benefit plan issuer or administrator to pay for an uncovered service or supply."

The intent of §21.5010(c) is to clarify that the mediation process is not for questions of coverage. The department disagrees that the mediation procedures lack limits in what issues may be mediated. Mediations are not meant for determining questions of coverage or other issues in dispute other than disputes over out-of-network provider charges, unless otherwise agreed to by the parties. The department emphasizes that parties are free to settle a broader scope of payment issues and may choose to include those issues in the mediation process if all parties agree. The department expects that payers will pay claims consistent with statutes and rules.

Comments on §21.5011(a)

Comment: Several commenters express concern about notification of mediation requests under §21.5011(a). Several commenters suggest that the department should permit facilities and health benefit plan issuers to designate an email or physical address for mediation notices on the department's website. A commenter notes that claim forms do not contain an email address and sometimes the mailing address on claim forms route to a secure mailbox or lockbox, which can create a delay or lack of proper delivery.

One commenter states that the timelines should be delayed until the other party is notified, or the portal should include automatic notification to the other party. The

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commenter also suggests that the department consider imposing a penalty if no notification has been sent. The commenter also requests that the department notify the parties that they may provide an email address dedicated only for dispute resolution requests, and that the use of the email for other purposes does not trigger other regulatory timeframes.

Agency Response: The department recognizes these concerns but disagrees with the commenters that changes are needed to the proposed text and declines to change the proposed rules. The department notes that §21.5011(a)(2) allows facilities to specify in the claim a mailing or email address where receipt of a mediation request should be submitted. The department wants to give the parties an opportunity to provide the most recent email or mailing address to each other instead of relying on the department's website.

The department does not want there to be delays in parties receiving notifications of mediation requests. Specifically, the department is providing additional time for certain notifications. For example, under amendments made to §21.5011(g)(4), the department is providing additional time to notify the department of conflicts of interest. The department may create additional functionality to the portal as time and resources permit. Under Insurance Code §1467.054(b-1), the Legislature provides that the person who requests a mediation must provide written notice on the date the mediation is requested. If a party does not send notification of a mediation request the day mediation is requested, then the department may refer the requesting party for enforcement.

The department believes it is understood that the email address provided in a claim form or explanation of benefits is for the purpose of dispute resolution. The department will closely monitor implementation and be ready to provide additional guidance as needed.

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Comment: One commenter suggests that the department revise §21.5011(a)(2) to require that the department be copied on all required communications and notices through its online portal. The commenter states that this will lower the burden on the department by reducing the number of complaints associated with the mediation process.

Another commenter suggests that the department remove the word "each" from §21.5011(a)(2) to clarify there will be only two parties to mediation.

Agency Response: The department recognizes these concerns but disagrees that changes are needed to the rule text and declines to revise the proposed rule. As currently designed, the website portal will notify the department when notices and requests are entered. The department agrees that this should help the department manage the mediation process. The department declines to remove the word "each," because the language is consistent with Insurance Code §1467.054(b-1).

Comment: One commenter requests that the department use the term "initiating" mediation instead of being "eligible" for mediation for clarity in §21.5011(a)(1). The commenter requests that the department clarify that mediation is not available for claims for which the out-of-network provider has obtained a "waiver" of the balance billing prohibition.

Agency Response: The department declines to make a change because the suggested language will not change the meaning. The party requesting mediation will answer questions on the department's website, which will let them know if they are eligible to initiate mediation. The department declines to make a change because the department also believes it is clear that an out-of-network provider that has obtained a "waiver" of

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the balance billing prohibition under Insurance Code Chapters 1271, 1301, 1551, 1575, and 1579 is not eligible for mediation.

Comment on §21.5011(b)

Comment: One commenter suggests that the requesting party indicate in a mediation request that a claim is a fully-insured claim or a Texas Employees Group, Texas Public School Employees Group, and Texas School Employees Uniform Group claim. The commenter suggests including an attestation as part of the mediation request that the submission is for a payment dispute and not another type of dispute.

Agency Response: The department recognizes these concerns but does not agree that changes are needed and declines to revise the proposed rule. The department anticipates that the information required by §21.5011(b) will be enough to determine if a claim is one that is subject to Insurance Code Chapter 1467. The language as adopted provides some flexibility to adjust solicited information so that only regulated claims enter the system. The department will continue to monitor all parties for abuse of the dispute resolution process and may make enforcement referrals as necessary.

Comment on §21.5011(c)

Comment: Several commenters express concern that the proposed §21.5011(c) requires parties to submit settlement offer amounts made in an informal settlement teleconference prior to mediation. A commenter notes that SB 1264 does not specifically require reporting this information for mediation. Another commenter requests that the requirement to submit information be placed on the party requesting the mediation. The commenter also suggests that only the final offer be reported.

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Agency Response: The department agrees with the commenters and has revised the proposed text by removing the requirement in §21.5011(c) regarding reporting the settlement offer amounts. The rule still requires parties to report the date the teleconference request was received and the date of the teleconference. In addition, the parties must still submit the agreement including the original billed amount, payment amount, and the total agreed amount under §21.5011(e)(2). The department needs this information to implement and administer the mediation program as required by Insurance Code §1467.0505. The department believes it is prudent to accept information from either or both parties.

Comments on §21.5011(d)

Comment: One commenter suggests having one party be responsible for reporting mediator selection information and allowing the other party to object, to avoid conflicts in information submission.

Agency Response: The department disagrees with the commenter and declines to make the requested change. The department believes information should be accepted from either or both parties.

Comment: One commenter suggests that mediation fees be paid entirely by the health benefit plan.

Agency Response: The department disagrees with the commenter and declines to make the requested change. Insurance Code §1467.053(d) provides that a mediator's fees must be split evenly and paid by both the health benefit plan issuer or administrator and the out-of-network provider.

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Comment: One commenter states that the department should specify a deadline for payment of a mediator fee. The commenter notes that failure to pay a fee "promptly" constitutes bad faith, which can result in a penalty.

Agency Response: The department agrees in part with the commenter and adopts a change to §21.5011(d)(2); however, it does not revise the proposed rule text to specify a deadline for payment. The department removes the word "promptly," to clarify that the nonrefundable mediator fee is due at mediator assignment. Under Insurance Code §1467.053(b-1), parties have 30 days after mediation is requested to select a mediator by mutual agreement, otherwise the department must select one. If the parties do not agree to settlement, selection of a mediator, or an extension to select a mediator within that time, the nonrefundable mediator fee is due under the rules. In addition under the rules, failure to pay the mediator when the mediator is assigned constitutes bad faith participation.

The department makes a similar change to the proposed arbitration rules in §21.5021(d)(2).

Comment on §21.5011(e)

Comment: One commenter suggests making the mediation report elements "as applicable" or conditioned on an agreement being reached under §21.5011(e).

Agency Response: The department disagrees with the commenter and declines to make a change, because it is understood that if an agreement is not reached then that information is not required for submission.

Comments on §21.5011(f)

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Comment: One commenter suggests adding a new §21.5011(f)(3) that would specifically state that the department or parties may engage in the alternative dispute resolution system authorized by Chapter 152 of the Texas Civil Practices and Remedies Code. The suggested new provision would state that the department would also list on its website the entities that have agreed to provide mediation services under that statute and execute interlocal agreements with entities that are governmental agencies to provide those services.

Agency Response: The department declines to make the requested change. Insurance Code §1467.052 provides specific guidance for mediator qualifications, and the rules must be consistent with the statute. However, the department supports the commenter's suggestion that parties settle disputes on their own, including through an alternative dispute resolution system under Chapter 152 of the Texas Civil Practices and Remedies Code. The department notes that under Insurance Code §1467.053(b-1), parties may select a mediator by mutual agreement and, under Insurance Code §1467.052(b), any person may be appointed as a mediator on agreement of the parties. At the hearing on October 23, 2019, staff for the department noted that "while mediation and arbitration will be available, parties can settle disputes on their own, informally. The parties can also choose their own mediator or arbitrator, and we encourage them to do so."

Comment: One commenter states that there should be more mandatory minimum qualifications and training for mediators. Further, the commenter says that mediator decisions should be completed within two weeks of request submission and, for fairness, mediators should be utilized on a rotational basis.

Agency Response: The department declines to make the suggested changes. Insurance Code §1467.052 provides specific guidance for mediator qualifications and the rules are

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consistent with statute. See *Cummins v. Travis Cnty. Water Control and Improvement Dist. No. 17*, 175 S.W.3d 34, 57 (Tex. App.—Austin 2005, pet. denied)("Agencies are not permitted to 'impose additional burdens, conditions, or restrictions in excess of the statutory provisions[.]"). To be a mediator, a person must have completed at least 40 hours of training in dispute resolution techniques. The department will closely monitor implementation and be ready to provide additional guidance.

Under Insurance Code §1467.060, the mediator has 45 days after the mediation concludes to send the mediator report to the Commissioner and the appropriate regulatory agency. This time frame is set by the Legislature.

Comment: One commenter recommends that the list of qualified mediators maintained by the department include information regarding the qualifications and fee amounts of each one, so that parties can more efficiently choose a mediator and identify any potential conflicts of interest.

Agency Response: The department recognizes these concerns but declines to amend the proposed rule because any such change is unnecessary. However, the department anticipates that it will provide information regarding mediator fees on its website. Mediators on the list will meet the minimum requirements under Insurance Code §1467.052(a), which includes completion of at least 40 classroom hours of dispute resolution training.

Comment on §21.5011(g)

Comment: Several commenters expressed concern over the requirement in §21.5011(g)(1) for an out-of-network provider to use best efforts to resolve a claim payment dispute through a health benefit plan issuer's or administrator's internal appeal

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process before requesting mediation. One commenter states that once an insurance company denies or submits a payment, it should automatically go to the department for mediation. Several commenters state that the phrase "best efforts" is vague or too subjective. One commenter states that "best efforts" would be difficult to demonstrate and suggests another term such as "attempt."

One commenter states that the proposed requirement places the burden on the provider, and that insurers will drag out the claims process. Another commenter states that the internal appeals process is often "an exercise in futility." Two commenters suggest specific boundaries for best efforts. Another commenter asks the department to clarify when a provider can extricate itself from the internal appeal process and proceed to mediation. The commenter requests that the department establish a threshold that would allow a provider to opt out of the internal appeal process if at least 50% of claims submitted do not result in a change in payment. One commenter requests that the rules clarify that a provider may not pursue an internal appeal process at the same time they pursue mediation.

Two commenters support the proposed language. One commenter states that it may benefit all parties in attempting to reach an informal resolution prior to the time and expense of mediation.

Agency Response: The department agrees to make a change. The department removes the "best efforts" language in §21.5011(g)(1) and replaces it with language to give the parties an opportunity (20 days) to resolve their dispute through the health benefit plan issuer's or administrator's internal appeal process before requesting mediation.

Several commenters suggest alternative language for this provision. The change the department adopts addresses these concerns and is consistent with the efficient

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administration of the mediation processes. The department adopts this changed provision under the authority of Insurance Code §1467.0505.

The department clarifies that a provider may pursue an internal appeal before they pursue mediation. There is nothing in SB 1264 or the rules that states that a party cannot pursue an internal appeal after mediation is requested or that the appeal process must be completed within 20 days.

Comment on §21.5011(g)(4)

Comment: Two commenters recommend the department revise the proposed rule and base the time frame for the parties to notify the department of a conflict of interest with any mediator on the department's list on receipt of a mediation request. Another commenter states that the section provides a very short time frame and is an onerous requirement for both parties to undertake.

Agency Response: The department declines to make the change regarding notification to the department based on receipt of the mediation request instead of when the mediation request is made. Under Insurance Code §1467.054(b-1) and adopted §21.5011(a)(2), the party who requests the mediation must provide written notice to the other party on the date the mediation is requested. The department anticipates that the requesting party will provide the required notice to the other party when the mediation is requested.

However, in response to the comments, the department lengthens the time for the parties to determine if there is a conflict of interest with any of the mediators under §21.5011(g)(4) from five days to 10 days. The department will have a list of mediators that parties can review at any time on the department's website. Parties do not need to request mediation or receive a request in order to assess whether they may have a conflict of

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interest with a mediator on the list. The parties can also choose their own mediator, including those mediators on the department's list, and are encouraged to do so. The change the department adopts addresses these concerns and is consistent with the efficient administration of the mediation program under Insurance Code §1467.0505.

Comment on §21.5011(g)(5)

Comment: Several commenters state that the department should not limit a requesting party's right to mediate multiple claims in a single mediation and they address the issue of whether to bundle claims. One of the commenters wants the department to clarify that "same facility" in proposed §21.5011(g)(5) should include any facility affiliate. Another commenter states that to limit bundling would destroy the efficiency that aggregation provides by forcing each claim to be mediated individually. One of the commenters has concerns that requiring the parties to agree to aggregate claims serves as a "unilateral veto" and requests the department clarify that the party requesting mediation may choose to aggregate claims.

One commenter supports the aggregation of claims only on agreement of the parties as specified in statute.

Agency Response: The department recognizes these concerns but does not agree that changes to the rule text are necessary and declines to revise the proposed rule. The department notes that the rules do not automatically limit the ability for parties to mediate multiple claims in a single mediation. As proposed, the provision is consistent with Insurance Code §1457.056(c), which states that "[n]othing in this chapter prohibits mediation of more than one claim between the parties during a mediation." The department believes that both parties must agree to bundle multiple claims, including from facility affiliates, just as other procedures in mediation require party agreement. The

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department will closely monitor implementation and provide additional guidance as needed.

Comments on §21.5012

Comment: One commenter recommends that the party requesting mediation should be required to schedule the teleconference.

Agency Response: The department disagrees with the commenter and declines to make the requested change, because mediation is a process based on agreement of parties. In an effort to settle a claim before mediation, the parties must participate in an informal settlement teleconference under Insurance Code §1467.054(d). The Legislature provides in Insurance Code §1467.084(d) that the health plan issuer or administrator must make a reasonable effort to arrange the teleconference for arbitration. Because the Legislature did not make this same requirement for mediation, the department believes that both parties should coordinate the informal settlement teleconference. See *Liberty Mut. Ins. Co. v. Adcock*, 412 S.W.3d 492, 497 (Tex. 2013) ("When the Legislature expresses its intent regarding a subject in one setting, but . . . remains silent on that subject in another, we generally abide by the rule that such silence is intentional.").

Comment: One commenter is concerned that proving "best efforts" to coordinate an informal settlement teleconference is vague and difficult to demonstrate.

Agency Response: The department disagrees with the commenter declines to make a change based on this comment. The "best efforts" language is the language in current §21.5012. Insurance Code §1467.101 provides that certain conduct "constitutes bad faith participation" including "failing to participate in the . . . mediation under this chapter." The statute requires participation, which the department believes provides enough clarity as

to what conduct is expected from the parties. This language has not caused an enforcement problem in the past. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comments on Division 3. Arbitration Process**Comment on Arbitrators**

Comment: Several commenters state that Independent Review Organizations (IROs) are best positioned to be the arbitrators for out-of-network claim dispute resolution, because IROs have history and experience, including in other states.

Agency Response: The department agrees that IROs have useful experience and knowledge but does not agree that any changes to the rule text are necessary to address the comment. The department encourages IROs to apply to be arbitrators if they meet the statutory requirements, including those under Insurance Code §1467.086(c).

Comments on §21.5020

Comment: Several commenters request clarification or suggest amendments to §21.5020. One commenter requests the department amend §21.5020(a)(1) to clarify that only out-of-network claims are eligible for arbitration. Other commenters request the department amend §21.5020(a)(1)(A) to expressly include "supplies" as part of what can be addressed in an arbitration claim for emergency care and covered services provided by an out-of-network provider.

In addition, one of the commenters states there is nothing in the criteria that explains a payment older than 90 days may not be arbitrated under Insurance Code §1467.084(a). Another commenter suggests alternative language for §21.5020(a)(1) to clarify the application of the provisions.

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Another commenter recommends that the department expressly add that services must be "covered" to be eligible for arbitration.

Agency Response: The department disagrees with the commenters that any change to §21.5020(a) is necessary. The department agrees with the commenter that only out-of-network claims are eligible for arbitration, but no change is necessary because the language in the rule conforms to Insurance Code §1467.084(a)(2)(A)-(D). The department declines to make a change regarding supplies because "emergency care" is defined in Insurance Code §1467.001(2-c) and has the meaning assigned by Insurance Code §1301.155. SB 1264 amends Insurance Code §1301.155 to include "supplies" where applicable.

The department declines to make a change to clarify that a payment older than 90 days may not be arbitrated. The rule includes the 90-day period to request arbitration in §21.5020(b), which is consistent with Insurance Code §1467.084(a).

The department declines to add "covered" to the section. Insurance Code §1467.084(a) provides that the out-of-network provider must receive initial payment before requesting arbitration. Payments are made for covered services or supplies, and the department believes the parties understand that the claim is covered and can only be decided by the arbitrator if the parties agree otherwise under Insurance Code §1467.087(d).

Comment: One commenter recommends that §21.5020(a)(2) be changed to clarify that copayments, coinsurance, and deductibles should be those for in-network cost sharing. The commenter also recommends that §21.5020(b) include additional clarification about an enrollee's in-network deductible.

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Agency Response: The department declines to make the requested change. SB 1264 imposes certain requirements related to out-of-network providers billing an enrollee for applicable copayments, coinsurance, and deductibles under the enrollee's health care plan, as provided by Insurance Code §1467.084(a)(1). The request is outside the scope of this rulemaking and is also already addressed by statute and rule. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comment: One commenter states support for the language in proposed §21.5020(b) that says the initial payment "could be zero dollars if the allowable amount was applied to an enrollee's deductible." Another commenter suggests clarifying that the initial payment may be zero dollars if the allowable amount was "wholly" applied to the enrollee's deductible.

Another commenter says that the department should interpret the first sentence of §21.5020(b) to apply so that if a health benefit plan issuer or administrator violates the law by paying its enrollee directly, rather than paying the physician, the 90-day-arbitration-initiation clock does not begin to run until the physician actually receives payment from the health benefit plan issuer or administrator. Also, the commenter asks, regarding the second sentence of §21.5020(b), when a physician would have "received" the zero payment for purposes of the initiation of arbitration and how the physician would know that the clock has started ticking.

Agency Response: The department declines to make changes to §21.5020(b) as they suggest. The department does not add "wholly" as suggested, because the change is not necessary.

The department declines to change the rule to address direct payment to enrollees. Insurance Code §1467.084(a) requires an out-of-network provider to receive an initial

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payment. The department anticipates that the health benefit plan issuer or administrator would send an explanation of benefits that explains the zero-dollar payment. The department believes that it is not the intent of statute for health benefit plan issuers and administrators to be able to limit arbitration eligibility through direct payment to an enrollee.

In response to the commenter's question about the second sentence of §21.5020(b), the department anticipates that health benefit plan issuers and administrators will provide providers explanation of benefits compliant with the statute and rules that show zero payment, which will provide parties the opportunity to request arbitration.

Comment: Several commenters support proposed §21.5020(c) and agree that the issue of whether a service or supply is covered by a health benefit plan may not be subject to arbitration unless the parties agree. Several commenters suggest that the rules should clarify that arbitration is not available for coverage disputes. One commenter asks for clarification on the provision that parties can agree to determine the issue of coverage. The commenter notes that a provider is usually unable to obtain the coverage document to determine whether a coverage decision is appropriate.

Agency Response: The department declines to make a change. The department notes that §21.5020(c) is consistent with Insurance Code §1467.087(d), and that coverage issues will not normally be addressed at arbitration "[u]nless otherwise agreed to by the parties."

The department encourages informal settlement before requesting arbitration as provided under SB 1264. The department agrees that it would be helpful for all parties to understand relevant policy documents and expects that if parties want to address coverage issues then parties will share information as reasonably necessary. The

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department will continue to monitor the process and be ready to provide additional guidance as needed.

Comments on §21.5021(a)

Comment: A commenter requests a standardized website portal for parties to use and standardized forms for the submission of arbitration requests.

Agency Response: The department declines to make a change because it anticipates that the website portal will provide the opportunity to enter information required by §21.5021(a). The department notes that the look and appearance of the portal may change as the experience is altered to ensure an efficient process and implementation of SB 1264, but it will remain consistent with statute and rules. The department welcomes feedback on the portal as it administers the arbitration program.

Comment: A commenter says that the language of §21.5021(a)(1) is ambiguous as proposed, and the commenter suggests new language, asking that the rule text be clarified to require completion of arbitration request information through the department's website. Another commenter requests that the department use the term "initiating" arbitration instead of being "eligible" for arbitration, for clarity. The commenter requests that the department clarify that arbitration is not available for claims for which the out-of-network provider has obtained a "waiver" of the balance billing prohibition.

Agency Response: The department declines to make a change because the suggested language would not change the effect of the rule. The party requesting arbitration will answer questions on the department's website, which will let them know if they are eligible for arbitration. And the department agrees but declines to make a change because the department believes it is clear that an out-of-network provider that has obtained a

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"waiver" of the balance billing prohibition under Insurance Code Chapters 1271, 1301, 1551, 1575, and 1579 is not eligible for arbitration.

Comment: A commenter says that proposed §21.5021(a)(2) appears to implement Insurance Code §1467.084(c), which requires a person who requests arbitration to "provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to: (1) the department and (2) each other party." However, the commenter says, the language in subsection (a)(2) that implements this is so vague that it is difficult to know what the "form" of the notice will require, since the rule merely cross references the department's website, which is not available to review. The commenter asks what information will be required in the notice, recommends that the department provide greater notice in its rules regarding the content of the notice by specifying the required elements in a finite form, and recommends that the department develop a form for the notice that a party may use to facilitate provision of notice.

Agency Response: The department disagrees with the commenter and declines to make a change. The portal on the department's website will provide a means for parties to submit an arbitration request.

The department believes this is consistent with the intent of Insurance Code §1467.082, which requires "the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.084 may be submitted." Required elements of the arbitration request are specified in §21.5021(b). The department anticipates that the same information submitted to the department through the portal will be what is sent to the other party. Flexibility is important, as the department learns to more effectively administer the portal, automate functions where possible, and adapt to changes in technology.

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The department notes that the look and appearance of the portal may change as the experience is altered to ensure an efficient process and implementation of SB 1264, but it will remain consistent with statute and rules. The department welcomes feedback on the portal as it administers the arbitration program. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comment: Two commenters express concern about §21.5021(a)(2) with how a carrier requesting arbitration will notify the other party. The commenters note that under the provision a carrier may choose to either email or mail the notice. The commenter is concerned that a mailed notice may be delayed, causing a party to miss the deadline to notify the department about a conflict of interest. The commenters are also concerned about the lack of space to provide an email or address on an electronically submitted claim.

A commenter says receiving notification by email may not be a desirable option for many physicians, because it may delay receipt.

A commenter is concerned that there is no requirement that a carrier make a good-faith effort to contact the provider and not the billing company. Additionally, the commenter is concerned that the notification does not require the other party to acknowledge receipt of the notice. The commenter suggests that arbitration requests be performed through the online portal. The commenter requests that the rules not start any deadline for either party until receipt of a request.

A commenter says the provision in the rule allowing a health benefit plan issuer or administrator to provide notice to a provider at the provider's last known address the issuer or administrator has on file for the provider, when the provider does not specify an address to receive notice requesting arbitration in the claim, practically encourages

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defective notice to out-of-network providers, because there is no way to know how defective or inadequate the address on file would be.

To address these concerns, the commenter suggests that the department establish a password-protected database on its website where out-of-network providers could submit their preferred contact email or mailing addresses, and that the department should work with the Texas Medical Board to reach out to all physicians on at least a quarterly basis to request updated information for this database. The commenter also says that the department should explore methods to shield the information contained in the database from open records requests, and if such information cannot be protected, the department should make sure physicians know that the information they provide may be subject to open records requirements.

The commenter is also concerned that the requirement for out-of-network providers who request arbitration to send notice to the email address specified in the explanation of benefits by a health benefit plan issuer or administrator could present similar challenges, because health benefit plan issuers and administrators cannot add an email address to the explanation of benefits form. To address this concern, the commenter suggests that the department establish a second database for health benefit plan issuer and administrator contact addresses similar to what the commenter requests for physicians and make the information in the database accessible via a drop-down field in the arbitration notice form on the department's website.

Another commenter suggests that the department remove the word "each" from §21.5021(a)(2) to clarify there will only be two parties to arbitration.

Agency Response: The department recognizes these concerns but does not agree that changes to the rule text are necessary and declines to revise §21.5021(a). The department notes that in §21.5021(a)(2), the rule allows providers to specify in a claim a mailing or

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email address where receipt of an arbitration request should be submitted. The department wants to give the parties an opportunity to provide the most recent email or mailing address to each other instead of relying on the department's website.

The department does not want there to be delays in parties receiving notifications of arbitration requests. However, the department is updating the proposed rule text to allow additional time for certain notifications. The department is providing additional time to notify the department of conflicts of interest in changes made to §21.5021(g)(5). The department may create additional functionality to the portal as time and resources permit. The Legislature provides that the person who requests the arbitration must provide written notice on the date the arbitration is requested under Insurance Code §1467.084(c).

The department understands that the commenter wants notification to require the other party to acknowledge receipt of the notice and deadlines to start on receipt of arbitration notification; however, the department declines to make a change because the time frame is based on when a party requests arbitration. If a party does not send notification of an arbitration request the day arbitration is requested, or the health plan issuer or administrator routinely sends the notice to someone other than the provider, then the department may refer the requesting party for enforcement.

The department anticipates that the portal may eventually have additional features from what is available initially. The department acknowledges that a notice clearinghouse may be useful; but establishing and maintaining such databases, as requested by the commenter, would be beyond the scope of the rule and would create costs for the department not anticipated or addressed by SB 1264. The department will continue to investigate potential technology solutions to the issue.

Additionally, the department notes that the appearance of the portal may change as time and experience warrant to ensure an efficient process and implementation of SB

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1264, but it will remain consistent with statute and rules. The department welcomes feedback on the portal as it administers the arbitration program. To meet the aggressive adoption timeline, the department focused on the elements required by statute. As with any major piece of legislation, issues may arise that are not addressed in the law or the department's rules. The department will closely monitor implementation and be ready to provide additional guidance as needed.

The department declines to make a change by removing "each" because the suggested language will not change the effect of the rule and the language is consistent with Insurance Code §1467.084(c)(2).

Comment on §21.5021(b)

Comment: One commenter notes that the word "including" in §21.5021(b) is one of expansion and not limitation. The commenter recommends that the proposed rules be changed to ensure a defined list of the exact items necessary to submit a request and not an unlimited, potentially expansive list.

Another commenter asks what is defined as a "claim number," noting that physicians' internal billing systems and health plan systems may assign numbers to a claim, but that they may not track each other's numbers and that this information may not always be apparent on an explanation of benefits. The commenter suggests striking "claim number" from the information required on a request form.

Other commenters ask for more guidance on §21.5021(b)(3) on what constitutes a "similar document" to a health benefit plan identification card. The commenters state that not all providers have ready access to a copy of the patient identification card. In addition, another commenter asks what constitutes "relevant information" and asserts that for an

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initial request, the only relevant information on a health benefit plan identification card is the enrollee's name, health plan ID number, and group number.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department acknowledges that the language used intentionally does not use a term of limitation. The specified information that the requesting party must submit will be on the department's website. Flexibility is important, as the department learns to more effectively administer the portal, automate functions where possible, and adapt to changes in technology. The information required for an initial arbitration request under §21.5021(b) will be reasonably related to the arbitration process.

Providers who do not have access to the health benefit plan identification card are encouraged to enter what specific billing information they do have, so that the other party can determine what claim for arbitration is being requested. Similarly, the requirement to provide a "claim number" is to aid parties in a mutual understanding of what claim is to be the subject of arbitration. The department believes it is better to solicit as much information as reasonably possible related to the claim for this purpose. As with any major piece of legislation, issues may arise that are not addressed in the law or the department's rules. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comments on §21.5021(c)

Comment: Several commenters express concern that §21.5021(c) as proposed requires parties to submit settlement offer amounts made in an informal settlement teleconference prior to arbitration.

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Agency Response: The department recognizes these concerns but declines to change the proposed rule. The department needs this information to implement and administer the arbitration program as required by Insurance Code §1467.082.

Settlement offers are a key component of the arbitration process. Under Insurance Code §1467.083(b)(10), an arbitrator's determination must consider an offer made during the informal settlement teleconference. The settlement offer information may be part of the department's study of trends and changes in the amounts paid to participating providers for the Balance Billing Prohibition Report, under Insurance Code §38.004(a). In addition, under Insurance Code §38.004(b) the department must collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Insurance Code Chapter 1467. Under Insurance Code §38.004(c), the department may not publish a particular rate paid to a participating provider in the study described by subsection (a), identifying information of a physician or health care provider, or non-aggregated study results. Information described by this subsection is confidential and not subject to disclosure under Government Code Chapter 552.

Comment: One commenter suggests avoiding any inadvertent disclosure of written settlement teleconference offers to the department by revising the rules so that such offers stay with the arbitrator. The commenter states that while the statute requires the reporting of the final binding award amount, disclosure of individual awards associated with an individual provider would violate Insurance Code §38.004(c), which deems confidential any information that would identify a physician or a particular rate paid to a physician. Another commenter states that they believe that the proposed settlement amounts offered and discussed should remain confidential.

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Agency Response: The department recognizes these concerns but declines to revise the proposed rule. The department believes that the Legislature contemplated that proposed settlement information can be shared with the department or another agency and remain confidential. Settlement offer information may be necessary for the department's study of trends and changes in the amounts paid for the Balance Billing Prohibition Report, under Insurance Code §38.004(a) and (b). The department will maintain confidentiality to the extent permitted by law, even though the alternative dispute resolution confidentiality provided in Title 7, Civil Practice and Remedies Code, as one commenter suggested, does not apply to arbitration in Insurance Code Chapter 1467.

In addition, Insurance Code §1467.087(f) states that "information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code." The Public Information Act is applicable to "governmental bodies," which an arbitrator is not. If the intent was that information provided by the parties would not be accessible to the department and would only be shared with the arbitrator, there would be no need to state that the information is not subject to disclosure under the Public Information Act, because the arbitrator is not subject to the Public Information Act. By including a reference to the Public Information Act in Insurance Code §1467.087(f), the department believes the Legislature contemplated that the information could be shared with the department or other state agencies and remain confidential.

Comment: A commenter objects to proposed §21.5021(c) regarding notice of teleconference outcome, on the basis that it is overly broad and vague. The commenter says that the department should only require disclosure of three items: (1) the date the teleconference request was received; (2) the date the teleconference was held; and (3) whether the teleconference resulted in an agreed-to settlement.

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The commenter specifically objects to the required submission of all settlement offer amounts. The commenter says that if the department insists on requiring this information, it should include language in the rule expressly stating that the information is confidential.

The commenter also recommends that the language in the rule be modified to require submission of the information within a reasonable period after the completion of the informal settlement teleconference period.

Finally, the commenter recommends that the disclosure of information requirement not apply if parties settle prior to participating in the informal settlement teleconference, because most of the information requested would be inapplicable and an unnecessary compliance burden.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. As noted in the department's previous responses, the department believes that the Legislature contemplated that proposed settlement information can be shared with the department or another agency and remain confidential. The department believes that settlement offer information may be necessary for the department's study of trends and changes in the amounts paid for the Balance Billing Prohibition Report, under Insurance Code §38.004(a) and (b). The department will maintain confidentiality to the extent permitted by law, even though the alternative dispute resolution confidentiality provided in Title 7, Civil Practice and Remedies Code, as one commenter suggested, does not apply to arbitration under Insurance Code Chapter 1467.

The department declines to change the proposed rule concerning submission of information, as requested by the commenter. The department believes that the wording for the requirement to submit the information at the end of the informal settlement

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teleconference period has the same meaning as giving a reasonable period after the completion of the informal settlement teleconference.

The department agrees that the disclosure of information requirement does not apply if the parties settle before participating in the informal settlement teleconference, but the department declines to change the proposed rule because it would be unnecessary.

Comments on §21.5021(d)

Comment: Several commenters stress the importance of keeping arbitration costs low. One commenter notes that if the amount a provider hopes to be paid is as much as or less than the cost of arbitration, the provider will not be able to afford arbitration and the purpose of the dispute resolution procedures will be defeated. Other commenters request the department cap arbitrator pricing. Several commenters request the arbitration fee be standardized, and one of the commenters suggests that the department use the fees set by New York as a model.

Agency Response: The department recognizes these concerns but does not agree that a change to the proposed rules is necessary and declines to revise them. The statute does not address fee amounts, but the department will post the arbitrators' fees on its website. The department will not have a fee cap; however, the department may consider an arbitrator's fee when making an assignment under §21.5021(d)(2). In addition, the parties will have an opportunity to settle before the department assigns an arbitrator, select their own arbitrators, or extend the deadline for arbitrator selection under §21.5021(d)(1), if the parties choose to do so.

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Comment: One commenter suggests having one party be responsible for reporting arbitrator selection information and allowing the other party to object, to avoid conflicts in information submission.

Agency Response: The department disagrees with the commenter and declines to make the requested change to §21.5021(d). The department believes it is prudent to accept information from either or both parties.

Comment: One commenter states that penalties for bad faith are intended to be administrative penalties overseen by the licensing authority of the party who committed the violation. The commenter is concerned about §21.5021(d)(2), which provides that failure to pay the arbitrator promptly constitutes bad faith, and says that the department does not have statutory authority to define this action as bad faith.

Another commenter states that upfront payment will unnecessarily increase the cost of arbitration.

Agency Response: The department disagrees with the commenters and declines to make a change regarding bad faith and payment for arbitration.

Under Insurance Code §1467.101, bad faith exists when a party fails to participate in an arbitration under Insurance Code Chapter 1467. The rule provides clarification that paying the arbitrator under Insurance Code §1467.087(e) is part of the arbitration process. The department believes that payment of fees to mediators and arbitrators on assignment is critical to providing efficient administration of the dispute resolution process under Insurance Code §1467.082.

Comment: A commenter lists six specific reasons why it objects to proposed §21.5021(d)(2).

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First, the commenter objects to full, upfront, nonrefundable payment, because it will be difficult to assess how much work an arbitrator will perform. The commenter says this will increase costs, not be fair, and could discourage parties from settling after the arbitrator is assigned.

Second, the commenter says that because the fee is non-refundable, even if the arbitrator ultimately performs no services, the arbitrator gets to keep the entire fee.

Third, the commenter says that a "prompt" payment requirement is vague and subjective.

Fourth, the commenter says that the proposed text fails to make it clear that each party is only responsible for half of the arbitrator's fee, as required by the statute.

Fifth, the commenter says that characterizing failure to promptly pay the arbitrator as bad faith participation is inconsistent with the statute, which establishes only three categories of actions as constituting bad faith participation.

Sixth, the commenter says that providing that failure to promptly pay an arbitrator is bad faith participation establishes a punitive remedy not contemplated by the Legislature. The commenter says that allowing an arbitrator to award the binding amount to a party in such an instance expands the arbitrator's decision-making functions beyond the scope of SB 1264.

Another commenter states that the requesting parties should be required to pay their fees as early in the process as practicable and urges the department to set a deadline for payment by parties requesting dispute resolution.

Agency Response: The department disagrees with most of the points raised by the commenters; however, the department agrees to make a change to the rule text.

Regarding the commenter's first point, the department believes that although it may be difficult to assess how much work an arbitrator will perform, paying the

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nonrefundable arbitrator fee when the arbitrator is assigned will not discourage parties from settling. It may be to a party's advantage to settle after paying the fee, and not wait for the arbitrator's decision, which may go against that party.

Regarding the commenter's second point, the department acknowledges that there may be a scenario where the arbitrator performs no services and the arbitrator gets to keep the entire fee, but declines to make a change. Under Insurance Code §1467.086(a), Insurance Code §1467.087(c), and §21.5021(d)(1), the department encourages the parties to settle, choose their own arbitrator, or extend the deadline for arbitrator assignment. Further, the department has concerns that if the language is removed, there may not be a sufficient arbitrator pool because arbitrators will not apply if there is a chance they will not be paid.

In response to the commenter's third point and comments made by other commenters, the department adopts a change to §21.5011(d)(2). The department removes the word "promptly," to avoid use of a vague or subjective term and clarify that the nonrefundable arbitrator fee is due at arbitrator assignment.

The department agrees that there needs to be a deadline to pay the arbitrator and the adopted rule provides that the parties pay the arbitrator when the arbitrator is assigned.

The department does not agree that a change is necessary to address the commenter's fourth point. Under Insurance Code §1467.087(e), the statute clearly states that each party is only responsible for half of the arbitrator fee, and it is not necessary to repeat the statutory language in the rules.

The department disagrees with the commenter's fifth and sixth points and declines to make a change. Insurance Code §1467.101 states that failing to participate in arbitration constitutes bad faith, and failure to pay the arbitrator when assigned would be a failure

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to participate. Therefore, this action would constitute bad faith where a penalty is warranted under Insurance Code §1467.102(a) and the arbitrator may award the binding amount to the other party. The rule clarifies that arbitrator payment is an essential part of arbitration participation under Insurance Code §1467.087. If the arbitrator is not paid, then the arbitration cannot proceed.

Comments on §21.5021(e)

Comment: Several commenters support the reporting of information as described in §21.5021(e). However, another commenter expresses concern that the provision is vague and overly broad. One commenter suggests the department adopt a standardized reporting format to be used by the arbitrator to report the required information in order to provide consistency.

Agency Response: The department appreciates the supportive comments, and the department disagrees with the commenters who suggest that the proposed text be revised and declines to make a change based on their comments. The department anticipates providing arbitrators material to aid compliance with the statute and rule, including reporting requirements.

Comment: A commenter says that it is imperative that the department add an express confidentiality provision to §21.5021(e) to ensure that information submitted in response to the provision is protected in accordance with the intent of the underlying statute.

Agency Response: The department recognizes this concern but disagrees with the commenter that a change is needed to the proposed rule text and declines to revise the proposed rule. The department believes that Insurance Code §38.004 and §1467.087(f) provide some measure of confidentiality that would be applicable to the information

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required by §21.5021(e), and the department will maintain confidentiality of information to the extent provided by law.

Comment: A commenter does not understand what §21.5021(e)(1)(A) means when it references the date of the arbitrator's report. The commenter asks that the department amend the provision to request the date the arbitrator provides the parties with a written decision. Another commenter suggests removing when payment is made from the arbitrator's report, saying that the language presumes that the health plan had to pay an additional amount and that the arbitrator knows when the payment is made.

Agency Response: The department disagrees with the commenters and declines to make a change. The date of the arbitrator's report is the date the arbitrator submits the report to the parties and the department. The department declines to remove the provision for reporting when a payment was made. Insurance Code §1467.089(d) provides that if additional payments are necessary, the health benefit plan issuer or administrator must pay the out-of-network provider not later than the 30th day after the date of an arbitrator's decision. Arbitrators will not be required to provide information they do not have, but the department would like to collect this information if it is known to the arbitrator. Having this information as part of the report ensures that the department will know when payment is made.

Comment: A commenter requests that the department strike the proposed language in §21.5021(e)(1)(A), which requires an arbitrator to disclose when an arbitration was held and clarifies that the arbitration is a document-driven review, because the law does not contemplate an in-person event or hearing.

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Agency Response: The department agrees with the commenter and makes a change to the proposed rule. In response to this comment, the department deletes the language "when the arbitration was held" from the information the arbitrator must submit to the department at the end of the arbitration. The department agrees that arbitration is a document-driven process and intends that it be conducted this way under §21.5021(g)(2) and (4). Because the rule does not require a hearing or other in-person proceeding, knowing when the arbitration was held is not necessary.

Comment: A commenter objects to the requirement in §21.5021(e)(1)(B) that an arbitrator submit to the department the "written decision, including any final offers made during the health benefit plan issuer's or administrator's internal appeal process or informal settlement." The commenter says this requirement is not authorized by statute and there is no reason the department needs the information. The commenter says that if the department adopts the provision, it should clarify the confidentiality provisions applicable to it.

Agency Response: The department recognizes these concerns but does not agree with the commenter and declines to revise the proposed rule. The department needs the information required by §21.5021(e)(1)(B) to implement and administer the arbitration program as required by Insurance Code §1467.082. Settlement offer information may be relevant to the department's study of trends and changes in the amounts paid for the Balance Billing Prohibition Report under Insurance Code §38.004(a). In addition, under Insurance Code §38.004(b) the department must collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Insurance Code Chapter 1467.

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The department cannot create a specific confidentiality provision and declines to make a clarification in the rule because such a change is not necessary. Insurance Code §38.004 and §1467.087(f) provide some measure of confidentiality, and the department will do what it can to maintain confidentiality to the extent permitted by the law.

Comment: A commenter objects to the requirement in §21.5021(e)(2) that if the parties settle the dispute before the arbitrator's decision, the parties must submit information including the date of the settlement and the amount of the settlement. The commenter says this requirement is vague, overly broad, and the department lacks statutory authority to request it.

Agency Response: The department disagrees with the commenter and declines to revise the proposed rule. The department needs the information required by §21.5021(e)(2) to implement and administer the arbitration program as required by Insurance Code §1467.082. The settlement offer information may be relevant for the department's study of trends and changes in the amounts paid for the Balance Billing Prohibition Report, under Insurance Code §38.004(a). In addition, under Insurance Code §38.004(b) the department must collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Insurance Code Chapter 1467.

Comment on §21.5021(f)

Comment: One commenter states that the rule should require arbitrators to have professional experience in medicine or billing and coding. This would expand the pool of arbitrators and be fairer. Another commenter recommends that standards for arbitrators should be established beyond those outlined and use those from the Affordable Care Act as a roadmap. Another commenter recommends that the list of qualified arbitrators

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maintained by the department include information regarding the qualifications and fee amounts of each one, so that parties can more efficiently choose an arbitrator and identify any potential conflicts of interest.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule are necessary and declines to revise the proposed rule.

The commenter's concerns regarding the professional experience of potential arbitrators are beyond what is required by SB 1264. Insurance Code §1467.086 requires that the Commissioner give preference to an arbitrator who is knowledgeable and experienced in contract and insurance law and the health care industry generally. However, there is nothing that prohibits an arbitrator from having additional professional experience as long the experience does not create a conflict of interest.

The department anticipates that it will provide information regarding arbitrator fees on its website. Arbitrators on the list will meet the minimum requirements under Insurance Code §1467.086.

Comments on §21.5021(g)

Comment: A commenter expresses concern with the arbitration process set out in §21.5021(g), asserting that it fails to provide sufficient guidance to parties seeking to navigate this new process and to arbitrators who will be the decision makers in the process, and that it will needlessly increase the burdens and expenses of arbitration.

Agency Response: The department appreciates the concern but does not agree with the commenter and declines to make a change in response to this comment.

The department acknowledges that parties have not yet had the opportunity to interact with the portal. The rules were developed with notice and transparency for all parties in mind, and to provide flexibility in the specific technical operation of the portal.

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It is not practicable to describe every facet of the operation of the portal and allow for the implementation and administration of the required dispute resolution process by January 1, 2020, as required by SB 1264. This flexibility is important, as the department learns to more effectively administer the portal, automate functions where possible, and adapt to changes in technology. But the department believes that the functionality of the portal is sufficiently described by these rules and SB 1264. The department is aware that significant changes to the portal may require further rulemaking. The department notes that the appearance of the portal may change as necessary to ensure an efficient process and implementation of SB 1264, but it will remain consistent with statute and rules. The department welcomes feedback on the portal as it administers the arbitration program. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comment: A commenter says that because there is a short time frame to challenge an arbitrator's decision in court, the rule text should include language requiring the arbitrator to include the parties' statutory rights in his or her written decision. The commenter suggests additional language for §21.5021(g) to make this change.

Agency Response: The department disagrees with the commenter and declines to make the requested change. Parties subject to the arbitration procedures are presumed to know their legal rights, and the department encourages all parties to educate themselves on the entirety of SB 1264. The department expects that arbitrators will be familiar with SB 1264 and use resources the department may provide, including information about Insurance Code §1467.089. The department will closely monitor implementation and be ready to provide additional guidance as needed.

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Comment: Several commenters express concern over the requirement in §21.5021(g)(1) for a provider to use best efforts to resolve a claim payment dispute through a health benefit plan issuer's or administrator's internal appeal process before requesting arbitration.

One commenter states that the phrase "best efforts" is vague and difficult to demonstrate and suggests another term such as "attempt." Two other commenters state that there is no statutory authority to compel a provider to use a carrier's internal dispute process.

One of the commenters also asserts that a similar provision was included in an early version of SB 1264, but failed to pass into law, showing the Legislature's rejection of the concept. The commenter says this inserts an additional condition to qualify for arbitration. The commenter also says that the department does not have jurisdiction to regulate Texas physicians, but that this provision is an attempt to do so. The commenter says that if the department maintains the proposed provision, it should remove the best efforts requirement, make provider participation entirely voluntary, and shift the language of the provision to impose a requirement on department licensees.

One commenter asks the department to allow for 20 days for appeals but be able skip the internal appeals process at the provider's option. One commenter suggests the language be revised so that both providers and health benefit plans and administrators use their respective best efforts. The commenter also suggests that the department establish quantifiable standards to measure the internal appeal process.

One commenter states that the 90-day time frame does not allow enough time for the internal appeal process. Several commenters state that the proposed requirement places the burden on the provider, and that insurers will drag out the claims process,

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making the claim no longer eligible for arbitration. One commenter states that internal appeals are frequently long, futile, and require unreasonable efforts.

One commenter requests that the rules clarify that a provider may not pursue an internal appeal process at the same time they pursue arbitration.

One commenter states that the use of the health plans' internal appeal process should be optional.

Agency Response: Regarding the comments about "best efforts," the department agrees to make a change. The department removes the "best efforts" language in §21.5021(g)(1) and replaces it with language to give the parties an opportunity (20 days) to resolve their dispute through the health benefit plan issuer's or administrator's internal appeal process before requesting arbitration.

The draft bill language concerning internal dispute resolution required exhaustion of those internal procedures. However, the language adopted in the rule only provides that parties may use a plan's internal appeal process. The intent of the language in the rule is not to bar a party's ability to utilize arbitration procedures, but rather to encourage parties to take advantage of all tools available to reach an agreed settlement. The department believes that the change made regarding commenters' concerns about the "best efforts" language helps clarify this point.

Several commenters suggested alternative language for this provision. The change the department adopts addresses these concerns and is consistent with the efficient administration of the arbitration processes.

The department clarifies that a provider may pursue an internal appeal before they pursue arbitration. There is nothing in SB 1264 or the rules that states that a party cannot pursue an internal appeal after arbitration is requested or that the appeal process must be completed within 20 days.

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Comment: Several commenters recommend amending §21.5021(g) to clarify that the arbitration process is a document review and limited to the 10 criteria for a decision listed in Insurance Code §1467.083. One of the commenters also says that the department should revise the proposed text so that it specifically itemizes the dollar amounts that are the figures an arbitrator ultimately chooses as being closest to the reasonable amount under Insurance Code §1467.088.

A commenter requests that the department add a provision to §21.5021(g) expressly stating that the only issue that an arbitrator may determine is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider. The commenter recommends pulling language to this effect verbatim from the statute.

Agency Response: The department recognizes these concerns but declines to revise the proposed rule. The department agrees with the commenter that the arbitration process is limited to written submissions and based on the 10 criteria specified in Insurance Code §1467.083. The process is a document review and not an in-person arbitration process. The department agrees that the amount of information must be quickly reviewed for a timely decision. But the department believes it is necessary for the arbitrator to have the ability to solicit additional information and to allow the other party to respond, as provided in §21.5021(g)(2) and §21.5021(g)(4).

The selected arbitrator is in the best position to control the arbitration process and timeline, within the limits provided by statute. The department agrees that SB 1264 provides that the arbitrator's written decision must be consistent with Insurance Code §1467.088. The rule does not need to specifically mirror every provision of the statute. The department expects that arbitrators will be familiar with SB 1264 and use resources the

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department may provide, including information about Insurance Code §1467.083 and §1467.088.

The department will closely monitor implementation and be ready to provide additional guidance as needed. Arbitrators who do not comply with statute will not be assigned to arbitrations and may be terminated from the list of arbitrators.

Comment: One commenter states that the rule does not limit the arbitrator's decision to one specific amount. The rules do not prohibit the arbitrator from modifying the binding award from one of these amounts.

One commenter asks whether a health benefit plan issuer or administrator will be able to discount the amount awarded by the arbitrator. The commenter notes that for some provider types, such as surgical assistants, payments often reflect a discount modifier. Another commenter suggests that a clarification be added stating "The amount of the arbitrator's award is the amount that must be paid by the insurer, and the insurer is not permitted to apply any discounts to, or to otherwise modify, the award."

Agency Response: The department recognizes these concerns but declines to amend the proposed rule. The department believes that Insurance Code §1467.088 provides what the arbitrator may award. The department reminds commenters that SB 1264 specifically allows an arbitrator to choose one of two amounts. This amount is binding and should not be further discounted after the arbitrator has made their final decision under Insurance Code §1467.088 and §1467.089. The department anticipates providing arbitrators with resource information to educate them on the statutory requirements. Additionally, arbitrators who do not comply with statute will not be assigned to arbitrations and may be terminated from the list of arbitrators.

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Comment: A commenter notes that SB 1264 contains multiple references to the term "geozip area" and requests that the department add a provision to §21.5021(g)(3) stating that for purposes of evaluating the factors in Insurance Code §1467.083(b)(1)(B), an arbitrator construe "region" as having the same meaning as "geozip area" under Insurance Code §1467.006(a).

Agency Response: The department disagrees with the commenter and declines to make a change because the suggested language would not change the effect of the rule. The data will be submitted for each geozip area and the selected benchmarking database organization will aggregate and calculate information to be used by the arbitrator. The department declines to add a provision relating to the terms used by Insurance Code §1467.006 and §1467.083. The department believes the intent of SB 1264 is clear. The department will closely monitor implementation and be ready to provide additional guidance, as needed.

Comment: A commenter expresses opposition to the text in §21.5021(g)(4) providing that an arbitrator must allow each party to review and respond in writing to the written information submitted by the other party. The commenter says the law does not allow parties to engage in discovery in connection with the arbitration, and that allowing this review and response will cut into an already limited timeframe. The commenter suggests revising the text to eliminate the language allowing parties to rebut submitted information, to only allow rebuttal if the parties agree to it, or to limit rebuttal to a one-time opportunity.

Agency Response: The department recognizes these concerns but disagrees with the commenter and declines to revise the proposed rule. Under Insurance Code §1467.087(a), the arbitrator sets a date for submission of all information to be considered by the

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arbitrator. The department anticipates that the arbitrator will be in control of the arbitration, subject to the requirements established by statute and rule. The intent of the provision is to give the parties an opportunity to respond, not to engage in discovery. Under Insurance Code §1467.087(b), discovery is not permitted. The department reminds the parties that it is to their benefit to respond timely to a request on the arbitrator's timeline.

Comment: One commenter recommends the department amend the proposed rule in §21.5021(g)(5) to base the time frame for the nonrequesting party to notify the department of a conflict of interest with any arbitrator on the department's list on its receipt of the arbitration request.

Another commenter suggests that a more appropriate time for this notice is at the end of the teleconference. The commenter states that parties should be focused on reaching a settlement at this stage of the process. Several commenters recommend an extension to notify the department of any conflicts. Another commenter requests the provision be amended to allow a responding party five days after receipt of the request.

Additionally, one commenter suggests that the department adopt an already-established process by which the parties attempt to agree to an arbitrator, to minimize the department appointing an arbitrator.

Agency Response: The department recognizes the concerns of the commenters and declines to make the changes requested but does make a change to §21.5021(g)(5). Under adopted §21.5021(a)(2), the party who requests the arbitration must provide written notice to the other party on the date the arbitration is requested. The department anticipates that parties will provide the required notice when the arbitration is requested. In response to comment, the department lengthens the time to determine if there is a

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conflict of interest with any of the arbitrators under §21.5021(g)(5) from five days to 10 days. The department will have a list of arbitrators that parties can review at any time. The department agrees that parties should attempt to resolve their disputes, choose their own arbitrator, or extend the deadline to select an arbitrator before it becomes necessary for the department to appoint an arbitrator. While arbitration will be available, parties can settle disputes on their own, informally. The parties can also choose their own arbitrator, and the department encourages them to do so.

Comment: One commenter suggests that the word "timely" be inserted into §21.5021(g)(6) before "respond" to clarify that the arbitrator need not consider information filed late.

Another commenter expresses concern that the text of §21.5021(g)(6) does not make it clear that only written information will be considered and that the proposed language fails to include the statutory requirement for the arbitrator to set a date for submission of all information to be considered by the arbitrator. The commenter suggests revised text to address these concerns.

Agency Response: The department recognizes these concerns but does not agree that changes are necessary to the proposed text and declines to revise the proposed rule. The department anticipates that the arbitrator will be in control of the arbitration, subject to the requirements established by statute and rule. The intent of the provision is to ensure that the arbitrator has the information necessary to make a decision. Under Insurance Code §1467.087(a), the arbitrator must set a date for the parties to submit information. The rule is consistent with the statute and does not set a date for the arbitrator. The department reminds the parties that it is in their best interest to respond timely to a request of the arbitrator.

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Comment: One commenter supports the provision in §21.5021(g)(7) allowing submission of multiple claims only for the same provider and health plan up to \$5,000.

Several commenters ask for clarification on how to determine when the amount in controversy threshold is met for purposes of §21.5021(g)(7). Several commenters suggest different methodologies for the amount in controversy, and caps for the number of claims and aggregated limits. One commenter requests that the department ensure that the reformed claim amount be applied to the bundled amount so that certain providers can bundle claims for the efficient utilization of the dispute resolution process.

Another commenter requests that groups who bill under the same federal tax identification number be able to aggregate eligible claims for review. Another commenter suggests allowing physicians within the same group and same specialty to submit bundled claims.

One commenter suggests that regardless of which party submits a claim for arbitration first, the other party should be allowed to request that additional eligible claims be added to the arbitration proceeding. The commenter states that guidance on bundling claims could be required to be provided within a certain number of days of receipt of notice that the arbitration request has been submitted.

Agency Response: The department recognizes these concerns but does not agree that a change to the proposed text is necessary and declines to revise the proposed rule. Insurance Code §1467.084(e)(1) uses the term "total amount in controversy." The department believes this term is clearly different from either the "amount paid" or "bill charged." The amount in controversy means the difference between the two amounts, subject to any reformed claim settlement or reformed charge under Insurance Code §1467.005, or offers made during the health benefit plan issuer's or administrator's

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internal appeal process. Additionally, Insurance Code §1467.088 provides what awards an arbitrator may decide, including potentially modified payments made by the health benefit plan issuer or administrator.

The department declines to accept the commenter's suggestion that groups billing under the same federal tax identification should be able to aggregate claims. Insurance Code §1467.084(e) is clear that multiple claims in one proceeding must be limited to the same out-of-network provider, and the department does not have authority to modify the specific limitations of statute.

The department declines to change the rule to address voluntary additions of other claims or to add a deadline for when claims must be bundled. The statute and rules already provide for informal settlement before arbitration, as well as voluntary extension of timelines in arbitration. The department intends that either party be allowed to request that additional eligible claims be added to the arbitration proceeding without agreement of the other party.

Comment: A commenter observes that the proposed rules omit language from Insurance Code §1467.087(c) that allows parties to extend any deadline under Insurance Code Chapter 1467. The commenter suggests adding a provision addressing this.

Agency Response: The department declines to make the change, as it does not agree that revisions are necessary to implement SB 1264 because the extension is sufficiently addressed in the statute. The department notes that extension of deadlines is mentioned in §21.5021(d)(1)(C) with respect to selecting an arbitrator and §21.5022 regarding the informal settlement teleconference. The department encourages parties to informally settle disputes, and it encourages their extension of deadlines where such additional time will help resolve the issues.

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Comment: A commenter says that a physician's services include a combination of professional components such as work interpreting or providing a service, and technical components such as providing equipment, supplies, and personnel. The commenter says that the department should make it clear that globally billed physician services composed of a professional service, a technical component, or both a professional and technical component are subject to arbitration; however, when these services are provided in a facility and are billed separately (technical and professional), the physician's professional component should be subject to arbitration and the facility's technical component should be subject to mediation laws.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary because SB 1264 is clear on this issue. Under Insurance Code §1467.050(a), mediation applies only to a health benefit claim submitted by an out-of-network provider that is a facility. In addition, under Insurance Code §1467.050(b), mediation does not apply to a health benefit claim for the professional or technical component of a physician service.

Comment: One commenter suggests clarifying responsibilities by changing §21.5021(g) to expressly state that the department is responsible for promptly providing the datapoints under Insurance Code §1467.083(b)(6), (7), and (9) to the arbitrator.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. Under Insurance Code Insurance Code §1467.006(c), the benchmarking database through the benchmarking database organization will have the information necessary to calculate the 80th percentile of billed charges of all physicians or health care providers who are not

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facilities and the 50th percentile of rates paid to participating providers who are not facilities. The department anticipates that the parties will provide the datapoints to the arbitrator.

Comments on §21.5022

Comment: One commenter is concerned that proving "best efforts" is vague and difficult to demonstrate.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to make a change to the rule text. The rule is consistent with the requirement in Insurance Code §1467.084(d) for a health benefit plan issuer or administrator to make a reasonable effort to arrange the teleconference at a date and time when the parties or representatives of the parties can participate in the informal settlement teleconference. The "best efforts" language is the language in the current §21.5012. Insurance Code §1467.101 provides that certain conduct "constitutes bad faith participation" including "failing to participate in the informal settlement teleconference under section 1467.084(d)[.]" The statute requires participation, which the department believes provides enough clarity as to what conduct is expected from parties. This language has not caused an enforcement problem in the past for mediation. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comment: A commenter says that under Insurance Code §1467.084(d), the health benefit plan issuer or administrator is responsible for arranging the teleconference, and that by stating "a party. . . must use best efforts to coordinate an informal settlement conference" in §21.5022 the rule text is in conflict with the statute. The commenter suggests revising

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this provision to expressly require the health benefit plan issuer or administrator to coordinate the teleconference.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to make a change to the rule text. The department notes that §21.5022 provides "The health benefit plan issuer or administrator must make a reasonable effort to arrange the teleconference at a date and time when the parties or representatives of the parties can participate in the informal settlement teleconference." The department acknowledges that this follows a requirement to "coordinate an informal settlement teleconference." This general requirement for both parties to coordinate is consistent with Insurance Code §1467.084(b), which requires that all parties participate. While both parties are required to participate generally, Insurance Code §1467.084(d) and the rule put the specific burden on the health benefit plan issuer or administrator to make a reasonable effort to arrange the teleconference.

Comments on §21.5023

Comment: One commenter suggests revising paragraph §21.5023(3) to require a representative participating in the informal settlement teleconference have the authority to enter into an agreement.

Agency Response: The department recognizes this concern but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. Insurance Code §1467.101 provides that conduct that constitutes bad faith includes failing to designate a representative participating in the arbitration with full authority to enter into any agreement. SB 1264 did not provide the same language for informal settlement teleconferences. However, the department believes it is in the party's best interest to have

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a representative at the informal settlement conference that has the authority to enter an agreement.

Comment: A commenter observes that proposed §21.5023 says "conduct that constitutes bad faith arbitration includes failing to . . ." The commenter says "includes" is a term of enlargement, and its use implies other acts might constitute bad faith; however, Insurance Code §1467.101 only specifies three acts that can constitute bad faith arbitration. The commenter requests that the department revise the text to remove the word "includes" and only specify the acts listed in the statute. The commenter also says that because the department only has authority to regulate its licensees, the text concerning bad faith arbitration should be revised to only address health benefit plan issuers or administrators.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to make a change to the rule text. Proposed §21.5023 is consistent with the existing language in §21.5013, which also contains the word "includes." This language is intended to clarify Insurance Code §1467.101. The department considered repealing §21.5013 entirely to avoid repeating statute but decided to mirror the mediation provision in the arbitration division for emphasis.

Comments on Division 4. Complaint Resolution

Comments on §21.5030

Comment: One commenter states that written complaints regarding mediation and arbitration should be confidential. The commenter expressed concern that the complaint could get back to the mediator or arbitrator.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary. Under Insurance Code §1467.151(c), the

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information collected and maintained under Subsection (b) is public information as defined by §552.002, Government Code, and may not include personally identifiable information or health care or medical information.

Comment: Two commenters request that the rules clarify that a request for mediation or arbitration should not automatically be classified as a "complaint," and should not be considered as a complaint made on behalf of an enrollee or insured, who is protected from balance billing. Another commenter asks that a request for arbitration be known as a complaint.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department agrees that a request for mediation or arbitration under the rules is not a "complaint." Insurance Code §1467.151 requires the department to review a complaint that relates to the settlement of an out-of-network health benefit claim that is subject to Insurance Code Chapter 1467. Under the adopted rules, a party may submit a written complaint on the department's website. This complaint process is different from the process to request mediation or arbitration. The department declines to consider each mediation or arbitration request as a complaint.

Comment: One commenter requests a group, independent of the insurance industry and the department, actively monitor fair-trade practices of the industry. The commenter also requests an anonymous hotline that allows the healthcare community to report related illegal activity.

Agency Response: The creation of a new complaint monitoring group is outside the scope of this rulemaking. The department notes that it has multiple ways to address

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complaints already. The department has an internal complaint hotline and Enforcement and Fraud Divisions to monitor the industry and handle illegal activity. In addition, SB 1264 requires the department to prepare a Balance Billing Prohibition Report, and many of the concerns raised by commenters can be addressed there. The report, authorized and required by Insurance Code §38.004, is prepared for and submitted to the Legislature. Nothing in rule or statute prevents outside interested parties from actively monitoring fair-trade industry practices.

Comment: A commenter opposes any amendments to the rule text and language in proposed §21.5030 that empowers the department to solicit and process complaints against parties over whom it does not have jurisdiction. A commenter asks that the department acknowledge that the Texas Medical Board or other appropriate regulatory agencies oversee their licensees, and the commenter suggests revising the rule text to specify that out-of-network providers may submit written complaints. The commenter also opposes any changes to rule text that would require physicians to file complaints on the department's website, asks why the department proposes changing the word "form" to "information" in addressing filing of complaints, and asks what additional information would be required in complaint information.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to make a change to the rule. The department will make referrals to appropriate regulatory agencies as necessary, consistent with SB 1264 and Insurance Code Chapter 752. The department notes that Insurance Code §1467.151 as written is not specific only to the department but requires the Texas Medical Board and other regulatory agencies, as appropriate, to adopt rules subject to the chapter.

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The most substantive amendment made in §21.5030 was to make conforming amendments that specifically removed "enrollees" from Insurance Code Chapter 1467 and reflects changes in Insurance Code §1467.151. The complaint information referenced in §21.5030 is the same complaint information from the form publicly available on the department's website for years. The department is not creating a different or alternative complaint process for this subchapter. An out-of-network provider may submit written complaints, as they have always been able to do. The existing complaint procedure has been an effective way for parties to communicate with the department and register their complaints. Parties may be directed to the complaints section of the department's website. The department will closely monitor implementation and be ready to provide additional guidance as needed.

Comments on Division 5. Explanation of Benefits

Comments on §21.5040

Comment: One commenter supports the requirement to have payers clearly state on the explanation of benefits what the patient's financial responsibility is with deductible and co-insurance under §21.5040. One commenter states they fully support the standard language for health benefit plan issuers to use for providers.

Agency Response: The department appreciates the supportive comments.

Comment: Several commenters have different recommendations to revise §21.5040(1).

A commenter expresses concern that the language of §21.5040 is not robust enough to aid physicians in their efforts to ensure that patients are not erroneously balance billed in circumstances when a prohibition applies under SB 1264, to properly inform physicians of their rights under SB 1264, and to prohibit health plan manipulation

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of the messaging in the explanation of benefits. The commenter suggests revised text to address these concerns. Other commenters encourage transparency on explanation of benefits.

Another commenter wants to include plain language requirements in §21.5040 and sample language and include direction to consumers on what to do if they are billed more than what the explanation of benefits indicates.

Another commenter recommends that any consumer notifications under SB 1264 contain timely and accurate information, and plain language that provides consumers with the information they need to understand costs, what is and is not covered by insurance, and if the exception to the balance billing prohibition may apply.

Another commenter requests the department provide clear language for health benefit plan issuers and administrators for §21.5040(1).

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department's adopted rule implements what is required by statute. The statement in §21.5040(2) specifically addresses Insurance Code §§1271.008(a)(3), 1301.010(a)(3), 1551.015(a)(3), 1575.009(a)(3), and 1579.009(a)(3), and provides for an explanation of benefits to be provided to the physician or provider, advising the physician or provider of the availability of mediation or arbitration, as applicable, under Insurance Code Chapter 1467. The department encourages health benefit plan issuers and administrators to use plain language in all communications, including the explanation of benefits. The department will closely monitor implementation and be ready to provide additional guidance as needed.

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Comment: One commenter states that §21.5040 should mandate that the required statement in the explanation of benefits provided by health benefit plans and administrators to enrollees whose claims are associated with emergency care provided in an out-of-network emergency room state that their in-network benefits are being applied to the claim. The commenter states that health benefit plans and administrators routinely attempt to apply the enrollee's out-of-network benefits despite the Texas and federal law mandate that the enrollee's in-network benefits are to be used.

Another commenter requests clarification about when in-network cost sharing is applied to a patient. One commenter states that §21.5040(1)(B) should be modified to reflect existing 28 TAC §§3.3725(d), 3.3708(b)(2) and (3), and 11.16119(d).

One commenter states that the department should require mandatory notification by health plans to consumers for out-of-network services subject to the prohibition on balance billing. The commenter states that SB 1264 does not include a notification requirement to consumers in the event they receive out-of-network care subject to the balance billing prohibition. A notice would increase consumer awareness and equip consumers with information they need to make informed decisions and understand the scope of their coverage and the nature of their cost-sharing obligations.

Another commenter requests that the department clarify that notice to the provider under §21.5040(2) does not apply when the out-of-network provider has obtained a "waiver" of the balance billing prohibition under Insurance Code Chapters 1271, 1301, 1551, 1575, and 1579.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to make a change to §21.5040. The department believes the current language requires health benefit plan issuers and administrators to supply the relevant cost sharing information, consistent with the language and intent of Insurance

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Code §§1271.008, 1301.010, 1551.015, 1575.009, and 1579.009. The department appreciates the commenter's concern related to the proper application of policy coverages. The department will monitor compliance with this provision and will accept feedback and complaints from all parties related to issues with the process. The department declines to amend §21.5040 to directly address payment of claims rules in 28 TAC Chapters 3 and 11 in this rulemaking.

The proposed language in §21.5040(2) fulfills the requirement in SB 1264 for an explanation of benefits to be provided to the physician or provider, advising the physician or provider of the availability of mediation or arbitration, as applicable, under Insurance Code Chapter 1467.

The department agrees that §21.5040(2) does not apply when the out-of-network provider has obtained a "waiver" of the balance billing prohibition but declines to make a change, because the department believes it is clear that notice to the provider does not apply when the out-of-network provider has obtained a "waiver" of the balance billing prohibition.

Comments on Division 6. Benchmarking

Comments on §21.5050

Comment: Several commenters expressed concern related to the sourcing of data for the benchmarking database in §21.5050. Several commenters criticize §21.5050 for requiring submission only from health benefit plan issuers and administrators. Commenters express concern that the benchmarking database would allow payers to drive down payment data.

One commenter states that the fairest data benchmarking should be based on claims paid out prior to 2017, and claim denials, or claims submitted and paid below billed charges for the past three years, should be immediately investigated by the department.

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One commenter suggests that data used in the creation of the benchmarking database include charges and payments by providers and plans covering patients who receive insurance through the federal marketplace as a fair representation of market payments.

Another commenter suggests that the department assume responsibility for benchmarking, because the datapoints likely required for consideration by the arbitrator would likely require a license and result in a cost to providers. The commenter also suggests that the department conduct regular audits on health plan data submissions to ensure compliance with law.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department's adopted rule conforms to SB 1264. The health benefit plan issuers will have the provider's billed charge. The benchmarking database organization will need the information necessary to calculate billed charges of all physicians and health care providers and rates paid to participating providers as required by Insurance Code §1467.006 and §1467.083, and to help facilitate the report required by Insurance Code §38.004. It is not a practicable method to source data from providers themselves. The department believes administrators are in the best position to report the necessary data.

The department declines to change the rule to ensure that only pre-2017 claims data are used. Because of the rapidly changing marketplace, the department believes that the benchmarking database should reflect recent amounts billed and rates paid. The authority to require submission of data in Insurance Code §1467.006(d) is consistent with this goal. For purposes of investigations, the department recommends parties with complaints refer their concerns to the department's complaint process.

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The department declines to specify whether the data will include charges and payments by providers and plans covering patients who receive insurance through the federal marketplace. Consistent with Insurance Code §1467.006(c), the benchmarking database must contain information necessary to calculate, with respect to a health care or medical service or supply certain billed charges and rates paid. The department believes that the benchmarking database organization will be in the best position to collect relevant data based on its expertise. The department will monitor the selected benchmarking organization for compliance with SB 1264 and other statutes.

The department declines the suggestion to perform the benchmarking itself. SB 1264 intends for selection of a third-party benchmarking organization. The benchmarking database organization is not prohibited from charging a fee for access to the benchmarking database. The department appreciates the suggestion that it conduct regular audits on health plan data submissions to ensure compliance with law. The department will monitor compliance with this and other provisions of the rules and SB 1264 and will take enforcement measures or make referrals, as necessary.

Comment: One commenter suggests the department revise §21.5050 and use the term "geozip area" in place of "geozip" in the rule text.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to replace the term "geozip" with "geozip area" because the change does not affect the meaning of the text or provide any additional clarification.

Comment: The department received comments regarding alternate uses for the data submitted in compliance with §21.5050. One commenter recommends that the department leverage the de-identified claims information that health plans are already

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required to report annually to prepare the health care pricing guide and use this information for the benchmarking database. Another commenter requests that the department allow the benchmarking data to be used for publicly supported research. One commenter suggests that the department limit the use of information contained in the database to only the arbitrators engaged in ongoing arbitration.

Agency Response: The department does not agree with the commenters. The data submission requirement in §21.5050 is authorized in Insurance Code §1467.006, and the benchmarking data is used by arbitrators to consider under Insurance Code §1467.083 and for the department to use in the Balance Billing Prohibition Report in Insurance Code §38.004.

Comment: One commenter supports the rule and states that by prescribing a general standard rather than a detailed list of information, §21.5050 recognizes that reporting for some services entails special fields and that new services and changes in official coding and practices may require corresponding adjustments in data submission.

Another commenter states the rules should specify the format in which health benefit plan issuers are required to provide the data to the database. One commenter states that the rule language is vague around the overly broad reporting requirements.

Agency Response: The department thanks the commenter for the support of the adopted rule.

The department does not agree that changes to the proposed rule text are necessary and declines to make changes to the text to specify the format for the data submission. The benchmarking database organization had not been selected at the time the rule was proposed. It is not practicable to specify the data submission format prior to the final selection of the benchmarking database organization. As part of its selection

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criteria, the department will ensure that the selected benchmarking database organization is able to provide the data arbitrators will need under Insurance Code §1467.083. The department believes that the benchmarking database organization will be in the best position to collect relevant data based on their expertise. The department will monitor the selected benchmarking organization for compliance with SB 1264 and other statutes.

Comment: One commenter asks if the term "administrator," as used in §21.5050, is meant to apply to those who administer plans for self-funded groups. The commenter asks if department intends for the requirement to apply to self-funded plans, third-party administrators, and regulated health benefit plans.

Agency Response: The department clarifies that the language "health benefit plan issuer or administrator" is used to be consistent with Insurance Code Chapter 1467. Administrators are intended to cover those entities that are providing services to certain state government health benefit programs, such as Texas Employees Group, Texas Public School Employees Group, and Texas School Employees Uniform Group. The department notes that "health benefit plan" and "administrator" are defined in §21.5003 and do not include entities that the department does not regulate.

Comment: Several commenters express concern related to the selection of the benchmarking database organization.

Several commenters request that the department use a transparent and competitive bidding process to choose a benchmarking organization. One commenter suggests if the department wants to explore using a commercial database, it should do so in a public review and issue requests for information and requests for proposals. One commenter stated the provision constituted an unconstitutional delegation of authority.

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The commenter states that the department consider selecting a benchmarking organization that already produces benchmarks. The commenter suggests that the rules authorize the use of already available benchmarks on a transitional basis for the interim period.

One commenter proposed guidelines for consideration in the selection of the benchmarking organization. Another commenter suggests the department adopt rules comparable to the Department of State Health Services.

Agency Response: The department recognizes these concerns but does not agree with the commenters. Generally, §21.5050 provides guidelines and requirements for the submission of data to the benchmarking database organization. The department considers selection of the benchmarking database organization to be an internal process decision. The Legislature provided that the Commissioner must select an organization to maintain a benchmarking database under Insurance Code §1467.006(b). The only criteria that the Legislature gave to the department was that the organization may not be affiliated with a health plan issuer or administrator or a physician, health care practitioner, or other health care provider or have any other conflict of interest. The department believes a request for information or request for proposal is not required, because the department will not pay the benchmarking database organization but understands that the process be transparent and meet conflict of interest requirements in the statute.

The department does not agree that the rule constitutes an unconstitutional delegation of authority. Insurance Code §1467.006 only requires the department to select the benchmarking database organization and adopt rules for submitting information. The department believes the Legislature intended for the benchmarking database organization, with the requisite expertise, to determine the methodology calculations. The benchmarking database organization will provide the format for the health benefit plan

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issuers and administrators to provide data to the database. SB 1264 anticipates that a benchmarking database organization selected by the department will be involved in the collection of data. The department will select the benchmarking database organization and can select a different benchmarking database organization if their requirements are unreasonable.

The department acknowledges that the selected benchmarking database organization may already have data to provide the relevant information contemplated by statute. The use of preexisting data may be necessary to calculate billed charges and rates paid. Insurance Code §1467.006(c) is consistent with the selection of a benchmarking database organization that already possesses some data.

The department will closely monitor implementation and may note trends in the effectiveness of the claim dispute resolution process under Insurance Code Chapter 1467, including privacy and confidentiality issues, in the Balance Billing Prohibition Report.

Comment: Several commenters ask for more explanation on the benchmarking calculations and the use of the data. Commenters request more information on how the benchmarking data will calculate the 80th percentile of billed charges and 50th percentile of rates paid for various scenarios. Commenters want to know how the calculations will account for specific provider types, benefit plans, and location-specific metrics.

Another commenter states that the department must monitor and validate benchmark data for accuracy and should scrutinize the impact of arbitration on provider payments. Two commenters express concerns about whether the data that is going to be used is statistically valid and the regions large enough. One commenter requests clarification related to submission and calculation of facility claims.

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Agency Response: The department appreciates these concerns but does not agree with the commenters. It is not practicable to specify the data calculation methodologies prior to the final selection of the benchmarking database organization without the expertise of the organization. As part of its selection criteria, the department will ensure that the selected benchmarking database organization is able to provide the data arbitrators will need under Insurance Code §1467.083. The department will monitor the benchmarking organization that is selected for compliance with SB 1264 and other statutes. The department notes that issues an arbitrator may determine that require use of the benchmarking database are intended for a health benefit claim submitted by an out-of-network provider who is not a facility.

Comment: One commenter asks whether providers will have access to the data in the benchmarking database. Another commenter asks whether the public will have access to the benchmarking data.

Agency Response: The department anticipates that providers and the public will have access to the benchmarking database.

Comment: One commenter has concerns about the ability of the third party to sell and profit off the database information. Another commenter suggests that the entity should not be able profit from the submitted data and enjoin future use if a different entity were to take over the database.

Agency Response: The department anticipates that it will have an agreement with the selected benchmarking database organization that will address privacy and security. These concerns are outside the scope of the proposed rules because the proposed rules implement what is required by SB 1264.

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Comment: One commenter suggests that data submissions be less frequent than monthly. Another commenter states that monthly data will reflect the current healthcare market in a timely manner. The commenter supports data submission "as required by the benchmarking organization" as it allows the organization flexibility to consider special circumstances. A commenter also suggests that the department require submission of benchmarking data as recommended by the selected database or on a monthly basis, whichever is more frequent.

Agency Response: The department does not agree with the commenter who suggests that data submissions be less frequent than monthly. As the other commenters state, frequency and flexibility are desirable. If monthly data submission is later determined unnecessary to reflect current pricing conditions, the benchmarking database organization may change the reporting deadline under §21.5050(c).

Comment: Several commenters state the need for protection of the proprietary data required to be submitted and that all data provided to the database is confidential. One commenter urges the department to protect the confidentiality of the data submitted to the benchmarking database.

Agency Response: The department acknowledges the concerns of the commenters over the confidentiality of proprietary data but does not agree that changes to the proposed rule text are necessary and declines to make a change to the rule text. The department anticipates the benchmarking database organization will keep non-aggregated information protected. However, the department does not have the authority to create confidentiality where it does not exist in statute. Policies and procedures for data security and confidentiality will be one of the considerations the Commissioner has when selecting

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a benchmarking database organization. The department is sensitive about concerns relating to the misuse of the data.

Comment on the proposal preamble

Comment: One commenter disagrees with the Public Benefit and Cost Note in the department's rule proposal. The commenter states that there will be a negative impact on public safety. The commenter expressed concern that based on the department's delays and lack of training in the current mediation process that the department will not adequately manage the new processes in a timely manner.

Agency Response: The department does not agree with the commenter. The modified and new dispute resolution processes are mandated by statute. Therefore, the costs associated with compliance of the rule are attributable to SB 1264. The new processes are different than the existing mediation process.

Comment: Several commenters disagree with the department's Regulatory Flexibility Analysis. The commenters stated that SB 1264 would have an adverse economic impact on licensed surgical assistants and other nondoctor assistants. The commenters state that the requirement to pay arbitrators will put many surgical assistants out of business.

Agency Response: The department does not agree with the commenters. The modified and new dispute resolution processes are mandated by statute, so the costs associated with compliance of the rule are attributable to SB 1264. In addition, the department anticipates that the arbitration process may help surgical assistants recover a reasonable amount for their services or supplies, despite sharing the cost of arbitration.

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Comment: One commenter disagrees with the department's Fiscal Note and Local Employment Impact Statement. The commenter states that the impact of SB 1264 will have far-reaching global economic impact that is already apparent by the number of providers being forced out of business or leaving the industry. Further, the commenter states that SB 1264 will affect every industry locally, statewide, nationally, and globally because the federal government is looking at Texas to determine how they will move forward on a national level.

Agency Response: The department does not agree with the commenter. The modified and new dispute resolution processes are mandated by statute, so the costs associated with compliance of the rule are attributable to SB 1264.

Comments on other issues

Comment: Many commenters express concern related to the lack of specific regulatory guidance on enrollee election as contemplated by Insurance Code §§1271.157(d), 1257.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d), and 1579.111(d). Commenters refer to these statutory provisions as "waivers" and the "loophole."

Commenters provide suggestions on how waivers should operate, including timelines. A commenter states that the disclosure forms should be by "mutual assent," and providers should not use blanket forms. Several commenters asked whether some types of providers give full disclosure in advance of surgery. They note that for certain providers, it may be impracticable to specify the time frame a service may require, and suggest that consent for certain providers, such as surgical assistants, should be tied to the surgeon or facility.

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Certain commenters state that there needs to be a hardline requirement that the provider is not paid by the payer unless the provider gives informed consent to the patient. The commenters are also concerned about forcing out-of-network providers to try to collect the out-of-network patient responsibility.

Another commenter recommends the rules provide for a minimum time frame for advance notice. Disclosure and election should be required for each out-of-network practitioner and must be specific to the services provided to the enrollee. Another commenter states that surgical consent and signing away protections from surprise billing are very different. One commenter states that the minimum time requirement should be tied to the date of scheduling. Another commenter wants one standardized form for the patient on what they must pay. One commenter requests the rule specify that the "exception" option is not available for care following stabilization of an emergency, or at least clarify that the same advance notice requirements apply.

One commenter states the loophole would exacerbate surprise bills by discouraging network affiliation.

One commenter requests that the department require claims subject to SB 1264 either indicate that no waiver has been obtained or include a copy of the waiver.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. These concerns are outside the scope of the rule, and to meet the aggressive timeline the department focused on the elements required by statute. As with any major piece of legislation, issues may arise that are not addressed in the law or agency rules. The department will closely monitor implementation and be ready to provide additional guidance.

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Comment: Several commenters express concerns related to rulemaking by other agencies and say they expect coordination between the department and other state agencies, including the Texas Medical Board and the Health and Human Services Commission.

One commenter states that while the department does not have the direct enforcement authority over physicians and other providers, the commenter feels all agencies should adopt the same rules and understanding around the exception process and prohibition. Another commenter expresses concerns about potential gaps in consumer protection created by multi-agency rules. The commenter states that without rule proposals from other agencies, it is impossible to see how the rules will work together.

One commenter is awaiting other rules related to the balance billing ban, enforcement, and guardrails for patient waivers for nonemergency care that could create a loophole, and then the commenter expects the department to propose rules and enforce the Insurance Code. Another commenter states that the agencies need to work together to hold their licensees accountable to uniform standards.

One commenter states that if licensing agencies do not adopt rules, then the department should. Several commenters urge the department to adopt rules to address the process and form. One commenter requests that the department not cede any rulemaking authority to agencies that may not share its mission, not protect patients, nor have the resources to enforce the balance billing ban.

Agency Response: The department recognizes these concerns but does not agree with the commenters. These concerns are outside the scope of the rule and to meet the aggressive timeline, the department focused on the elements required by statute. This rule is only one of several that may ultimately be required to implement SB 1264. As with any major piece of legislation, issues may arise that are not addressed in the law or rules.

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The department has communicated with other state agencies and will continue to work with them to implement SB 1264. The department will closely monitor implementation and be ready to provide additional guidance, as needed.

Comment: Two commenters ask how health benefit plan issuers and administrators are supposed to know if a waiver has been signed.

Agency Response: The department anticipates that where an enrollee has received a valid complete written disclosure, that the provider would be able to provide documentation in response to a health benefit plan issuer's or administrator's request for arbitration. The situation may be similar to how a health benefit plan or issuer might demonstrate, in response to a request for mediation or arbitration, that a claim is not eligible for the dispute resolution process where a question of coverage exists.

Comment: Several commenters request future rulemaking to address other issues. A commenter objects to the department addressing any comments brought up during the hearing that are outside the scope of the rule as proposed without formally proposing new rules that address the issues raised in those comments.

Agency Response: The department does not propose or adopt rules for any section not included in the rule proposal. Future rulemaking may amend other provisions of the Administrative Code as implementation of SB 1264 continues. However, such potential action is outside the scope of this current rule proposal and adoption.

Comment: One commenter recommends the rule contain an explicit prohibition on balance billing as laid out in SB 1264. The commenter recommends that this rule be mirrored in rules by the Texas Medical Board and the Health and the Human Services

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Commission. The commenter notes that there may be providers who are not licensed by any state agency. The commenter urges the department to articulate how and when it will refer complaints to licensing agencies and the Office of the Attorney General.

One commenter requests the department clarify the application of the balance billing prohibitions in SB 1264. The commenter states that it may not always be readily apparent if a claim filed by an out-of-network facility-based provider provides services in connection with an in-network provider. The commenter states that the department should recognize that health benefit plans may sometimes need additional information to determine how SB 1264 applies.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department does not adopt rules for any section not included in the rule proposal. Insurance Code §752.0003(a) states that the appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action. Further, Insurance Code §752.0003(b) states that the department may take disciplinary action against a health benefit plan issuer or administrator. Also, the department may refer violations to the Attorney General's Office under Insurance Code §752.0002. The department welcomes feedback on the portal as it administers the arbitration program.

The department recognizes that there may be instances where a claim that appears to be eligible for arbitration initially is in fact not eligible. If there are questions on the eligibility of a claim, the department suggests that parties cooperate and extend timelines as SB 1264 provides.

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Comment: One commenter states that the department should develop fines, penalties, and injunctive relief for health benefit plan issuers and administrators that exhibit a pattern of unwarranted coverage denials or underpayment related to out-of-network bills. The commenter states that payers and providers should be equally accountable for improper or illegal practices. Another commenter wants to make sure that there is clear enforcement language for illegal balance billing.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to amend the proposed rule. Insurance Code §1467.102 provides for an administrative penalty for bad faith participation. The Insurance Code provides for other administrative penalties, including sanctions under Insurance Code Chapters 82 and 84. The department will monitor compliance with the provisions of SB 1264 and other insurance laws and may take further regulatory action as necessary, including referral to other state agencies.

Comment: One commenter has several questions and concerns relating to payment standards and hold-harmless provisions, reimbursement rates, claim denial, coverage, applicability of state regulation, payment recovery, enforcement, prompt pay, and unfair business practices.

Agency Response: The department recognizes these concerns but declines to amend the proposed rule. While some of the comments reference SB 1264, the questions and concerns raised are not regarding the proposed rule text, nor do they request changes or additions to the proposed rule text. These comments are outside of the scope of the proposal and this adoption order.

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Comment: One commenter asks the department to publish a list of insurance policies that are subject to the rule. The commenter was unsure if the rules would apply to their Medicare Advantage plan.

Agency Response: The rules apply to state-regulated plans, Texas Employees Group, Texas Public School Employees Group, and Texas School Employees Uniform Group. It appears that Medicare Advantage plans are regulated under federal law and these rules do not apply to them. The department notes that one of the changes that SB 1264 made to Insurance Code Chapter 1467 was to take the enrollee out of the statutory dispute resolution process.

Comment: One commenter requests that the department specify in the rules that the physician or provider may submit to the health maintenance organization a subject's complete medical and billing records when the physician or provider submits an electronic claim under Insurance Code §843.336. The commenter states that this clarification would simplify and increase the efficiency of the billing and payment process by eliminating requests for additional information and the associated delay in payment and claims disputes. Another commenter states that payers should be required to provide all benefits information about a patient's plan on its website or through a clearinghouse. The commenter states that a provider may find it necessary to assume deductibles and other limitations that have not been met and get a refund later, if the provider does not have access to information from payers.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. These concerns are outside the scope of the proposed rules, because the proposed rules

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implement what is required by SB 1264. Clean-claim requirements are found in 28 TAC Chapter 21, Subchapter T.

Comment: One commenter requests that the department add new requirements for initial payments and provide for administrative penalties for failure to promptly pay claims. The commenter expresses concern that because the arbitration process cannot start without the initial payment, the rules fail to address a delayed payment, or a payment made to the enrollee, rather than the physician. Certain providers have concerns about getting paid at the in-network rate if there are no in-network providers of the same type.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. SB 1264 establishes timelines for payments, and Insurance Code Chapters 843 and 1301 contain provisions for the payment of clean claims. Rules for the submission and payment of clean claims are found in 28 TAC Chapter 21, Subchapter T. The Insurance Code provides for other sanctions and penalties, including those under Insurance Code Chapters 82 and 84. The department will monitor compliance with the provisions of SB 1264 and other insurance laws and may take further regulatory action as necessary, including referral to other state agencies. The department notes that out-of-network providers will be subject to the balance billing prohibitions, payment regulations, and dispute resolution processes, as applicable, as provided by SB 1264.

Additionally, these concerns are outside the scope of the proposed rule because the proposed rule implements what is required by SB 1264.

Comment: Several commenters express concerns over network adequacy and health benefit plan contracting practices. One commenter states that network adequacy is the

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foundation for decreasing the likelihood a patient will encounter an out-of-network provider. The commenter requests the department ensure its current network adequacy rules are enforced and review requirements for efficacy. Several commenters also share frustration over unfair provider contracting practices with health benefit plan issuers. Several commenters suggest that the department monitor contracting between providers and health benefit plans, including how long it takes to become in-network and for adequate coverage. One commenter is concerned that the rules could inadvertently discourage new providers from entering the market. One commenter states that charging out-of-network rates is often the only leverage providers have when negotiating contracts. The commenter suggests that the department monitor the unintended consequences that may arise and consider the experience of other states with similar regulations.

Several commenters are concerned that the statute will drive surgical assistants and other health care professionals from healthcare. One commenter states that hospitals have been strategically eliminating providers who are not in-network. Several commenters are concerned that the statute and rules will eliminate the out-of-network option and reduce competition. Another commenter has concerns that health plans refuse to negotiate rates, forcing surgical assistants to become out-of-network providers. Several commenters have broader concerns specific to assistant surgeons, including payment determinations and discriminatory practices by hospitals.

One commenter specifically states that network availability is the biggest issue for surgical assistants. Several commenters are concerned that the rules will reduce the use of surgical assistants, and that this would diminish the quality of care provided patients and potentially increase costs.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rules.

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These concerns are outside the scope of this rulemaking. For providers and insurance consumers with specific complaints related to claims handling, the department encourages filing a complaint with the department. The department will closely monitor implementation and may note trends in the Balance Billing Prohibition Report. Also, the department may recommend any needed changes in the law in its Biennial Report to the Legislature.

Comment: Several commenters have concerns that the proposed rules do not address provisions of SB 1264 related to payment at the usual and customary rates and hold harmless provisions. Commenters encourage the department to amend other rules to be consistent with SB 1264.

Commenters state that excessive payment standards inflate health care costs, which consumers pay for in higher premiums and out-of-pocket costs. Several commenters request that the department require health benefit plans to pay surgical assistant contracts using the usual and customary rate. One commenter states that the department should contemplate if usual and customary rates should vary across the state based on geography.

Another commenter states that current rules cover the possibility of in-network providers not being reasonably available, and states that the department should take care to provide that out-of-network rates are still offered in those areas where network gaps may exist.

Agency Response: The department recognizes these concerns but notes that amendments to 28 TAC Chapters 3 and 11 must be made in different rule proposals. To meet the aggressive adoption timeline, the department focused on the elements required

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by statute. Other changes and issues outside the scope of SB 1264 may be addressed in other rule projects.

Comment: Several commenters express concern about coverage decisions, including characterizing claims as either emergency or nonemergency. Several commenters state that the rule should provide additional clarity regarding whether a claim qualifies as emergency care under the "prudent layperson" standard subject to the balance billing prohibition or later characterized as nonemergent.

A commenter expresses concern that a unilateral determination could allow a health benefit plan to skirt the intent of the new law. A commenter also asked that the department's rules prevent health benefit plan issuers from requiring prior authorization before emergency care. The commenter wants the department to adopt more stringent regulations for retrospective reviews. One commenter states that policy administrators will often deny claims submitted as emergent.

Another commenter has concerns about what happens if a patient is moved from a hospital emergency room facility to a subsequent emergency setting or has subsequent services. The commenter requests the department clarify where emergency care begins and ends.

Another commenter states that the rule should be clarified to prevent a health benefit plan issuer or administrator from making a retrospective determination based on a final diagnosis as opposed to presenting symptoms that could result in a patient losing the protections of SB 1264.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. Disputes over coverage regarding nonemergent care, prior authorization, and

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retrospective review are outside the scope of the proposed rule, because the proposed rule implements what is required by SB 1264. The department assumes that the mediation and arbitration procedures will not involve issues of coverage, unless the parties agree. The department will closely monitor implementation and be ready to provide additional guidance.

Comment: One commenter requests clarification of whether ambulance services are included in the SB 1264 dispute process. Another commenter asks if air ambulance services are subject to mandatory arbitration.

Agency Response: The department notes that Insurance Code §1467.001 and §21.5003 of the rules define "emergency care" has the meaning assigned by Insurance Code §1301.155. That section states that "emergency care" means "health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition [. . .]." Services not provided in a facility, such as ambulance services and air ambulances services, are not included in the meaning of "emergency care" and are not subject to mandatory arbitration.

Comment: One commenter requests clarification of whether out-of-state services provided to enrollees are covered under Texas-issued benefit plans.

Agency Response: The department believes that the balance billing prohibition applies only to Texas providers.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION DIVISION 1. GENERAL PROVISIONS

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28 TAC §§21.5001 – 21.5003

STATUTORY AUTHORITY. The department adopts §§21.5001 – 21.5003 under Insurance Code §§1301.007, 1467.003, and 36.001.

Insurance Code §1301.007 states that the Commissioner may adopt rules necessary to implement Chapter 1301.

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

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

TEXT.

§21.5001. 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), §1301.010 (concerning Balance Billing Prohibition Notice), §1551.015 (concerning Balance Billing

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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), or 1579 (concerning Texas School Employees Uniform Group Health Coverage); 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

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in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose.

§21.5003. Definitions.

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

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001 (concerning Definitions).

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

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

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

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

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

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

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

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

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

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

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

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843;

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

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, 1575, or 1579.

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

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

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

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

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

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

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

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION **DIVISION 2. MEDIATION PROCESS** **28 TAC §§21.5010 – 21.5013**

STATUTORY AUTHORITY. The department adopts amendments to §§21.5010 – 21.5013 under Insurance Code §§1467.003, 1467.0505, 1467.054, 1467.151, and 36.001.

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

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

Insurance Code §1467.054 states that the Commissioner may provide by rule the form and manner the written notice sent to the department and the other party by a person who requests a mediation.

Insurance Code §1467.151(b) states that the Commissioner may maintain information specified by the section, including information about a health benefit plan issuer or administrator or out-of-network provider that the Commissioner requires by rule.

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

TEXT.

§21.5010. 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; or
- (C) an out-of-network diagnostic imaging service.

(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

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

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(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.

(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

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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.

§21.5012. Informal Settlement Teleconference.

All parties subject to mandatory mediation requested by an out-of-network provider that is a facility or a health benefit plan issuer or administrator under this subchapter must use best efforts to coordinate the informal settlement teleconference required by Insurance Code §1467.054 (concerning Request and Preliminary Procedures for Mandatory Mediation). The parties or representatives of the parties must arrange a date and time when the parties or representatives of the parties can participate in the informal settlement teleconference, which must occur not later than the 30th day after the date on which the party submitted a request for mediation, unless the parties agree to extend the deadline.

§21.5013. Mediation Participation.

Under Insurance Code §1467.101 (concerning Bad Faith), conduct that constitutes bad faith mediation includes failing to:

- (1) participate in the mediation;
- (2) provide information that the mediator believes is necessary to facilitate an agreement; or

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(3) designate a representative participating in the mediation with full authority to enter into any mediated agreement.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION **Repeal of DIVISION 3. REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION** **28 TAC §21.5020**

STATUTORY AUTHORITY. The department repeals Division 3 and 28 TAC §21.5020 under Insurance Code §1467.003 and §36.001.

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

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

TEXT.

§21.5020. Required Notice of Claims Dispute Resolution.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION **DIVISION 3. ARBITRATION PROCESS** **§§21.5020 – 21.5023**

STATUTORY AUTHORITY. The department adopts new §§21.5020 – 21.5023 under Insurance Code §§1467.003, 1467.082, 1467.084, 1467.088, 1467.151, and 36.001.

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

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

Insurance Code §1467.084(c) states that the Commissioner may provide by rule the form and manner the written notice sent to the department and the other party by the person who requests the arbitration.

Insurance Code §1467.084(e) states the Commissioner may adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding.

Insurance Code §1467.088(c) states that an arbitrator must provide written notice in the form and manner prescribed by Commissioner rule of the reasonable amount for the services or supplies and the binding award amount, and that if the parties settle before a decision, the parties shall provide written notice in the form and manner prescribed by Commissioner rule of the amount of the settlement.

Insurance Code §1467.151(b) states that the Commissioner may maintain information specified by the section, including information about a health benefit plan issuer or administrator or out-of-network provider that the Commissioner requires by rule.

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

TEXT.

§21.5020. 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; or

(D) an out-of-network diagnostic imaging service; 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.

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(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) name of the arbitrator, 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

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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.

(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 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.

§21.5022. Informal Settlement Teleconference.

A party subject to mandatory arbitration requested by an out-of-network provider or a health benefit plan issuer or administrator under this division must use best efforts to coordinate an informal settlement teleconference, as required by Insurance Code §1467.084 (concerning Availability of Mandatory Arbitration). The health benefit plan issuer or administrator must make a reasonable effort to arrange the teleconference at a date and time when the parties or representatives of the parties can participate in the

informal settlement teleconference. The informal settlement teleconference must occur no later than the 30th day after arbitration is requested, unless the parties agree to extend the deadline.

§21.5023. Arbitration Participation.

Under Insurance Code §1467.101 (concerning Bad Faith), conduct that constitutes bad faith arbitration includes failing to:

- (1) participate in the informal settlement teleconference under §1467.084(d) or an arbitration;
- (2) provide information that the arbitrator believes is necessary to facilitate a decision; or
- (3) designate a representative participating in the arbitration with full authority to enter into any agreement.

**SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
DIVISION 4. COMPLAINT RESOLUTION
28 TAC §21.5030**

STATUTORY AUTHORITY. The department adopts amendment to §21.5030 under Insurance Code §§1467.003, 1467.151, and 36.001.

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

Insurance Code §1467.151(a) provides for the Commissioner to adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Insurance Code Chapter 1467.

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Insurance Code §1467.151(b) states that the Commissioner may maintain information specified by the section, including information about a health benefit plan issuer or administrator or out-of-network provider that the Commissioner requires by rule.

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

TEXT.

§21.5030. Complaint Resolution.

(a) Written complaint. A party may submit a written complaint on the department's website regarding the settlement of an out-of-network health benefit claim that is subject to Insurance Code Chapter 1467.

(b) Complaint information. The recommended information for filing a complaint under subsection (a) of this section, includes:

(1) whether the complaint is within the scope of Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution);

(2) whether emergency care, health care, or a medical service has been delayed or has not been given;

(3) whether the health care, medical service, or supply, or a combination of health care, medical service, or supply, that is the subject of the complaint was for emergency care; and

(4) specific information about the qualified mediation claim or qualified arbitration claim, including:

(A) the name, type, and specialty of the provider;

(B) the type of service performed or supplies provided;

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(C) the city and county where the service or supply was performed;

and

(D) the dollar amount of the disputed claim.

(c) Department processing. The department will maintain procedures to ensure that a written complaint made through the department's website under this section is not dismissed without appropriate consideration, including:

(1) review of all of the information submitted in the written complaint;

(2) contact with the parties that are the subject of the complaint; and

(3) review of the responses received from the subjects of the complaint to

determine if and what further action is required, as appropriate.

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

STATUTORY AUTHORITY. The department adopts §21.5040 under Insurance Code §§1301.007, 1467.003, and 36.001.

Insurance Code §1301.007 states that the Commissioner may adopt rules necessary to implement Chapter 1301.

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

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

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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), §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 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 copayments, coinsurance, deductibles, and other amounts included in that total;

(2) 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 PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 6. BENCHMARKING

28 TAC §21.5050

STATUTORY AUTHORITY. The department adopts new §21.5050 under Insurance Code §§38.004, 1467.003, 1467.006, 1467.151, and 36.001.

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Insurance Code §38.004(b) provides that in conducting the study described by §38.004(a), the department must collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Chapter 1467. Insurance Code §38.004(d) provides that the department may utilize any reliable external resource or entity to acquire information reasonably necessary to prepare the report required by Insurance Code §38.004(e).

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

Insurance Code §1467.006 states that the Commissioner may adopt rules governing the submission of information for the benchmarking database.

Insurance Code §1467.151(b) states that the Commissioner may maintain information specified by the section, including information about a health benefit plan issuer or administrator or out-of-network provider that the Commissioner requires by rule.

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

TEXT.

§21.5050. Submission of Information.

(a) Required submission. A health benefit plan issuer or administrator must submit information to the benchmarking database organization selected by the Commissioner as required by this section.

(b) Information required. For each geozip in Texas, a health benefit plan issuer or administrator must submit information necessary for the benchmarking database organization to calculate a health care or medical service or supply, as determined by the benchmarking database organization, including:

(1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and

(2) the 50th percentile of rates paid to participating providers who are not facilities.

(c) Submission frequency. A health benefit plan issuer or administrator must submit 2019 plan year data by February 1, 2020, to the benchmarking database organization. After February 1, 2020, health benefit plan issuers must submit data monthly to the benchmarking database organization, or as required by the selected benchmarking organization.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
DIVISION 4. COMPLAINT RESOLUTION
Repeal of 28 TAC §21.5031

STATUTORY AUTHORITY. The department repeals §21.5031 under Insurance Code §§1467.003, 1467.151, and 36.001.

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

Insurance Code §1467.151(a) provides for the Commissioner to adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Insurance Code Chapter 1467.

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

TEXT.

§21.5031. Department Outreach.

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

Issued at Austin, Texas, on December 3, 2019.

/s/ James Person _____
James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 TAC §§21.5001 – 21.5003, 21.5010 – 21.5013, and 21.5030; repeals §21.5020 and §21.5031, and adopts new §§21.5020 – 21.5023, 21.5040, and 21.5050.

/s/ Kent C. Sullivan _____
Kent C. Sullivan
Commissioner of Insurance

Commissioner's Order No. **2019-6172**

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