

SUBCHAPTER PP, OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

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INTRODUCTION. The Texas Department of Insurance proposes to amend 28 TAC §§21.5001 – 21.5003, 21.5010 – 21.5013, and 21.5030; repeal §21.5020 and §21.5031, and adopt new §§21.5020 – 21.5023, 21.5040, and 21.5050, concerning out-of-network claim dispute resolution. The amendments and repeals implement Senate Bill 1264, 86th Legislature, Regular Session (2019).

EXPLANATION. The new sections, amendments, and repeals are necessary to implement SB 1264, 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. The amendments 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 provided by network physicians or providers. SB 1264 requires the department to establish a portal on its website to handle mediation and arbitration requests.

The amendments included in this proposal 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 proposal. As provided by SB 1264, the Commissioner will conduct a study on the impacts of the bill, which is not part of this rule proposal. 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 role of 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 explanations of benefits required by Insurance Code Chapters 1271, 1301, 1467, 1551, 1575, and 1579 as proposed 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 proposed 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 definitions no longer necessary and to reflect new definitions in amended Insurance Code Chapter 1467. The proposed 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 applies to enrollees and only applies to a health benefit claim submitted by an out-of-network provider that is a facility. Existing §21.5010(c) is proposed to be amended because Insurance Code §1467.051(c) and (d) were repealed by SB 1264, and subsection (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 proposed to be 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 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 internet website through which mediation requests may be submitted.

Section 21.5011(a) is revised to update mediation request requirements and address notice requirements. Proposed 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. Proposed 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 proposed for deletion, 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.

Proposed 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 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.

Proposed §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.

Proposed §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 promptly if the Commissioner is required to select a mediator.

Proposed §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.

Proposed §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 proposed rules allow for flexibility in how mediators will be added to the list, subject to the statutory qualification standards in Insurance Code §1467.052.

Proposed §21.5011(g) provides specific guidance on certain elements of the mediation process. Subsection (g)(1) requires an out-of-network provider to use best efforts to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process. Resolving disputes in the internal appeal process will make for more efficient administration of the mediation process. The proposed requirement does not require unreasonable efforts that would cause delay under Insurance Code Chapter 1467.

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

Proposed §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 time line will allow for timely selection of a mediator and will help the department efficiently administer the mediator program.

Proposed §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 proposed §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 proposed §21.5012 provide that all parties arrange a workable date and time. An additional amendment is proposed to clarify that the deadline to have an informal telephone 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 role of 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 proposed for repeal 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.

Proposed 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, 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. Proposed §21.5020(a)(1) is consistent with Insurance Code §1467.084(a)(2). Proposed §21.5020(a)(2) is consistent with Insurance Code §1467.084(a)(1). Proposed §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. Proposed §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 proposed 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 program to resolve disputes over out-of-network provider charges, and to establish a portal on the department's website. Proposed §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.

Proposed §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 proposed 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.

Proposed §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 proposed rule requires notification to the department if the parties have settled, 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 promptly if the Commissioner is

required to select the arbitrator. Immediate payment may encourage qualified arbitrators to seek placement on the list.

Proposed §21.5021(e) requires certain information to 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 proposed §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.

Proposed §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 proposed 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.

Proposed §21.5021(g) provides specific guidance on certain elements of the arbitration process. The proposed rules require a provider to use best efforts to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process. The department believes that resolving disputes in the internal appeal process will make for more efficient administration of the arbitration process. The proposed requirement does not require unreasonable efforts that would cause delay under Insurance Code Chapter 1467.

Proposed §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.

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

Proposed §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 time line.

Proposed §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.

Proposed §21.5021(g)(6) states the consequences in the arbitration decision for parties that do not participate in good faith. Without sufficient 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.

Proposed §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.

Proposed §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 proposed section permits extension of the deadline, in accordance with Insurance Code §1467.087(c).

Section 21.5023. Arbitration Participation. This section requires arbitration participants not to 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 §1464.101 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 proposed 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 proposed to make the section apply more broadly to both the mediation and arbitration procedures.

Section 21.5031. Department Outreach. This section is proposed for repeal. 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 proposed to provide requirements for the required 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 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 proposed 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 will be consistent with Insurance Code §1467.006 and Insurance Code §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 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 proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to the department's current style and to improve the rule's clarity.

The department received comments in response to questions the department posted on its website on July 15, 2019. The department also received oral comments at a stakeholder meeting on July 29, 2019, and additional comments were sought and received until August 9, 2019. The department considered those comments when drafting this proposal.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Chris Herrick, deputy commissioner of the Customer Operations Division, has determined that during each year of the first five years the proposed new sections, amendments, and repeals are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. This determination was made because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

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

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new sections, amendments, and repeals are in effect, Mr. Herrick expects that administering the proposed new sections, amendments, and repeals will have the public benefit of ensuring that the department's rules conform to Insurance Code Chapter 1467 and SB 1264, allowing for the efficient mediation and arbitration of certain out-of-network health claims. Mr. Herrick expects that the proposed new sections will not increase the cost of compliance with SB 1264 because they do not impose requirements beyond those in the statute. Insurance Code Chapter 1467 requires the use of a portal for mediation and arbitration for certain claims. As a result, any cost associated with complying with the process does not result from the enforcement or administration of the proposed new sections, amendments, and repeals.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed new sections, amendments, and repeals will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities. Because the proposed rule is designed to implement Insurance Code §§1271.008, 1301.010, 1551.015, 1575.009, 1579.009 and Insurance Code Chapter 1467, any economic impact results from the statute itself. The new sections, amendments, and repeals do not impose requirements beyond those in statute and will not create an increase in cost of compliance with statute. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does not impose requirements beyond those in the

statute, and therefore this rule does not impose a cost on regulated persons. No additional rule amendments are required under Government Code §2001.0045 because all costs result from the statute and proposed new sections, amendments, and repeals are necessary to implement legislation. The proposed rule implements Insurance Code §§1271.008, 1301.010, 1551.015, 1575.009, 1579.009 and Insurance Code Chapter 1467, as added and amended by SB 1264. Insurance Code §1467.003 provides that Government Code §2001.0045 does not apply to a rule adopted under Insurance Code Chapter 1467.

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

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

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

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., central time, on October 28, 2019. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2814 at 9:30 a.m. central time, on October 23, 2019, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

SUBCHAPTER PP, OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
DIVISION 1. GENERAL PROVISIONS
28 TAC §§21.5001 - 21.5003

STATUTORY AUTHORITY. The department proposes §§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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5001 and §21.5002 implement Insurance Code Chapters 1271, 1301, 1467, 1551, 1575, and 1579,

and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5003 implement Insurance Code §1467.001 and SB 1264, 86th Legislature, Regular Session (2019).

TEXT.

§21.5001. Purpose.

The [~~As authorized by Insurance Code §1467.003 (concerning Rules), the~~] purpose of this subchapter is to:

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

(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 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; [øf]

(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 [This] subchapter applies to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2020 [2018]. A claim for health care or medical services or supplies provided before January 1, 2020 [2018], is governed by the rules in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose.

§21.5003. Definitions.

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

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001 (concerning Definitions). [~~An administering firm or a claims administrator for a health benefit plan, other than a health maintenance organization (HMO) plan, providing coverage 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).]~~

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

~~[(2) Chief administrative law judge--The chief administrative law judge of the State Office of Administrative Hearings.]~~

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

(7) [(5)] Emergency care provider--Has the meaning assigned by Insurance Code §1467.001. ~~[A physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.]~~

(8) [(6)] Enrollee--Has the meaning assigned by Insurance Code §1467.001. ~~[An individual who is eligible to receive benefits through a preferred provider benefit plan or a health benefit plan under Insurance Code Chapters 1551, 1575, or 1579.]~~

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

(10) ~~[(8)]~~ 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)]~~ 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) ~~[(B)]~~ a plan, other than an HMO plan, under Insurance Code Chapters 1551, 1575, or 1579.

(11) ~~[(9)]~~ Facility-based provider--Has the meaning assigned by Insurance Code §1467.001. ~~[A physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.]~~

~~[(10) Health care practitioner--An individual who is licensed to provide health care services.]~~

(12) ~~[(11)]~~ 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) ~~[(12)]~~ Mediation--Has the meaning assigned by Insurance Code §1467.001. ~~[A process in which an impartial mediator facilitates and promotes agreement~~

~~between the insurer offering a preferred provider benefit plan, or the administrator, and a facility-based provider or emergency care provider or the provider's representative to settle a qualified claim of an enrollee.]~~

(14) ~~[(13)]~~ Mediator--Has the meaning assigned by Insurance Code §1467.001. ~~[An impartial person who is appointed to conduct mediation under Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution).]~~

(15) ~~[(14)]~~ 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 ~~[a facility-based provider or emergency care provider that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator].~~

(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.

~~[(15) Preferred provider--A facility, facility-based provider, or emergency care provider that contracts on a preferred-benefit basis with an insurer issuing a preferred provider benefit plan under Insurance Code Chapter 1301 to provide medical care or health care to enrollees covered by a health insurance policy.]~~

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

STATUTORY AUTHORITY. The department proposes 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.

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

CROSS-REFERENCE TO STATUTE. The proposed amendments to 28 TAC §21.5010 implement Insurance Code §§1467.050, 1467.051, and 1467.054; and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5011 implement Insurance Code §§1467.050 – 1467.060 and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5012 implement Insurance Code §1467.054 and §1467.055 and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5013 implement Insurance Code §1467.101 and SB 1264, 86th Legislature, Regular Session (2019).

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 ~~[enrollee]~~ may request mandatory mediation of an out-of-network claim under §21.5011 of this title (relating to Mediation Request ~~[Form and]~~ 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) ~~[health care or]~~ emergency care; ~~[or]~~

(B) an out-of-network laboratory service; or

(C) an out-of-network diagnostic imaging service ~~[(B) a health care or medical service or supply, provided by a facility-based provider in a facility that is a preferred provider with the insurer or that has a contract with the administrator].~~

(2) There is an ~~[The aggregate]~~ amount billed by the provider and unpaid by the health benefit plan issuer or administrator after ~~[for which the enrollee is responsible to the facility-based provider or emergency care provider for the out-of-network claim, not including]~~ copayments, deductibles, and coinsurance, for which an enrollee may not be billed ~~[or amounts paid by an insurer or administrator directly to the enrollee, must be greater than \$500].~~

(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.

~~[(1) An out-of-network claim is not eligible for mandatory mediation under this subchapter if:]~~

~~[(A) the facility-based provider has provided a complete disclosure to an enrollee under Insurance Code §1467.051(c) (concerning Availability of Mandatory Mediation; Exception), and this subsection before providing the health care or medical service or supply or both and has obtained the enrollee's written acknowledgment of that disclosure; and]~~

~~[(B) the amount billed by the facility-based provider is less than or equal to the maximum amount specified in the disclosure.]~~

~~[(2) A complete disclosure under paragraph (1) of this subsection must:]~~

~~[(A) explain that the facility-based provider does not have, as applicable, either a contract with the enrollee's health benefit plan as a preferred provider or a contract with the administrator of the plan, other than an HMO plan, provided 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);]~~

~~[(B) disclose projected amounts for which the enrollee may be responsible; and]~~

~~[(C) disclose the circumstances under which the enrollee would be responsible for those amounts.]~~

~~[(d) Qualification continues. A claim that meets the criteria to be a qualified claim after claim adjudication by the insurer or administrator does not lose that status by virtue of the aggregate amount for which the enrollee is responsible being reduced below the thresholds set out in this section without the consent of the enrollee.]~~

§21.5011. Mediation Request [Form and] Procedure.

(a) Mediation request and notice. [~~form. The Commissioner adopts by reference Form No. CP029 (Health Insurance Mediation Request Form), which is available at www.tdi.texas.gov/consumer/cpmmediation.html. Form No. CP029 (Health Insurance Mediation Request Form) requires information necessary for the department to properly identify the qualified claim, including:]~~

(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.

~~[(1) the name and contact information, including a telephone number, of the enrollee requesting mediation;]~~

~~[(2) a brief description of the qualified claim to be mediated, including the amount sought from the enrollee, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee;]~~

~~[(3) the name and contact information, including a telephone number, of the requesting enrollee's counsel, if the enrollee retains counsel;]~~

~~[(4) the name of the facility-based provider or emergency care provider;]~~

~~[(5) the name of the insurer or administrator;]~~

~~[(6) the name and address of the facility where services were rendered; and]~~

~~[(7) an authorization allowing the department to disclose the enrollee's protected health information or other confidential information for the purpose of mediating the claim at issue to the facility-based provider or emergency care provider, facility-based provider's or emergency care provider's representative or representatives, the enrollee's health benefit plan's insurer or administrator, the benefit plan's representative or representatives, the insurer or administrator's representative or representatives, the appointed mediator, and the State Office of Administrative Hearings.]~~

(b) Submission of request. The requesting party must submit information necessary to complete the initial mediation request, including: ~~[An enrollee may submit a request for mediation by completing and submitting Form No. CP029 (Health Insurance Mediation Request Form) as provided in this subsection. The request may be submitted:]~~

(1) facility details, including identifying the facility type, facility contact information, and facility representative information ~~[by mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091];~~

(2) claim information, including the claim number, type of service or supply provided, date of service, billed amount, amount paid, and balance ~~[by fax to 512-490-1007]; and~~

(3) relevant information from the enrollee's health benefit plan identification card or other similar document, including plan number and group number. ~~[by email to ConsumerProtection@tdi.texas.gov; or]~~

~~[(4) online, when the department makes Form No. CP029 (Health Insurance Mediation Request Form) available to be completed and submitted online.]~~

(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) 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 promptly when the mediator is assigned. Failure to pay the mediator promptly 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

(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) An out-of-network provider that is a facility must use best efforts to resolve a claim payment dispute through a health benefit plan issuer's or administrator's internal appeal process before requesting mediation.

(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 five days of the request for mediation whether there is a conflict of interest with any of the mediators on the list to avoid the department assigning a mediator with a conflict of interest.

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

~~(h) [(e)] Assistance. Assistance with submitting a request for mediation is available on [at] the department's website at www.tdi.texas.gov [toll-free telephone number, 800-252-3439].~~

§21.5012. Informal Settlement Teleconference.

~~All parties [An insurer or administrator] subject to mandatory mediation requested by an out-of-network provider that is a facility or a health benefit plan issuer or administrator [an enrollee] 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 [by:]~~

~~[(1) arranging insurer or administrator; the enrollee or the enrollee's representative, if the enrollee or the enrollee's representative chooses to participate; and the facility-based provider or emergency care provider or the facility-based provider's or emergency care provider's representative] can participate in the informal settlement teleconference, which must occur not later than the 30th day after the date on which the party [enrollee] submitted a request for mediation, unless the parties agree to extend the deadline.[; and]~~

~~[(2) providing a toll-free telephone number for participation in the informal settlement teleconference.]~~

§21.5013. Mediation Participation.

~~[(a) An insurer or administrator subject to mediation under this subchapter must participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge under Insurance Code §1467.003 (concerning Rules).]~~

~~[(b)]~~ 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
- (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 proposes the repeal of 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.

CROSS-REFERENCE TO STATUTE. The repeal of 28 TAC §21.5020 implements the repeal of Insurance Code §1467.0511 by SB 1264, 86th Legislature, Regular Session (2019).

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 proposes new §§21.5020 – 21.5023 under Insurance Code §§1467.003, 1467.082, 1467.084, 1467.088, 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 §1467.082 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 the 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.

CROSS-REFERENCE TO STATUTE. The proposed new 28 TAC §21.5020 implement Insurance Code §§1467.081, 1467.082, and 1467.084; and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5021 implement Insurance Code §§1467.081 – 1467.089 and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5022 implement Insurance Code §1467.084 and §1467.087 and SB 1264, 86th Legislature, Regular Session (2019). The proposed amendments to 28 TAC §21.5023 implement Insurance Code §1467.101 and SB 1264, 86th Legislature, Regular Session (2019).

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.

(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 promptly when the arbitrator is assigned. Failure to pay the arbitrator promptly 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, when the arbitration was held, the date of the decision, the date of the arbitrator report, and when payment was made; and

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

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

(A) the date of the settlement; and

(B) the amount of the settlement.

(f) Arbitrator approval and removal.

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

(2) A list of qualified arbitrators will be maintained on the department's website. An arbitrator who no longer meets the qualification requirements in Insurance Code §1467.086 (concerning Selection and Approval of Arbitrator) will be terminated. An

arbitrator must notify the department immediately if the arbitrator wants to voluntarily withdraw from the list.

(g) Arbitration process.

(1) An out-of-network provider must use best efforts to resolve a claim payment dispute through a health benefit plan issuer's or administrator's internal appeal process before a party requests arbitration.

(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 five 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 [~~AND OUTREACH~~]
28 TAC §21.5030**

STATUTORY AUTHORITY. The department proposes 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.

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.

CROSS-REFERENCE TO STATUTE. Amendments to 28 TAC §21.5030 implements Insurance Code §1467.151 and SB 1264, 86th Legislature, Regular Session (2019).

TEXT.

§21.5030. Complaint Resolution.

(a) Written complaint.

A party [~~(1) An individual~~] may submit a written complaint on the department's website [~~to the department~~] regarding the settlement of an out-of-network health benefit claim that is subject to Insurance Code Chapter 1467. [~~a qualified claim or a mediation requested under §21.5010 of this title (relating to Qualified Claim Criteria).~~ A

~~recommended form for filing a complaint under this subsection is available online at www.tdi.texas.gov/consumer/cpmmediation.html. The complaint may be submitted by:]~~

~~[(A) mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;]~~

~~[(B) fax to 512-490-1007;]~~

~~[(C) email to ConsumerProtection@tdi.texas.gov; or]~~

~~[(D) online submission.]~~

~~[(2) Assistance with filing a complaint is available at the department's toll-free telephone number, 800-252-3439.]~~

(b) Complaint information ~~[form]~~. The recommended information ~~[form]~~ for filing a complaint under subsection (a), includes ~~[of this section requests information concerning the complaint, including]:~~

(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 have been delayed or have 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 ~~[facility-based]~~ provider ~~[or emergency care provider];~~

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

(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. [~~and~~]

~~[(4) notification to the enrollee of the mediation process, as described in Insurance Code Chapter 1467, Subchapter B (concerning Mandatory Mediation).]~~

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

STATUTORY AUTHORITY. The department proposes §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 states that the Commissioner shall adopt rules as necessary to implement their respective powers and duties under Insurance Code Chapter 1467.

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

CROSS-REFERENCE TO STATUTE. The proposed new 28 TAC §21.5040 implements Insurance Code §§1271.008, 1301.010, 1551.015, 1575.009, and 1579.009; and SB 1264, 86th Legislature, Regular Session (2019).

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 proposes new §21.5050 under Insurance Code §§1467.003, 1467.006, 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 §1467.006 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.

CROSS-REFERENCE TO STATUTE. The proposed new 28 TAC §21.5050 implements Insurance Code §1467.006 and SB 1264, 86th Legislature, Regular Session (2019).

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 proposes the repeal of §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.

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

CROSS-REFERENCE TO STATUTE. The repeal of 28 TAC §21.5031 implements Insurance Code §1467.151 and SB 1264, 86th Legislature, Regular Session (2019).

TEXT.

§21.5031. Department Outreach.

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

Issued in Austin, Texas, on September 16, 2019.

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