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INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§21.4902, 21.5002, 21.5003, 21.5010, and 21.5040, concerning out-of-network provider disclosures and the claim dispute resolution process, and §21.5070 and §21.5071, concerning data submission and payment requirements for emergency medical services. The amendments are adopted without changes to the proposed text published in the October 3, 2025, issue of the *Texas Register* (50 TexReg 6461).

REASONED JUSTIFICATION. Amendments to §§21.4902, 21.5002, 21.5003, and 21.5040 are necessary to implement Senate Bill 1409, 89th Legislature, 2025, which authorizes postsecondary educational institutions to offer health benefit plans under Insurance Code Chapter 1683. SB 1409 also amends Insurance Code Chapter 1275 to make higher education health benefit plans subject to state balance billing protections and

independent dispute resolution processes. Insurance Code Chapter 1275 establishes balance billing protections for plans that are otherwise not subject to state regulation. The protections in Insurance Code Chapter 1275 closely align with the requirements for out-of-network billing that were originally established by Senate Bill 1264, 86th Legislature, 2019, for health maintenance organizations and preferred provider benefit plans, and health benefit plans administered by the Employees Retirement System of Texas and Teacher Retirement System of Texas.

The amendments to §§21.4902, 21.5002, and 21.5003 add health benefit plans offered under Insurance Code Chapter 1683 to the definition and scope sections to clarify that these plans are subject to the rules found in 28 TAC Chapter 21, Subchapters OO and PP. Insurance Code §1275.004 makes Insurance Code Chapter 1467 applicable to health benefit plans identified in Insurance Code Chapter 1275.

In addition, amendments to §21.5040 require health benefit plans offered by postsecondary educational institutions to include additional information in the explanation of benefits (EOB) provided to physicians and providers. Specifically, the EOB must include an instruction that is substantially similar to the following language: "The request for mediation or arbitration must identify the plan type as 'Higher Ed Plan.'" This addition is consistent with the treatment of other plan types under Insurance Code §1275.002 and should assist in identifying and processing eligible mediation and arbitration requests through the Texas IDR process.

Amendments to §21.5010 are necessary to implement Senate Bill 2544, 89th Legislature, 2025, which creates a statutory deadline for an out-of-network provider or health benefit plan issuer or administrator to request mandatory mediation under Insurance Code Chapter 1467, Subchapter B. The amendment to §21.5010 adds new

subsection (d) to clarify that mediation under Subchapter PP, Division 2, must be requested by the out-of-network provider or health benefit plan issuer or administrator not later than 180 days after the date the initial payment is received. The amended language in new subsection (d) is consistent with the treatment of arbitration claims under §21.5020(d), except that the mediation deadline is 180 days.

Amendments to §21.5070 and §21.5071 are necessary to implement Senate Bill 916, 89th Legislature, 2025, which authorizes political subdivisions to annually adjust rates submitted to TDI under Insurance Code §38.006, subject to certain statutory limits. A political subdivision may not adjust a rate submitted to TDI under Insurance Code §38.006 by more than the lesser of (1) the Medicare Ambulance Inflation Factor or (2) 10% of the provider's previous calendar year rates.

Political subdivisions first submitted rates under Insurance Code §38.006 for calendar year 2024 to implement Senate Bill 2476, 88th Legislature, 2023, which expired on September 1, 2025. While SB 2476 included a method for plan payment rates to increase when plans renewed, it did not give political subdivisions an opportunity to submit rates for calendar year 2025. Since SB 916 is effective for emergency medical services provided on or after September 1, 2025, TDI announced a new reporting opportunity in Commissioner's Bulletin #B-0011-25 to allow political subdivisions to submit adjusted rates between August 1 and September 1, 2025. If a political subdivision did not submit a rate adjustment during this reporting window, the previously reported rates continue to apply to claims made between September 1, 2025, and December 31, 2025. On September 15, 2025, TDI published new rate data submitted by the September 1, 2025, deadline.

For calendar year 2026, the data submission deadline will be 30 days after the date this adoption order becomes effective. TDI will issue a message through the GovDelivery system that will announce when political subdivisions and their designees may begin submitting 2026 rate data. Sign up to receive messages through the GovDelivery system here: public.govdelivery.com/accounts/TXINSUR/subscriber/new?topic_id=TXINSUR_3.

For subsequent years, the data submission deadline will be December 1 of the year prior to the calendar year for the data being reported. For example, a political subdivision that elects to submit a rate adjustment must submit data applicable for calendar year 2027 by December 1, 2026. TDI will publish data within 10 business days of the data submission deadline, according to §21.5070(e). Issuers must apply the published rate for the calendar year during which the service or transport was provided or, if rate data was not adjusted for that year, the most recent available rate.

TDI intends to continue to publish previously submitted data in the four emergency services billing rates datasets on the Texas Open Data Portal at data.texas.gov. Information in these datasets include code rates, National Provider Identifier Standard numbers, ZIP codes, and contact lists. For more information about rate data submission, including frequently asked questions and links to other resources, visit www.tdi.texas.gov/health/esbindex.html.

Consistent with SB 916, a political subdivision may annually adjust a rate by not more than the lesser of the Medicare Ambulance Inflation Factor or 10% of the provider's previous calendar rates. For 2025, the Medicare Ambulance Inflation Factor is 2.4%, so an adjusted rate that was submitted by a political subdivision for 2025 could not be more than 2.4% higher than the rate submitted for 2024 for the same service. TDI audited data submitted between August 1 and September 1, 2025, for compliance and referred

noncompliant rates to the Texas Department of State Health Services for further action as authorized under Health and Safety Code §773.061(a-1). TDI will continue to review compliance and take necessary actions under SB 916.

Descriptions of the sections' amendments follow.

Section 21.4902. This section provides definitions for use in Subchapter OO. The amendments to §21.4902 expand the definition of an "administrator" to include an administrator of a health benefit plan offered by a postsecondary educational institution under new Insurance Code Chapter 1683, as added by SB 1409. The amendments also expand the definition of "health benefit plan" to include a plan offered by a postsecondary educational institution under Insurance Code Chapter 1683.

Section 21.5002. This section describes the scope of Subchapter PP. The amendments to §21.5002 expand the applicability of Subchapter PP to a qualified mediation or qualified arbitration claim filed under health benefit plan coverage administered by an administrator of a health benefit plan under new Insurance Code Chapter 1683. The amendments add a citation to Insurance Code Chapter 1683 in subsections (a) and (c) of §21.5002 to reflect this expanded applicability.

Section 21.5003. This section provides definitions for use in Subchapter PP. The amendments to §21.5003 expand the definition of an "administrator" to include an administrator of a health benefit plan offered by a postsecondary educational institution under new Insurance Code Chapter 1683. The amendments also expand the definition of

"health benefit plan" to include a plan offered by a postsecondary educational institution under Insurance Code Chapter 1683.

Section 21.5010. The amendment to §21.5010 adds new subsection (d) to narrow the availability of mediation for eligible claim disputes that occur on or after June 20, 2025, consistent with SB 2544. Specifically, new subsection (d) requires the out-of-network provider or health benefit plan issuer or administrator to request mediation under the section not later than 180 days after the date the initial payment is received. The amendment also clarifies that the initial payment made to the out-of-network provider could be zero dollars if the allowable amount was applied to an enrollee's deductible, which is consistent with how arbitration claims are treated in 28 TAC §21.5020(d).

Section 21.5040. This section provides the content required in an EOB provided to an enrollee, physician, or provider. The amendment to §21.5040 adds new subsection (b)(3) to address the specific requirements for EOBs provided by a health benefit plan offered by a postsecondary educational institution under Insurance Code Chapter 1683. New subsection (b)(3) requires the health benefit plan to include in the EOB to the physician or provider an instruction to identify the plan type as "Higher Ed Plan" when requesting mediation or arbitration.

Section 21.5070. This section provides the requirements for political subdivisions or their designees to submit emergency medical service rates to TDI for publication under Insurance Code §38.006. The amendments to §21.5070 specify the deadlines for submission of a rate based on the calendar year the rates apply to. For calendar year 2026,

the deadline for a political subdivision to submit new or adjusted rates is 30 days after the date §21.5070 becomes effective. The deadline for political subdivisions to submit new or adjusted rates to be used in the following calendar year is December 1 of the current year.

New subsection (g) limits the amount that a political subdivision or its designee may adjust a rate submitted under Insurance Code §38.006 compared with its rate for the previous calendar year. Consistent with SB 916, new subsection (g) states a political subdivision may annually adjust a rate by not more than the lesser of the Medicare Ambulance Inflation Factor or 10% of the provider's previous calendar year rates. For 2026 rates, the Medicare Ambulance Inflation Factor is 2%.

Section 21.5071. This section outlines the requirements that certain health benefit plan issuers or administrators must meet when making payments to emergency medical services providers. The amendments clarify that the health benefit plan issuer or administrator must pay the lesser of the billed charge or the EMS rate published by TDI in the EMS provider rate database for the calendar year that the service or transport was provided. The adopted section specifies that if a new or adjusted rate was not submitted and published in the EMS provider rate database for the calendar year in which the service or transport was provided, the health benefit plan issuer or administrator must use the most recently submitted rate published in the EMS provider rate database established by TDI.

The adoption order also deletes former subsections (c) - (e), concerning payments by issuers and administrators, and Figure: 28 TAC §21.5071(e), which provided examples illustrating how a health benefit plan should apply published rates to a plan year under subsection (d). Subsections (c) - (e) and Figure: 28 TAC §21.5071(e) are no longer

necessary because SB 916 removes the requirement that health benefit plans recalculate previously submitted rates and authorizes political subdivisions to submit adjusted rates annually.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on November 3, 2025, and at a public rule hearing held on October 21, 2025.

Commenters: TDI received comments from four commenters. One commenter spoke at the public hearing. The three others submitted written comments. Commenters in support of the proposal were Texas Association of Health Plans and Texas EMS Alliance. Commenters in support of the proposal with changes were Texas College of Emergency Physicians and Texas Medical Association.

General Comments

Comment. One commenter thanks TDI for the proposed rules and recommends adoption.

Agency Response. TDI appreciates the commenter's support.

Comment. One commenter encourages TDI to proactively audit the rate data submitted to ensure compliance with the statutory limits on annual rate increases.

Agency Response. TDI agrees and has added a column containing a validation rate to the "Emergency Services Billing Rates - Code Rates" Open Data Portal dataset for each billing code for which a political subdivision submitted rates for the years of 2024 and 2025. The validation rate is calculated by multiplying the 2024 rate by 1.024, consistent

with the Medicare Ambulance Inflation Factor of 2.4% for 2025. A rate for 2025 is marked as "Noncompliant" if it exceeds the validation rate. A rate for 2025 is marked as "N/A" in the "Compliance" column if no 2025 rate was submitted.

Comment. One commenter suggests that TDI establish a method to monitor which group numbers qualify for the Texas IDR process and notify providers of qualifying group numbers.

Agency Response. TDI already encourages health plans subject to Insurance Code Chapter 1467 to voluntarily submit group numbers that are not eligible for the Texas IDR process. This information is used in the Texas IDR portal to validate requests submitted in real time, which gives providers immediate feedback on requests that are ineligible and lessens the amount of time health plans use to manually identify ineligible requests. TDI also notes that Senate Bill 1236, 89th Legislature, 2025, requires health plans to use group numbers on identification cards for pharmacy benefits that differ based on whether the plan is subject to Insurance Code provisions. As health plans develop new processes to comply with SB 1236, TDI encourages the plans to consider how these processes may be leveraged to improve efficiency in validating IDR requests. TDI welcomes additional information provided by health plans regarding methods TDI could consider to validate IDR requests and make the Texas IDR portal more efficient. TDI declines to publish group number information, as it is provided on a voluntary basis and already used to validate IDR requests.

Comment. One commenter asks that TDI add a new section that requires TDI to establish and maintain a website that displays a list of health benefit plans subject to the Texas IDR

process under Insurance Code Chapter 1275, including information about the plan year and the plans' registered agents. Another commenter suggests creating a website with similar information as a supplement to the information included on EOB notifications.

Agency Response. TDI agrees that this information may be of use to the public but declines to make a change to the rule text, as the requested action is outside the scope of the rule as proposed. TDI has existing webpages that explain which plans are eligible for the Texas IDR process and how to identify eligible plans based on ID cards. TDI also has a webpage that lists ERISA plans that have opted in to the Texas IDR process under Insurance Code Chapter 1275. Once self-funded student health plans begin registering with TDI, as is required under Insurance Code §1683.005, TDI will consider listing the plans on a webpage similar to the opt-in ERISA plans webpage.

Comments on §21.5040

Comment. Two commenters note that most claims are submitted and returned electronically in the form of an electronic remittance advice (ERA) file. However, certain payors may opt to provide the EOB in a hardcopy format or in a non-machine-readable PDF format, which creates administrative burdens to determine if the claim is eligible for the state or federal IDR process. One commenter recommends that plan identification or IDR eligibility information be included in ERA files, in lieu of or in addition to hardcopy EOBs. Another commenter recommends adding rule text to §21.5040 that would require health plans subject to Insurance Code Chapter 1275 to return EOBs in a searchable, standardized remark code.

Agency Response. TDI declines to make a change at this time, as the requested action is outside the scope of this rulemaking. As noted in TDI's 2023 rule adoption, TDI has

monitored this issue but has not received complaints about payors providing this information using methods that are not standardized and searchable. TDI will continue monitoring the issue and encourages providers and facilities subject to Insurance Code Chapter 1467 to file complaints if payors are not meeting expectations for electronic claims processing.

Subchapter OO. Disclosures by Out-of-Network Providers
28 TAC §21.4902

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.4902 under Insurance Code §§1275.004, 1467.003, and 36.001.

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

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

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

TEXT.

§21.4902. Definitions.

Words and terms defined in Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, have the same meaning when used in this subchapter unless the context clearly indicates otherwise, and the following words and terms have the following meanings when used in this subchapter unless the context clearly indicates otherwise.

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations; an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans; and an administrator of a postsecondary educational institution under Chapter 1683, concerning Health Benefits Provided by Certain Postsecondary Educational Institutions, offering a health benefit plan.

(2) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

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

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

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

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; 1682; or 1683; or

(D) a self-insured or self-funded plan established by an employer under ERISA (29 USC §1001 et seq.) for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 1. General Provisions
28 TAC §21.5002 and §21.5003

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5002 and §21.5003 under Insurance Code §§1275.004, 1467.003, and 36.001.

Insurance Code §1275.004 provides that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

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

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

TEXT.

§21.5002. Scope.

(a) This subchapter applies to a qualified mediation claim or qualified arbitration claim filed under health benefit plan coverage:

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

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations; or 1683, concerning Health Benefits Provided by Certain Postsecondary Educational Institutions;

(3) offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations; or

(4) offered by a self-insured or self-funded plan established by an employer under ERISA if the plan sponsor submitted election according to §21.5060 of this title (relating to Election Submission Requirements).

(b) This subchapter does not apply to a claim for health benefits that is not a covered claim under the terms of the health benefit plan coverage.

(c) Except as provided in §21.5050 of this title (relating to Submission of Information), this subchapter applies to a claim for emergency care or health care or medical services or supplies, provided on or after January 1, 2020. A claim for health care or medical services or supplies provided before January 1, 2020, is governed by the rules

in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose. This subchapter applies to a claim filed for emergency care or health care or medical services or supplies by the administrator of a health benefit plan under Insurance Code Chapters 1682 and 1683.

§21.5003. Definitions.

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

(1) Administrator--Has the meaning assigned by Insurance Code §1467.001, concerning Definitions. The term also includes an administrator of a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations; an administrator of a self-insured or self-funded ERISA plan under Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans; and an administrator of a postsecondary educational institution under Chapter 1683, concerning Health Benefits Provided by Certain Postsecondary Educational Institutions, offering a health benefit plan.

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

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

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

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

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

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

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

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

(8) ERISA--The Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

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

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

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

(A) a health benefit plan offered by an HMO operating under Insurance Code Chapter 843, concerning Health Maintenance Organizations;

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

(C) a plan, other than an HMO plan, under Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public

School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; 1682; or 1683; or

(D) a self-insured or self-funded plan established by an employer under ERISA for which the plan sponsor has elected to apply Insurance Code Chapter 1275 to the plan for the relevant plan year.

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

(13) 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.

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

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

(16) 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.

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

(18) 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

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5010 under Insurance Code §§1467.003, 1467.0505, and 36.001.

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

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

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

TEXT.

§21.5010. Qualified Mediation Claim Criteria.

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

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

(A) emergency care;

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

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

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

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

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

(d) Availability. With respect to a dispute that occurs on or after June 20, 2025, the out-of-network provider or the health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim not later than the 180th day after the date an out-of-network provider receives the initial payment for a health care or medical service or supply. The initial payment could be zero dollars if the allowable amount was applied to an enrollee's deductible.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 5. Explanation of Benefits
28 TAC §21.5040

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5040 under Insurance Code §§1275.004, 1467.003, and 36.001.

Insurance Code §1275.004 provides that Insurance Code Chapter 1467 applies to a health benefit plan to which Insurance Code Chapter 1275 applies, and the administrator of a health benefit plan to which Insurance Code Chapter 1275 applies is an administrator for purposes of Insurance Code Chapter 1467.

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

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

TEXT.

§21.5040. Required Explanation of Benefits and Enrollee Identification Card Information.

(a) General requirements for explanation of benefits. A health benefit plan issuer or administrator subject to Insurance Code §1271.008, concerning Balance Billing Prohibition Notice; §1275.003, concerning Balance Billing Prohibition Notice; §1301.010, concerning Balance Billing Prohibition Notice; §1551.015, concerning Balance Billing Prohibition Notice; §1575.009, concerning Balance Billing Prohibition Notice; or §1579.009, concerning Balance Billing Prohibition Notice, must provide written notice in accordance with this section in an explanation of benefits in connection with a health care or medical service or supply or transport 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 in-network copayments, coinsurance, deductibles, and other amounts included in that total; and

(2) to the physician or provider, for a claim that is subject to mediation or arbitration under Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution, 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}."

(b) Specific requirements for explanation of benefits provided by health benefit plans subject to Insurance Code Chapter 1275. In addition to the requirements in subsection (a) of this section, the following requirements apply.

(1) For a health benefit plan offered by a nonprofit agricultural organization under Insurance Code Chapter 1682, concerning Health Benefits Provided by Certain Nonprofit Agricultural Organizations, the notice to a physician or provider for a claim must also include an instruction that is substantially similar to the following: "The request for mediation or arbitration must identify the plan type as 'Ag Plan.'"

(2) For a self-insured or self-funded plan under ERISA where the plan sponsor has elected to apply Insurance Code Chapter 1275, concerning Balance Billing Prohibitions and Out-Of-Network Claim Dispute Resolution for Certain Plans, to the plan for the relevant plan year, the notice to a physician or provider for a claim must also

include a statement that is substantially similar to the following: "The plan sponsor has opted in to the Texas Independent Dispute Resolution Process under Insurance Code Chapter 1275 for this plan year. A dispute related to this claim must proceed through the Texas process and may not proceed through the Federal No Surprises Act Independent Dispute Resolution Process. The request for mediation or arbitration must identify the plan type as 'ERISA Opt-In.'"

(3) For a health benefit plan offered by a postsecondary educational institution under Insurance Code Chapter 1683, concerning Health Benefits Provided by Certain Postsecondary Educational Institutions, the notice to a physician or provider for a claim must also include an instruction that is substantially similar to the following: "The request for mediation or arbitration must identify the plan type as 'Higher Ed Plan.'"

(c) Requirements for ID cards issued to enrollees of health benefit plans subject to Insurance Code Chapter 1275. For a plan that is delivered, issued for delivery, or renewed on or after 90 days following the effective date of this section, a health benefit plan issuer or administrator that is subject to Insurance Code §1275.003 must include the letters "TXI" on the front of the ID card issued to enrollees.

Subchapter PP. Out-of-Network Claim Dispute Resolution
Division 8. Emergency Medical Service Rate Submission and Payment Requirements
28 TAC §21.5070 and §21.5071

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5070 and §21.5071 under Insurance Code §§38.006, 1301.007, and 36.001.

Insurance Code §38.006 authorizes the commissioner to prescribe the form and manner by which political subdivisions may submit rates for ground ambulance services.

Insurance Code §1301.007 directs the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

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

TEXT.

§21.5070. Rate Database for Emergency Medical Services Providers.

(a) Consistent with Insurance Code §38.006, concerning Emergency Medical Services Provider Balance Billing Rate Database, this section applies to:

(1) a political subdivision that sets, controls, or regulates a rate charged for a health care service, supply, or transport provided by an emergency medical services (EMS) provider, other than an air ambulance; and

(2) an EMS provider or its designee that provides a health care service, supply, or transport on behalf of a political subdivision that sets, controls, or regulates a rate.

(b) A political subdivision or EMS provider subject to this section may not issue a bill for a health care service, supply, or transport that exceeds the amount of the rate set, controlled, or regulated by the political subdivision.

(c) A political subdivision that chooses to submit data to the Texas Department of Insurance (TDI) under this section must submit data using the data submission method available at www.tdi.texas.gov and must include at a minimum:

(1) the political subdivision's name and contact information;

(2) if known, the National Provider Identification (NPI) number of each EMS provider that provides a health care service, supply, or transport that is subject to rates set, controlled, or regulated by the political subdivision;

(3) each ZIP code that is subject to the rates set, controlled, or regulated by the political subdivision; and

(4) the applicable billing code, code type, and dollar amount for each health care service, supply, or transport rate that is set, controlled, or regulated by the political subdivision.

(d) The data submission deadline for a political subdivision that chooses to submit data for calendar year 2026 is 30 days after the date this section becomes effective. For all other data submissions under this section, the data submission deadline is December 1.

(e) TDI will publish data reported by a political subdivision no later than 10 business days after the data reporting deadline specified in subsection (d) of this section.

(f) A claim submitted by an EMS provider or its designee for a health care service, supply, or transport provided on behalf of a political subdivision must include the ZIP code in which the health care service, supply, or transport originated.

(g) For a rate submitted with respect to emergency medical services provided on or after September 1, 2025, the difference between the provider's rate for the previous calendar year and the adjusted rate may not exceed the lesser of:

(1) the Medicare Ambulance Inflation Factor; or

(2) 10%.

§21.5071. Payments to Emergency Medical Services Providers.

(a) This section applies to a health benefit plan issuer or administrator that is subject to one of the following statutes:

(1) Insurance Code §1271.159, concerning Non-Network Emergency Medical Services Provider;

(2) Insurance Code §1275.054, concerning Out-of-Network Emergency Medical Services Provider Payments;

(3) Insurance Code §1301.166, concerning Out-of-Network Emergency Medical Services Provider;

(4) Insurance Code §1551.231, concerning Out-of-Network Emergency Medical Services Provider Payments;

(5) Insurance Code §1575.174, concerning Out-of-Network Emergency Medical Services Provider Payments; or

(6) Insurance Code §1579.112, concerning Out-of-Network Emergency Medical Services Provider Payments.

(b) For a covered health care or medical service, supply, or transport that is provided to an enrollee by an out-of-network emergency medical services (EMS) provider, a health benefit plan issuer or administrator must pay:

(1) for a service or transport that originated in a political subdivision that sets, controls, or regulates the rate, the lesser of the billed charge or the applicable rate for that political subdivision that is published in the EMS provider rate database

established by the department for the calendar year during which the service or transport was provided or the most recent rate data submitted; or

(2) if there is not a rate published in the EMS provider rate database for the political subdivision in which the service or transport originated, the lesser of:

(A) the provider's billed charge; or

(B) 325% of the current Medicare rate, including any applicable extenders or modifiers.

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 30, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§21.4902, 21.5002, 21.5003, 21.5010, 21.5040, 21.5070, and §21.5071 are adopted.

Signed by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2026-9776