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INTRODUCTION. The Texas Department of Insurance (TDI) proposes 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. Amendments to §§21.4902, 21.5002, 21.5003, and 21.5040 implement Senate Bill 1409, 89th Legislature, 2025. Amendments to §21.5010 implement Senate Bill 2544, 89th Legislature, 2025. Amendments to §21.5070 and §21.5071 implement Senate Bill 916, 89th Legislature, 2025.

EXPLANATION. The amendments to §§21.4902, 21.5002, 21.5003, and 21.5040 are necessary to implement SB 1409, 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 proposed 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 SB 2544, 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 proposed 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 proposed 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 SB 916, 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 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 between August 1 and September 1, 2025, to allow political subdivisions to submit adjusted rates. If a political subdivision does not submit a rate adjustment, the rates previously reported will continue to apply. TDI will publish new rate data within 10 days following the September 1, 2025, submission deadline. TDI recognizes the challenges of quickly implementing the published rates but seeks to comply with the statutory deadlines in SB 1409.

Going forward, TDI will provide an annual opportunity for political subdivisions to adjust previously submitted rates. For calendar year 2026, the proposed data submission

deadline will be 30 days after the date this rule becomes effective. For subsequent years, the data submission deadline will be December 1 of the year prior to the calendar year for which the data is being reported. For example, a political subdivision that elects to submit a rate adjustment must submit rates applicable for calendar year 2027 by December 1, 2026. TDI will continue to publish data within 10 days of the data submission deadline. Issuers must apply the published rate for the applicable calendar year during which the service or transport was provided or, if rate data is not adjusted for the current year, the most recent available rate.

TDI intends to continue to publish previously submitted data in the four Emergency Services Billing Rates datasets available 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 is submitted by a political subdivision for 2025 may not be more than 2.4% higher than the rate submitted for 2024 for the same service. TDI may audit the data to ensure compliance and will refer rates that violate the statutory limits to the Texas Department of State Health Services for further action as authorized under Health and Safety Code §773.061(a-1), as added by SB 916.

Descriptions of the sections' proposed 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 §21.5002(c) 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 proposed 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, proposed 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 §21.5020(d).

Section 21.5040. This section provides the content required in an explanation of benefits (EOB) provided to an enrollee, physician, and 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. Proposed 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 for which the rates apply. For calendar year 2026, the proposed deadline for a political subdivision to submit new or adjusted rates is 30 days after the date §21.5070 becomes effective. The deadline for new or adjusted rates to be filed with TDI for use in a subsequent calendar year is December 1.

Proposed new subsection (g) limits the amount that a political subdivision or their designee may adjust a rate submitted under Insurance Code §38.006 compared to the provider's 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.

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 during which the service or transport was provided. The proposed rule 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 proposal also deletes subsections (c) - (e), concerning payments by issuers and administrators, and Figure: 28 TAC §21.5071(e), which provides examples illustrating how a health benefit plan should apply published rates to a plan year under subsection (d). Subsections (c) - (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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of the Regulatory Initiatives Office, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments, other than that imposed by statute. Ms. Bowden made this determination 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. The rule applies to political subdivisions that choose to submit rates to TDI, but political subdivisions are not required to participate. Any

measurable fiscal impact on a political subdivision that voluntarily submits rates to TDI are a result of those requirements imposed by statute when and if a political subdivision chooses to submit rates. Likewise, the rule applies to a postsecondary educational institution, but only if it voluntarily chooses to offer higher education health benefits.

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

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Bowden expects that administering the proposed amendments will have the public benefit of ensuring that TDI's rules conform to Insurance Code Chapters 1275, 1467, and 1683, and §§38.006, 1271.008, 1271.159, 1275.003, 1275.054, 1301.010, 1301.166, 1551.015, 1551.231, 1575.009, 1575.174, 1579.009, and 1579.112.

Ms. Bowden expects that the proposed amendments that implement SB 916 will not increase the cost of compliance with Insurance Code §§38.006, 1271.008, 1271.159, 1275.003, 1275.054, 1301.010, 1301.166, 1551.015, 1551.231, 1575.009, 1575.174, 1579.009, and 1579.112 because the amendments do not impose requirements beyond those in statute. Political subdivisions are authorized, but are not required, to annually adjust an EMS rate submitted to TDI under Insurance Code §38.006. Health benefit plan issuers and administrators are required by statute to cover certain EMS-related claims according to SB 916. As a result, the cost associated with submitting new or adjusted rates or payment of EMS claims does not result from enforcement or administration of the amended sections.

Ms. Bowden expects that the proposed amendments that implement SB 1409 will not increase the cost of compliance with Insurance Code Chapter 1275 because it does not impose requirements beyond those in the statute. Insurance Code §1275.002 states

that a health benefit plan offered by a postsecondary educational institute is subject to the requirements in Insurance Code Chapter 1275, including the requirement in Insurance Code §1275.004. Insurance Code §1275.004 requires a health benefit plan or administrator subject to Insurance Code Chapter 1275 to comply with the requirements in Insurance Code Chapter 1467. As a result, the cost associated with complying with the requirement to use the Texas Independent Dispute Resolution system does not result from the enforcement or administration of the proposed amendments.

Ms. Bowden expects that the proposed amendments that implement SB 2544 will not increase the cost of compliance with Insurance Code Chapter 1467, Subchapter B, because it does not impose requirements beyond those in statute. Insurance Code §1467.054 creates a 180-day deadline for an out-of-network provider or health benefit plan issuer or administrator to request mandatory mediation after the date an initial payment is received for a claim. As a result, the cost associated with meeting the 180-day deadline does not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. However, even if the proposal did impose a cost on regulated persons, Insurance Code §1467.003(b) exempts a rule adopted under Insurance Code Chapter 1467 from Government Code §2001.0045, and the proposed amendments are necessary to implement legislation. The proposed amendments implement Insurance Code Chapter 1683 and §§38.006, 1271.008, 1271.159, 1275.002, 1275.003, 1275.054, 1301.010, 1301.166, 1467.054, 1551.015, 1551.231, 1575.009, 1575.174, 1579.009, and 1579.112 as added or amended by SBs 916, 1409, and 2544.

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

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will not create a new regulation;
- will 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. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by no later than 5:00 p.m., central time, on November 3, 2025. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2855 at 2:00 p.m., central time, on October 21, 2025, in Room 2.035 of the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701.

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

STATUTORY AUTHORITY. TDI proposes amendments to §21.4902 under Insurance Code §§1275.004, 1467.003, and 36.001.

Insurance Code §1275.004 states that Insurance Code Chapter 1467 applies to a health benefit plan to which 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 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

CROSS-REFERENCE TO STATUTE. Section 21.4902 implements Insurance Code §§1275.002, 1275.003, and 1275.004, and SB 1409.

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;[~~, and~~] 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; [~~or~~] 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. TDI proposes amendments to §21.5002 and §21.5003 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 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

CROSS-REFERENCE TO STATUTE. Sections 21.5002 and 21.5003 implement Insurance Code §1275.002 and SB 1409.

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; [~~or~~] 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 [~~Chapter~~] 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;[~~, and~~] 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; [~~or~~] 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. TDI proposes amendments to §21.5010 under Insurance Code §§1467.003, 1467.0505, and 36.001.

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

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

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

CROSS-REFERENCE TO STATUTE. The proposed amendments to §21.5010 implement Insurance Code §1467.054 and SB 2544.

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. TDI proposes amendments to §21.5040 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 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Insurance Code Chapter 1467.

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

CROSS-REFERENCE TO STATUTE. Section 21.5040 implements Insurance Code §1275.003 and SB 1409.

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 [~~the following~~] 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. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 21.5070 and §21.5071 implement Insurance Code §§38.006, 1271.159, 1275.054, 1301.166, 1551.231, 1575.174, and 1579.112, and SB 916.

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 [~~and adjusted as required in subsection (d) of this section~~]; 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.

[~~(c) For claims incurred during a plan year that starts before September 1, 2024, for a claim for emergency medical services that is provided on or after January 1, 2024, and before September 1, 2025, a health benefit plan issuer or administrator that must make a payment consistent with subsection (b)(1) of this section must use the rate data published in the department's EMS provider rate database for calendar year 2024.~~]

[~~(d) For claims incurred during a plan year that starts on or after September 1, 2024, a health benefit plan issuer or administrator that must make a payment consistent with subsection (b)(1) of this section must pay the lesser of:~~]

[~~(1) the billed charge;~~]

[~~(2) the rate published in the department's EMS provider rate database for calendar year 2024 increased by 10%; or~~]

[~~(3) the rate published in the department's EMS provider rate database for calendar year 2024 increased by the Medicare Economic Index rate that applies to the first day of the new plan year.~~]

[~~(e) Figure: 28 TAC §21.5071(e) provides examples illustrating how a health benefit plan should apply published rates to a plan year under subsection (d) of this section.~~]

[~~Figure: 28 TAC §21.5071(e)~~]

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

Issued in Austin, Texas, on September 19, 2025.

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