Subchapter TT. All-Payor Claims Database
28 TAC §21.5401 and §§21.5403 - 21.5406

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §21.5401 and §§21.5403 - 21.5406, concerning the all-payor claims database. The amendments to the rule text are adopted with changes to the proposed text published in the August 16, 2024, issue of the *Texas Register* (49 TexReg 6158). The commissioner adopts §§21.5401, 21.5404, and 21.5406 without changes to the proposed text. The commissioner adopts §21.5403 and §21.5405 with nonsubstantive changes to the proposed text. Changes have also been made to the Texas APCD CDL version 3.0.1, referenced in §21.5403.

REASONED JUSTIFICATION. The amendments make changes in accordance with House Bill 3414, 88th Legislature, 2023, which made amendments to Insurance Code Chapter 38, including revisions to the definition of "payor" in Insurance Code §38.402, the membership of the stakeholder advisory group in §38.403, and permissible data collection in Insurance Code §38.404. A nonsubstantive amendment to §21.5401 is made to conform with House Bill 4611, 88th Legislature, 2023, which changed the location of statutes concerning Medicaid managed care programs in the Government Code. Other amendments are made in accordance with House Bill 2090, 87th Legislature, 2021. The amendments include a new version of the Texas APCD Common Data Layout (CDL) to conform with changes to the national CDL and other changes to support the purpose and mission of the APCD.

The CDL is a technical and natural language description of the file format that payors are required to use to submit data to the APCD. The CDL details the data structure

and organization necessary for successful file submissions. Clear technical instructions--including definitions of data fields, required headers, and descriptions--in the CDL are necessary to ensure the integrity and validity of the APCD data. Periodic updates to the technical instructions ensure the CDL's long-term usability and relevance by allowing clarifications that improve payor understanding of the CDL requirements and accommodating technological improvements or changes in claim standards.

In addition, the amendments enhance clarity, streamline the sections, and make the text consistent with current agency drafting style and plain language preferences. These nonsubstantive changes include adding rule cross-references; deleting unnecessary statutory citations; and otherwise improving wording, such as by replacing "such" with "this" and "said" with "the." These amendments are not noted in the following descriptions of the amendments unless it is necessary or appropriate to provide additional context or explanation.

Descriptions of the sections' amendments follow.

Section 21.5401. The amendments to §21.5401 revise subsection (b) to clarify that the listing of payors required to submit data files is not exclusive but includes any payor subject to Insurance Code Chapter 38. Self-insurance funds established under Government Code Chapter 2259, concerning Self-Insurance by Governmental Units, are added to the listing to clarify applicability to those payors, and subsequent paragraphs are renumbered to reflect this addition. In paragraph (19), the citation to the Government Code for Medicaid managed care plans is changed to Title 4, Subtitle I, instead of Chapter 533, because of a change in the citation to these programs in Insurance Code §38.402(7) made in Section 2.117 of HB 4611.

Section 21.5403. An amendment to §21.5403(a) updates the CDL version that a payor is required to follow. The Texas APCD CDL has been updated to align with the national CDL. It identifies the types of data a payor is required to report by listing the standardized data elements for each data file identified in §21.5404(c) and identifying whether the data element is required. For each data element, it also identifies data quality standards and provides technical guidance describing the information payors must submit, including the source of the information and coding standards. In response to comments, CDL version 3.0.1 has been modified to change the reporting threshold for data elements CDLPV021 and CDLMC142 from 100% to 90%.

Amendments to subsection (b) permit the Center for Health Care Data at the University of Texas Health Science Center at Houston (Center) to adopt future versions of the Texas APCD CDL, as long as no additional data elements are required beyond those required in version 3.0.1 and no data elements are required that fall outside the scope of Insurance Code Chapter 38, Subchapter I. TDI modifies the first sentence in subsection (b) to avoid a double negative for clarity. This will streamline the Center's ability to update technical guidance and will reduce confusion by payors, clarifying that such guidance can be incorporated in the Texas APCD CDL, rather than in a separate document. It will also allow the Center to monitor changes taking place across the country to maximize uniformity with other states' APCDs, which is more cost-effective for the payors subject to reporting. Any addition of required data elements would occur only through TDI rulemaking. If the Center publishes an updated version of the Texas APCD CDL, it will communicate an implementation deadline and provide at least 90 days for payors to transition to the new version of the Texas APCD CDL.

Section 21.5404. An amendment to subsection (a)(1) updates the cross-reference to §21.5401 to conform with changes to numbering in that section. An amendment in subsection (b) clarifies that the requirement to register applies to payors or their designees that are subject to the subchapter where §21.5404 is located. An amendment removes paragraph (1) from subsection (d) to eliminate the option to use a USB drive because it is less efficient to administer, and no payors have chosen to use this option. Subsequent paragraphs are renumbered to reflect this change. The prohibition against using data with a unique coding system is eliminated from subsection (k) because it duplicates language in subsection (m).

Section 21.5405. The amendments to subsection (a) modify the monthly due date of payor reporting, reducing the time to submit the data from 90 days post-adjudication to 30 days. This change will provide more timely data to researchers and will allow the APCD to better and more timely support infectious disease monitoring efforts in coordination with the Texas Epidemic Public Health Institute. The updated submission timeframe will also allow the APCD, at the aggregate-geographic-region level, to support other state agency epidemiological monitoring of acute health conditions or events like pandemics or natural disasters.

Former subsection (b) is deleted because its provisions relating to the original commencement of APCD reporting are no longer necessary. A new subsection (b) is added to clarify the circumstances in which payors must submit test data files. TDI made a nonsubstantive change to subsection (b)(3) as proposed to replace "TX" with "Texas" when referencing the APCD CDL. This change is needed to be consistent with the term as defined in §21.5402(15).

Former subsections (c) and (e) are deleted, and their exception and extension provisions have been incorporated into former subsection (d), which is redesignated as subsection (c). The text of redesignated subsection (c) is also revised to allow payors to submit requests for exceptions and extensions 15 days in advance rather than 30 days, and to clarify that the deadline for data submissions is tolled while the Center considers a request for exception or extension. Redesignated subsection (c) authorizes payors to request temporary exceptions or extensions for up to 12 months if they demonstrate that compliance would impose an unreasonable cost or burden relative to the public value that would be gained from full compliance. To ensure APCD reporting is not a barrier to new payors entering the market, the subsection allows an extension for a payor's first required reporting if the payor registers with the Center and demonstrates it has fewer than 10,000 covered lives across all plans subject to reporting. This approach ensures that the Center can make reasonable accommodations to help payors comply with APCD reporting obligations. To assist with the oversight and enforcement required by Insurance Code §38.409(a)(3), redesignated subsection (c) is also amended to add an annual reporting requirement for the Center to share information with TDI about payor compliance, exceptions, and extensions.

Former subsections (f) and (g) are redesignated as subsections (d) and (e).

A new subsection (f) is added. It states that payors must provide reasonable follow-up information requested by the Center, limited to ensuring that the payor submitted complete and correct information.

Former subsections (h) and (i) are redesignated as subsections (g) and (h).

A new subsection (i) is added. It provides the starting date for the new data submission time frames found in subsection (a).

Section 21.5406. New subsection (d) is added, establishing a one-year term of office for the new advisory member representing an institution of higher education, as required by HB 3414. New subsection (e) is added, limiting terms of office to no more than six consecutive years, except as provided by current subsection (d), which is redesignated as subsection (f). An amendment to redesignated subsection (f) changes the required designation of a replacement member to serve the remainder of a term to a permissive designation.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on September 16, 2024.

Commenters: TDI received comments from three commenters. The Center commented in support of the proposal. Commenters in support of the proposal with changes, were the Texas Association of Health Plans and the Texas Medical Association. Consistent with Insurance Code §38.409(a), TDI has consulted with the Center regarding these comments.

Comments on §21.5401

Comment. A commenter supports the changes as they appropriately clarify the application of the law concerning certain health benefit plans and address changes made by HB 3414.

Agency Response. TDI appreciates the support.

Comments on §21.5403

Comment. A commenter strongly supports and urges the adoption of the rule changes. The commenter states that the changes will bring the Texas APCD CDL into better alignment with the standard CDL maintained by the APCD Council, which will facilitate future academic research allowing for robust comparisons between states and help multistate companies maintain compliance. The commenter further states that the changes will provide additional flexibility to correct citations and provide clarifying updates, which are crucial to the technical document. On the other hand, the commenter agrees that it is appropriate that, should new fields be added to the CDL, a rulemaking process should be pursued.

Agency Response. TDI appreciates the support.

Comment. A commenter believes the proposed language strikes an appropriate balance between flexibility and fair notice of substantive changes and notes that aligning with national standards typically reduces administrative burden. However, the commenter notes that plans have had difficulty meeting the 100% reporting threshold for one item in the CDL (CDLPV021), which requires reporting of the National Uniform Claim Committee Health Care Provider Taxonomy (specialty) code (which is included in a standard claim). The commenter requests that the threshold for reporting this field be 95%.

Agency Response. TDI agrees with the commenter. In addition, according to information provided to TDI by the Center, plans have had similar difficulties reporting field CDLMC142, which is for the referring provider specialty. The plans rely on providers to provide this information, and plans currently must seek an exception if they do not have

data in the field 100% of the time. Because the data is sometimes not provided to the plans, TDI, with the agreement of the Center, is changing the threshold for reporting these fields in the CDL from 100% to 90%. Plans must still report any data that they have for these fields but will not have to seek exceptions as often when they lack data. The Center believes that this change will not compromise data quality. TDI is revising Texas APCD CDL v3.0.1 to make changes to fields CDLPV021 and CDLMC142.

Comment. A commenter notes that the proposed rule authorizes the Center to adopt subsequent versions of the CDL despite the statutory requirement for TDI to adopt rules specifying the types of data required. The commenter states that the rule would authorize the Center to alter data elements and collect new data elements even if not specified in TDI rule without checks on the Center's authority, such as public comment or TDI review. The commenter adds that the Center could collect any information, including information on patients, physicians, and other health care providers, as long as a payor agreed. The commenter notes that decisions on the collection of health care data should be discussed in a public forum and in a manner that precludes even the potential appearance of impropriety. The commenter also states that the rule permits the Center to specify new technical requirements in the CDL, but the statute does not authorize the Center to unilaterally specify the manner or layout of data submissions, such as provisions that a payor uses to determine what data to provide. The commenter states that the rule should clearly differentiate between data collection procedure guidance and types of data and/or manner of providing data.

Agency Response. The proposed rule appropriately addresses the responsibilities the Legislature placed with TDI while leaving discretion to the Center on the matters the

Legislature left to it. TDI first notes that the statutes creating the APCD in Insurance Code Chapter 38 largely contemplate a supporting role by TDI to the Center. Section 38.404(a) begins with the requirement that TDI "collaborate with the center under this subchapter to aid in the center's establishment of the database." The section then focuses on what data the Center should and should not require to be submitted. Subsection (c) also focuses on the Center: "In determining the information a payor is required to submit to the center . . . , the center must consider . . . ." Subsection (c-1) then qualifies that "the center may not require a payor" to collect data that is not on a standard claim form, but "the center may require submission of such data if it is otherwise collected by the payor . . . ." Finally, subsection (d) states that each payor "shall submit the required data under Subsection (c) at the schedule and frequency determined by the center and adopted by the commissioner by rule." Then, in §38.409, the Legislature set out TDI's rulemaking authority, requiring TDI to adopt rules "specifying the types of data a payor is required to provide to the center under Section 38.404." This does not require TDI to specify all aspects concerning the specific data that must be provided, but only the "types" of data. TDI's rule proposal does this by adopting the CDL with the agreement of the Center and by leaving future updates and clarifications of the CDL to the Center, with the limitation that TDI is not requiring payors to provide any additional data elements in future iterations of the CDL adopted by the Center unless they fall within both TDI's adopted version referenced in §21.5403 and within the scope of Chapter 38, Subchapter I.

It is also notable that §38.409 only requires TDI to adopt rules that specify the type of data a payor is "required" to provide the Center. The subchapter does not address the ability of TDI or the Center to permit payors to provide additional information that is not

required, and it does not require TDI's rules to limit the types of data the APCD may collect from payors on a voluntary basis.

Aside from TDI's determination by rule of the categories of information that are required to be provided, the Center is given broad authority under the statute regarding the actual collection of the information. Section 38.403 provides that the stakeholder advisory group will assist the Center with "establishing and updating the standards, requirements, policies, and procedures relating to the collection" of the data. Section 38.404 requires that the Center "establish" and "update" its data collection procedures. While §38.409 does require TDI's rules to also address data submission schedules and provisions relating to "data submission," the Legislature clearly did not intend for every detail of data submission to be articulated by rule. TDI's rules provide an appropriate balance in TDI's support of the Center's mission.

Comments on §21.5405

Comment. A commenter states that they strongly support the proposed changes, which are extremely important updates that will permit the Texas APCD to better supplement Texas' wastewater monitoring program. The commenter also supports the continued ability of the Center to grant temporary exemptions and exceptions, which will enable the Center to work with carriers for the benefit of the public without impairing the affordability that may be offered by small plans. The commenter welcomes the elimination of submission by USB drive and secure courier, as no payors use those methods.

Agency Response. TDI appreciates the support.

Comment. A commenter supports the changes. While the commenter does not believe that it is necessary for the Center to report exceptions and extensions to TDI, the

commenter is not concerned about the information that will be provided and has heard positive feedback from health plans about the Center's administration of the extension and exception processes.

Agency Response. TDI appreciates the support.

Comment. A commenter states that TDI lacks authority to grant exceptions or extensions from any submission requirements and requests clarification on why there is an ongoing need for exceptions or extensions. The commenter also states that the rule would permit the Center to grant extensions allowing payors to provide data less frequently than quarterly, as required by §38.409(a)(2)(A) and that there is no authority to permit an extension of a payor's first required reporting for up to 12 months.

Agency Response. TDI disagrees with the commenter’s statement that TDI lacks statutory authority to grant exceptions and extensions. TDI notes that the Legislature granted TDI broad authority in Insurance Code §38.409 in 2021 to specify "the schedule, frequency, and manner in which a payor must provide data," while emphasizing that TDI's rules should be "reasonable and cost-effective for payors." While the Legislature amended the statutes in 2023 in HB 3414, it chose not to address rulemaking generally or any issues of exceptions and extensions.

Comment. A commenter objects to the rule allowing exceptions or extensions for payors of any size and notes that there is no description of what constitutes an unreasonable cost or burden relative to the public value or what factors would be considered. The commenter also says that the rule would authorize exceptions from any requirements not contained in the statute, but it is unclear whether the rule prevents the Center from granting exceptions for any requirement described by §38.404(c) or if it only prevents the

Center from granting an exception for any requirement actually listed in the nonexclusive list because §38.404(c) requires submission of useful information, so all the data requirements are contained in it. The commenter also notes that, if data is not collected, the public value of the APCD's data could be reduced.

Agency Response. TDI's rule proposal does not substantively change the ability of the Center to grant exceptions and extensions set forth in the existing APCD rules that were adopted by TDI in June of 2022. The rule, as adopted, permits the Center to grant an exception from a requirement, but the Center may not grant an exception to a requirement contained in Chapter 38, Subchapter I. The Center would not be able to grant an exception to reporting of the data elements listed in §38.404(c). While the Center could grant an extension to the reporting of any data if immediate compliance would impose an unreasonable cost or burden relative to the public value, the data would nevertheless have to be reported once the extension expires. This flexibility ensures that the data required by the Legislature is provided, while also complying with the statutory mandate to adopt rules that are reasonable and cost-effective for payors. For instance, it might be reasonable under this standard to grant a payor of any size an extension if its computer operations were impacted by a severe weather event.

Comment. A commenter objects to the 12-month extension available to small payors with fewer than 10,000 covered lives and suggests narrowing the threshold to payors with fewer than 1,000 lives. The commenter also asks TDI to clarify whether, if a payor has multiple plans and one is less than 10,000, then would the payor qualify entirely for an extension or just the one plan.

Agency Response. TDI's proposal does not change the Center's ability under the existing rule to grant a year's extension to a new payor with under 10,000 lives. TDI declines to narrow the threshold, as this extension continues to provide important flexibility for new payors. Smaller payors entering the market may need additional time to create the computer processes to properly submit the required data. The threshold for this extension looks at enrollment at the issuer level, such that enrollment in all plans subject to reporting are counted towards the 10,000 life threshold. The rule as adopted clarifies that a payor "that registers with the Center and demonstrates that it has fewer than 10,000 covered lives in plans subject to [the] subchapter qualifies for an extension." TDI notes that the most recent APCD biennial report (https://sph.uth.edu/research/centers/center-for-health-care-data/assets/tx-apcd/TX-APCD-Biennial%20Report-2022.pdf) from September 2022, prior to the APCD receiving any data, estimated that the APCD would receive data on almost 15 million individuals. In this context, granting a temporary extension for a plan with under 10,000 lives will not materially impact the quality of the APCD's data.

Subchapter TT. All-Payor Claims Database
28 TAC §21.5401 and §§21.5403 - 21.5406

STATUTORY AUTHORITY. The commissioner adopts amendments to §21.5401 and §§21.5403 - 21.5406 under Insurance Code §38.409 and §36.001.

Insurance Code §38.409 provides that the commissioner adopt rules specifying the types of data a payor is required to provide to the Center and also specifying the schedule, frequency, and manner in which a payor must provide data to the Center. It also requires

the commissioner to adopt rules establishing oversight and enforcement mechanisms to ensure the submission of data.

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.

§21.5401. Applicability.

(a) This subchapter applies to a payor that issues, sponsors, or administers a plan subject to reporting under subsection (b) of this section.

(b) Payors must submit data files as required by this subchapter with respect to health benefit plans or dental benefit plans issued in Texas that are subject to Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database, including:

(1) a health benefit plan as defined by Insurance Code §1501.002, concerning Definitions;

(2) an individual health care plan that is subject to Insurance Code §1271.004, concerning Individual Health Care Plan;

(3) an individual health insurance policy providing major medical expense coverage that is subject to Insurance Code Chapter 1201, concerning Accident and Health Insurance;

(4) a health benefit plan as defined by §21.2702 of this title (relating to Definitions);

(5) a student health plan that provides major medical coverage, consistent with the definition of student health insurance coverage in 45 CFR §147.145, concerning Student Health Insurance Coverage;

(6) short-term limited-duration insurance as defined by Insurance Code §1509.001, concerning Definition;

(7) individual or group dental insurance coverage that is subject to Insurance Code Chapter 1201 or Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance;

(8) dental coverage provided through a single service HMO that is subject to Chapter 11, Subchapter W, of this title (relating to Single Service HMOs);

(9) a Medicare supplement benefit plan under Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, if the payor elects to submit such data;

(10) a health benefit plan as defined by Insurance Code Chapter 846, concerning Multiple Employer Welfare Arrangements;

(11) basic coverage under Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act;

(12) a basic plan under Insurance Code Chapter 1575, concerning Texas Public School Employees Group Benefits Program;

(13) a health coverage plan under Insurance Code Chapter 1579, concerning Texas School Employees Uniform Group Health Coverage;

(14) basic coverage under Insurance Code Chapter 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System;

(15) a county employee health benefit plan established under Local Government Code Chapter 157, concerning Assistance, Benefits, and Working Conditions of County Officers and Employees;

(16) group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program;

(17) coverage for medical expenses provided under a self-insurance fund established under Government Code Chapter 2259, concerning Self-Insurance by Governmental Units;

(18) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program;

(19) a Medicaid managed care plan operated under Government Code Title 4, Subtitle I, concerning Health and Human Services;

(20) the child health plan program operated under Health and Safety Code Chapter 62, concerning Child Health Plan for Certain Low-Income Children;

(21) the health benefits plan for children operated under Health and Safety Code Chapter 63, concerning Health Benefits Plan for Certain Children;

(22) a Medicare Advantage Plan providing health benefits under Medicare Part C as defined in 42 USC §1395w-21, *et seq*., concerning Medicare+Choice Program;

(23) a Medicare Part D voluntary prescription drug benefit plan providing benefits as defined in 42 USC §1395w-101, *et seq*., concerning Voluntary Prescription Drug Benefit Program; and

(24) a health benefit plan or dental plan subject to the Employee Retirement Income Security Act of 1974 (29 USC §1001 *et seq*.) if the plan sponsor or administrator elects to submit this data.

(c) Data files required by this subchapter must include information with respect to all Texas resident members, as defined in §21.5402(16) of this title (relating to Definitions). Information on persons who are not Texas resident members is not required.

§21.5403. Texas APCD Common Data Layout and Submission Guide.

(a) Payors must submit complete and accurate data files for all applicable plans as required by this subchapter and consistent with the data elements and technical requirements found in the Texas APCD CDL v3.0.1. The Texas APCD CDL v3.0.1 is available on the Center's website.

(b) If the Center adopts subsequent versions of the Texas APCD CDL, payors must submit data consistent with the requirements of each subsequent version, but this subchapter does not require the submission by payors of additional data elements unless they are both required in the Texas APCD CDL v3.0.1 and within the scope of Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database. The Center will communicate to payors an implementation deadline for use of an updated version of the Texas APCD CDL that is not less than 90 days after the updated version has been published by the Center in its final form.

(c) The Center will establish, evaluate, and update data collection procedures within a submission guide, consistent with Insurance Code §38.404(f), concerning Establishment and Administration of Database. Notwithstanding subsection (b) of this section, in the

event of an inconsistency between this subchapter and the submission guide, this subchapter controls.

§21.5404. Data Submission Requirements.

(a) Payors must submit the data files required by subsection (c) of this section to the Center according to the schedule provided in §21.5405 of this title (relating to Timing and Frequency of Data Submissions). Payors are responsible for submitting or arranging to submit all applicable data under this subchapter, including data with respect to benefits that are administered or adjudicated by another contracted or delegated entity, such as carved-out behavioral health benefits or pharmacy benefits administered by a pharmacy benefit manager. Payors may arrange for a third-party administrator or delegated or contracted entity to submit data on behalf of the payor but may not submit data that duplicates data submitted by a third party.

(1) The Texas Health and Human Services Commission may submit data on behalf of all applicable payors participating in a plan or program identified in §21.5401(b)(18) - (b)(21) of this title (relating to Applicability).

(2) A payor that acts as an administrator on behalf of a health benefit plan or dental plan for which reporting is optional per Insurance Code §38.407, concerning Certain Entities Not Required to Submit Data, may ask the plan sponsor whether it elects or declines to participate in or submit data to the Center and may include data for such plans within the payor's data submission. Both the inquiry to and response from the plan sponsor should be in writing.

(3) A payor providing Medicare Supplement benefit plans may elect to submit Medicare Supplement benefit plan data to the Center.

(b) Payors or their designees that are subject to this subchapter must register with the Center each year, consistent with the instructions and procedures contained in the submission guide. Payors must communicate any changes to registration information by contacting the Center within 30 days using the contact information provided in the submission guide. Upon registration, the Center will assign a unique payor code and submitter code to be used in naming the data files and provide the credentials and information required to submit data files.

(c) Payors must submit the following files, consistent with the requirements of the Texas APCD CDL:

(1) enrollment and eligibility data files;

(2) medical claims data files;

(3) pharmacy claims data files;

(4) dental claims data files; and

(5) provider files.

(d) Payors must package all files being submitted into zip files that are encrypted according to the standard provided in the submission guide. Payors must submit the encrypted zip files to the Center using one of the following file submission methods:

(1) transmit the files to the Center's Managed File Transfer servers using the Secure File Transport Protocol (SFTP) and the credentials and transmittal information provided upon registration;

(2) upload files from an internet browser using the Hypertext Transfer Protocol Secure (HTTPS) protocol and the credentials and transmittal information provided upon registration; or

(3) transmit the files using a subsequent electronic method as provided in the data submission guide.

(e) Payors must name data files and zip files consistent with the file naming conventions specified by the Center in the submission guide.

(f) Payors must format all data files as standard 8-bit UCS Transformation Format (UTF-8) encoded text files with a ".txt" file extension and adhere to the following standards:

(1) use a single line per record and do not include carriage returns or line feed characters within the record;

(2) records must be delimited by the carriage return and line feed character combination;

(3) all data fields are variable field length, subject to the constraints identified in the Texas APCD CDL, and must be delimited using the pipe (|) character (ASCII=124), which must not appear in the data itself;

(4) text fields must not be demarcated or enclosed in single or double quotes;

(5) the first row of each data file must contain the names of data columns as specified by the Texas APCD CDL;

(6) numerical fields (e.g., ID numbers, account numbers, etc.) must not contain spaces, hyphens, or other punctuation marks, or be padded with leading or trailing zeroes;

(7) currency and unit fields must contain decimal points when appropriate;

(8) if a data field is not to be populated, a null value must be used, consisting of an empty set of consecutive pipe delimiters (||) with no content between them.

(g) Data files must include information consistent with the Texas APCD CDL that enables the data to be analyzed based on the market category, product category, coverage type, and other factors relevant for distinguishing types of plans.

(h) Payors must include data in medical, pharmacy, and dental claims data files for a given reporting period based on the date the claim is adjudicated, not the date of service associated with the claim. For example, a service provided in March but adjudicated in April would be included in the April data report. Likewise, any claim adjustments must be included in the appropriate data file based on the date the adjustment was made and include a reference that links the original claim to all subsequent actions associated with that claim. Payors must report medical, pharmacy, and dental claims data at the visit, service, or prescription level. Payors must also include claims for capitated services with all medical, pharmacy, and dental claims data file submissions.

(i) Payors must include all payment fields specified as required in the Texas APCD CDL. With respect to medical, pharmacy, and dental claims data file submissions, payors must also:

(1) include coinsurance and copayment data in two separate fields;

(2) clearly identify claims where multiple parties have financial responsibility by including a Coordination of Benefits, or COB, notation; and

(3) include specified types of denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. The data submission guide will specify the types of denied claims that must be included on the basis of the claim adjustment reason code associated with the denial. In general, denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. Denied claims are required when they accurately reflect care

that was delivered to an eligible member but not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. Payors are not required to include data for rejected claims or claims that are denied because the patient was not an eligible member.

(j) Every data file submission must include a control report that specifies the count of records and, as applicable, the total allowed amount and total paid amount.

(k) Unless otherwise specified, payors must use the code sources listed and described in the Texas APCD CDL within the member eligibility and enrollment data file and medical, pharmacy, and dental claims data file and provider file submissions.

(l) Payors must use the member's social security number as a unique member identifier (ID) or assign an alternative unique member ID as provided in this subsection.

(1) If a payor collects the social security number for the subscriber only, the payor must assign a discrete two-digit suffix for each member under the subscriber's contract.

(2) If a payor does not collect the subscriber's social security number, the payor must assign a unique member ID to the subscriber and the member in its place. The payor must also use a discrete two-digit suffix with the unique member ID to associate members under the same contract with the subscriber.

(3) A payor must use the same unique member ID for the member's entire period of coverage under a particular plan. If a change in the unique member ID or the use of two different unique member IDs for the same individual is unavoidable, the payor must provide documentation, if available, linking the member IDs in the form and method provided by the Center.

(m) When standardized values for data variables are available and stated within the Texas APCD CDL, no specific or unique coding systems will be permitted as part of the health care claims data set submission.

(n) Within the enrollment and eligibility data files, payors must report member enrollment and eligibility information at the individual member level. If a member is covered as both a subscriber and a dependent on two different policies during the same month, the payor must submit two member enrollment and eligibility records. If a member has two different policies for two different coverage types, the payor must submit two member enrollment and eligibility records.

(o) Payors must include a header and trailer record in each data file submission according to the formats described in the Texas APCD CDL. The header record is the first record of each separate file submission, and the trailer record is the last.

§21.5405. Timing and Frequency of Data Submissions.

(a) Payors must submit monthly data files according to the following schedule:

(1) January data must be submitted no later than March 7 of that year;

(2) February data must be submitted no later than April 7 of that year;

(3) March data must be submitted no later than May 7 of that year;

(4) April data must be submitted no later than June 7 of that year;

(5) May data must be submitted no later than July 7 of that year;

(6) June data must be submitted no later than August 7 of that year;

(7) July data must be submitted no later than September 7 of that year;

(8) August data must be submitted no later than October 7 of that year;

(9) September data must be submitted no later than November 7 of that year;

(10) October data must be submitted no later than December 7 of that year;

(11) November data must be submitted no later than January 7 of the following year; and

(12) December data must be submitted no later than February 7 of the following year.

(b) Payors must submit test data files as provided in the submission guide:

(1) after registering for the first time with the Center as a payor that is subject to reporting under this subchapter;

(2) after a merger, acquisition, divestiture, or other change of ownership that requires an update to a payor's registration; and

(3) before the effective date of a new version of the Texas APCD CDL, consistent with §21.5403 of this title (relating to Texas APCD Common Data Layout and Submission Guide) that contains additional data elements.

(c) A payor may request a temporary exception or extension of time from complying with one or more requirements of this subchapter or the Texas APCD CDL by submitting a request to the Center, as provided in the submission guide posted on https://go.uth.edu/DSG, no less than 15 calendar days before the date the payor is otherwise required to comply with the requirement.

(1) The Center may grant an exception or extension for good cause for not more than 12 consecutive months, if the payor demonstrates that compliance would impose an unreasonable cost or burden relative to the public value that would be gained

from full compliance. An exception may not be granted from any requirement contained in Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database.

(2) A payor that registers with the Center and demonstrates that it has fewer than 10,000 covered lives in plans subject to this subchapter qualifies for an extension under this subsection for the payor's first required reporting. The Center may grant an extension for new payors for not more than 12 consecutive months.

(3) The Center may request additional information from a payor in order to make a determination on an exception or extension request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received. The deadline for data submission is tolled while the Center makes a determination on an exception or extension request.

(4) A request for an exception or extension that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (3) of this subsection, the 14-day timeline begins the day after the payor submits the information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an exception or extension may be deemed withdrawn by the Center at the end of the 14-day period.

(5) In order to assist TDI's oversight and enforcement required by Insurance Code §38.409, the Center will provide TDI on or before July 1st of each year for the prior year:

(A) the names of payors that timely reported data;

(B) information about payors that did not report data and either requested an exception or extension that the Center did not grant or otherwise failed to demonstrate an exemption from reporting under this subchapter;

(C) information about payors that obtained exceptions and extensions, including the nature of the exceptions and amount of extensions granted;

(D) information about payors that failed to report timely without obtaining an exception or extension, including the filing due dates and the dates of actual filing; and

(E) information about payors that otherwise failed to materially comply with the requirements of Insurance Code Chapter 38, Subchapter I, or this subchapter.

(d) The Center will assess each data submission to ensure the data files are complete, accurate, and correctly formatted.

(e) The Center will communicate receipt of data within 14 calendar days, inform the payor of the data quality assessments, and specify any required data corrections and resubmissions.

(f) Payors must provide reasonable follow-up information requested by the Center, limited to ensuring that the payor submitted complete and correct information.

(g) Upon receipt of a resubmission request, the payor must respond within 14 calendar days with either a revised and corrected data file or an extension request.

(h) If a payor fails to submit required data or fails to correct submissions rejected due to errors or omissions, the Center will provide written notice to the payor. If the payor fails to provide the required information within 30 calendar days following receipt of the written notice, the Center will notify the department of the failure to report. The

department may pursue compliance with this subchapter via any appropriate corrective action, sanction, or penalty that is within the authority of the department.

(i) The reporting schedule under subsection (a) of this section applies to monthly data submissions due on or after March 7, 2025, containing data for months beginning January 1, 2025. Payors must submit data for November and December 2024 at the same time as January 2025 data.

§21.5406. Stakeholder Advisory Group Terms.

(a) Except as otherwise provided in this section, the term of office for seats on the stakeholder advisory group, as specified by Insurance Code §38.403, concerning Stakeholder Advisory Group, is three years.

(b) Initial terms of office for the members of the stakeholder advisory group will end December 31, 2024.

(c) Subsequent terms of office for the members of the stakeholder advisory group will begin January 1, 2025, and will be staggered as follows:

(1) the terms of office for the seats of the two members representing the business community and the two members representing consumers will expire December 31, 2026;

(2) the terms of office for the seats of the member designated by the Teacher Retirement System of Texas, the two members representing hospitals, and the two members representing health benefit plan issuers will expire December 31, 2027; and

(3) the terms of office for the seats of the member designated by the Employees Retirement System; the two members representing physicians; and the two members not professionally involved in the purchase, provision, administration, or review

of health care services, supplies, or devices, or health benefit plans will expire December 31, 2028.

(d) The term of office for the seat of a member representing an institution of higher education is one year.

(e) Except as provided by subsection (f) of this section, members may not serve for more than six consecutive years.

(f) If a member does not complete the member's three-year term, a replacement member may be designated to complete the remainder of the term.

(g) Members and prospective members of the stakeholder advisory group are subject to the conflicts of interest and standards of conduct provisions in paragraphs (1) - (4) of this subsection.

(1) A prospective member of the stakeholder advisory group must disclose to the designating entity any conflict of interest before being designated to the group.

(2) A member of the stakeholder advisory group must immediately disclose to the Center and the member's designating entity any conflict of interest that arises or is discovered while serving on the group.

(3) A conflict of interest means a personal or financial interest that would lead a reasonable person to question the member's objectivity or impartiality. An example of a conflict of interest is employment by or financial interest in an organization with a financial interest in work before the stakeholder advisory group, such as evaluating data requests from qualified research entities under Insurance Code §38.404(e)(2), concerning Establishment and Administration of Database.

(4) A member of the stakeholder advisory group must comply with Government Code §572.051(a), concerning Standards of Conduct; State Agency Ethics Policy, to the same extent as a state officer or employee.

(h) A member may be removed from the stakeholder advisory group for good cause by the member's designating entity.

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 November 8, 2024.

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

The amendments to 28 TAC §21.5401 and §§21.5403 - 21.5406 are adopted.

Signed by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2024-8945