

PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to

submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. “(No change)” indicates that existing rule text at this level will not be amended.

TITLE 13. CULTURAL RESOURCES

PART 2. TEXAS HISTORICAL COMMISSION

CHAPTER 13. TEXAS HISTORIC PRESERVATION TAX CREDIT PROGRAM

13 TAC §§13.1 - 13.6, 13.8, 13.9

The Texas Historical Commission (hereafter referred to as the Commission) proposes amendments to §§13.1 - 13.6, 13.8, and 13.9 of Chapter 13 of the Texas Administrative Code, Title 13, Part 2, related to the Texas Historic Preservation Tax Credit Program.

The proposed amendments clarify administrative procedures and further explain the relationship between this program and the Federal Rehabilitation Tax Credit Program. Specifically, the proposed amendments refine definitions and remove language that is redundant with subsequent sections in §13.1; explain the circumstances under which disparate scopes of work may be treated as part of a single or separate applications in §13.2; add evaluation criteria for designation as a Recorded Texas Historic Landmark, and provide clarification and remove typographical errors regarding nonhistoric surface materials in §13.3; clarify procedures for the evaluation of Part B of the application and amendments in §13.4; consolidate duplicative information in §13.5; clarify application review procedures, including for buildings that are not yet certified historic structures in §13.6; disambiguate processing procedures between projects seeking both federal and state tax credits and projects seeking state tax credits only during the federal recapture period in §13.8; and establish that Part A of the application cannot be appealed in §13.9. No revisions are proposed to §13.7 at this time.

FISCAL NOTE. Joseph Bell, Executive Director, has determined that for the first five-year period the rules are in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the rules.

PUBLIC BENEFIT. Mr. Bell has also determined that for each year of the first five-year period the rules are in effect the public benefit anticipated as a result of the implementation of these rules will be the certified rehabilitation of certain designated historic buildings.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES, MICROBUSINESSES, AND RURAL COMMUNITIES. Mr. Bell has also determined that there will be no impact on rural communities, small businesses, or micro-businesses as a result of implementing these rules. Accordingly, no regulatory flexibility analysis, as specified in Texas Government Code §2006.002, is required.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT. There are no anticipated economic costs to persons who are required to comply with the amendments to these rules, as proposed. There is no effect on local economy for the first five years that the proposed new section is in effect; therefore, no local employment impact statement is required under Texas Government Code §2001.022 and 2001.024(a)(6).

GOVERNMENT GROWTH IMPACT STATEMENT. During the first five years that the amendments would be in effect, the proposed amendments: will not create or eliminate a government program; will not result in the addition or reduction of employees; will not require an increase or decrease in future legislative appropriations; will not create a new regulation; will not repeal an existing regulation; and will not result in an increase or decrease in the number of individuals subject to the rule. Implementation of this legislation will lead to an increase in fees paid to a state agency through application fees collected in accordance with Texas Government Code §442.005(f) and 13 Texas Administrative Code §13.1(3). During the first five years that the amendments would be in effect, the proposed amendments will positively affect the Texas economy through the creation of construction-related jobs.

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

PUBLIC COMMENT. Comments on the proposal and as to whether the reasons for initially adopting these rules continue to exist may be submitted to Joseph Bell, Executive Director, Texas Historical Commission, P.O. Box 12276, Austin, Texas 78711. Comments will be accepted for 30 days after publication in the *Texas Register*.

STATUTORY AUTHORITY. These amendments are proposed under the authority of Texas Government Code §442.005(q), which provides the Commission with the authority to promulgate rules to reasonably affect the purposes of the Commission, and Texas Government Code §172.110, of the Texas Tax Code, which authorizes the Commission to adopt rules necessary to implement the Tax Credit for Certified Rehabilitation of Certified Historic Structures.

CROSS REFERENCE TO OTHER LAW. No other statutes, articles, or codes are affected by these amendments.

§13.1. Definitions.

The following words and terms when used in these rules shall have the following meanings unless the context clearly indicates otherwise:

(1) Applicant--The entity that has submitted an application for a building or structure of which it is the owner, [it owns] or for which it has a contract to purchase.

(2) Application--A fully completed Texas Historic Preservation Tax Credit Application form submitted to the Commission, which includes three parts:

(A) Part A - Evaluation of Significance, to be used by the Commission to make a determination whether the building is a certified historic structure;

(B) Part B - Description of Rehabilitation, to be used by the Commission to review proposed projects for compliance with the Standards for Rehabilitation; and

(C) Part C - Request for Certification of Completed Work, to be used by the Commission to review completed projects for compliance with the work approved under Part B.

(3) Application fee--The fee charged by the Commission and paid by the applicant for the review of Part B and Part C of the application as follows:

Figure: 13 TAC §13.1(3) (No change.)

(4) Audited cost report--Such documentation as defined by the Comptroller in 34 TAC Chapter 3, Tax Administration.

(5) Building--Any edifice enclosing a space within its walls, and usually covered by a roof, the purpose of which is principally to shelter any form of human activity, such as shelter or housing, or to provide working, office, parking, display, or sales space. The term includes, among other examples, banks, office buildings, factories, warehouses, barns, railway or bus stations, and stores ~~and may also be used to refer to a historically and functionally related unit, such as a courthouse and jail or a house and barn~~. Functional constructions made usually for purposes other than creating human shelter or activity such as bridges, windmills, and towers are not considered buildings under this definition and are not eligible to be certified historic structures.

(6) Certificate of Eligibility--A document issued by the Commission to the owner, following review and approval of a Part C application, that confirms the property to which the eligible costs and expenses relate is a certified historic structure and the rehabilitation qualifies as a certified rehabilitation; and specifies the date the certified historic structure was first placed in service after the rehabilitation.

(7) Certified historic structure--A building or buildings located on a property in Texas that is certified by the Commission as:

(A) listed individually in the National Register of Historic Places;

(B) designated as a Recorded Texas Historic Landmark under §442.006, Texas Government Code~~;~~ or as a State Antiquities Landmark under Chapter 191, Texas Natural Resources Code~~;~~ §21.6 ~~[and §26.3(66) and (67)]~~ of this title (relating to Recorded Texas Historic Landmark Designation ~~[and Definitions, respectively]~~); ~~or~~

(C) designated as a State Antiquities Landmark under Chapter 191, Texas Natural Resources Code; §26.3 of this title (relating to Definitions); or

(D) ~~[(E)]~~ certified by the Commission as contributing to the historic significance of:

(i) a historic district listed in the National Register of Historic Places; or

(ii) a certified local district as per 36 CFR §67.9.

(8) Certified local district--A local historic district certified by the United States Department of the Interior in accordance with 36 CFR §67.9.

(9) Certified rehabilitation--The rehabilitation of a certified historic structure that the Commission has certified as meeting the Standards for Rehabilitation. If the project is submitted for the federal rehabilitation tax credit, it must be reviewed by the National Park Service prior to a determination that it meets the requirements for a certified rehabilitation under this rule. In the absence of a determination for the federal rehabilitation tax credit, the Commission shall have the sole responsibility for certifying the project.

(10) Commission--The Texas Historical Commission.

(11) Comptroller--The Texas Comptroller of Public Accounts.

(12) Contributing--A property [building] in a historic district considered to be historically, culturally, or architecturally significant according to the criteria established by state or federal government, including those formally promulgated by the National Park Service and the United States Department of the Interior at 36 CFR Part 60 and applicable National Register bulletins.

(13) Credit--The tax credit for the certified rehabilitation of certified historic structures available pursuant to Chapter 172 of the Texas Tax Code.

(14) District--A geographically definable area, urban~~;~~ or rural, possessing a significant concentration, linkage, or continuity of sites, buildings [building], structures, or objects united by past events or aesthetically by plan or physical development. A district may also comprise individual elements separated geographically but linked by association or history.

(15) Eligible costs and expenses--The qualified rehabilitation expenditures as defined by §47(c)(2), Internal Revenue Code, including rehabilitation expenses as set out in 26 CFR §1.48-12(c), incurred during the project, except as otherwise specified in Chapter 172 of the Texas Tax Code, or, for a time period beginning January 1, 2026, until the statute reverts on January 1, 2035, by authorized investment of funds by an institution of higher education or university system as defined by Section 61.003, Education Code, if the other provisions of Section 47(c)(2) are met.

(16) Federal rehabilitation tax credit--A federal tax credit for 20% of qualified rehabilitation expenditures with respect to a certified historic structure, as defined in §47, Internal Revenue Code; 26 CFR §1.48-12; and 36 CFR Part 67.

(17) Functionally related buildings--A collection of buildings that were constructed or used to serve and support an overall single purpose during their period of significance. Examples include but are not limited to: a residence and carriage house; a multi-building apartment complex; a multi-building industrial or commercial complex; or buildings constructed as a campus. Buildings within a typical neighborhood or downtown commercial historic district, among other property types, do not count as functionally related buildings with other buildings in the district, unless there is a certain historical attachment other than community development. Functionally related buildings owned by one entity are viewed as a single property while those owned by separate entities are viewed as separate properties.

(18) National Park Service--The agency of the U.S. Department of the Interior that is responsible for certifying projects to receive the federal rehabilitation tax credit.

(19) Owner--A person, partnership, company, corporation, whether for profit or not, governmental body, an institution of higher

education or university system or any other entity holding a legal or equitable interest in a Property or Structure, which can include a full or partial ownership interest. Not all of these owner entities can qualify as an applicant for the credit, based on the requirements listed in Chapter 172 of the Texas Tax Code. A long-term lessee of a property may be considered an owner if their current lease term is at a minimum 27.5 years for residential rental property or 39 years for nonresidential real property, as referenced by §47(c)(2), Internal Revenue Code.

(20) ~~Phased development--A rehabilitation project which may reasonably be expected to be completed in two or more distinct states of development, as defined by United States Treasury Regulation 26 CFR §1.48-12(b)(2)(v). [Each phase of a phased development can independently support an Application for a credit as though it was a stand-alone rehabilitation, as long as each phase meets the definition of a Project. If any completed phase of the rehabilitation project does not meet the requirements of a certified rehabilitation, future applications by the same owner for the same certified historic structure will not be considered.]~~

(21) ~~Placed in Service--A status obtained upon completion of the rehabilitation project as described in Part B of the application, and any subsequent amendments, and documented in Part C of the application. Evidence of the date a property is placed in service must be provided as described in §13.5(b)(4) of this title (relating to Request for Certification of Completed Work). [includes a certificate of occupancy issued by the local building official and/or an architect's certificate of substantial completion. Other documents will suffice when certificates of occupancy and/or substantial completion are not available for a specific project, including final contractor invoices or other verifiable statements of completion. Alternate documents should be approved by the Commission before submission. Placed in Service documentation must indicate the date that work was completed.]~~

(22) ~~Project--A specified scope of work, as described in a rehabilitation plan submitted with Part B of the application and subsequent amendments, comprised of work items that will be fully completed and Placed in Service. Examples of a project may include, but are not limited to, a whole building rehabilitation, rehabilitation of individual floors or spaces within a building, repair of building features, or replacement of building systems (such as mechanical, electrical, and plumbing systems). Partial or incomplete scopes of work, such as project planning and design, demolition, or partial completion of spaces, features, or building systems are not included in this definition as projects. Per §13.6(f) of this title (relating to Application Review Process), the Commission's review encompasses the entire building and site, including all concurrent work regardless of whether that work is eligible to generate qualified rehabilitation expenditures [even if other work items are not included in a submitted project].~~

(23) ~~Property--A parcel of real property containing one or more buildings or structures that is the subject of an application for a credit.~~

(24) ~~Rehabilitation--The process of returning a building or buildings to a state of utility, through repair or alteration, which makes possible an efficient use while retaining those portions and features of the building and its site and environment which are significant.~~

(25) ~~Rehabilitation plan--Descriptions, drawings, construction plans, and specifications for the proposed rehabilitation of a certified historic structure in sufficient detail to enable the Commission to evaluate compliance with the Standards for Rehabilitation.~~

(26) ~~Standards for Rehabilitation--The United States Secretary of the Interior's Standards for Rehabilitation as defined by the National Park Service in 36 CFR §67.7.~~

(27) ~~Structure--A building; see also certified historic structure. "Structure" may be used in place of the word "building," but all tax credit projects must involve rehabilitation of a building as defined in §13.1(5) of this title.~~

(28) ~~Tax Credit--A credit earned against either the state franchise tax or the insurance premium tax per Chapter 172 of the Texas Tax Code and any limitations provided therein.~~

§13.2. Qualification Requirements.

(a) *Qualification for credit.*

(1) An Owner is eligible for a credit for eligible costs and expenses incurred in the certified rehabilitation of a certified historic structure if:

(A) the rehabilitated certified historic structure is placed in service on or after September 1, 2013;

(B) the Owner has an ownership interest in the certified historic structure in the year during which the structure is placed in service after the rehabilitation; and

(C) the total amount of the eligible costs and expenses incurred exceeds \$5,000.

(2) A property for which eligible costs and expenses are submitted for the credit must meet Internal Revenue Code §47(c)(2) which includes:

(A) non-residential real property;

(B) residential rental property; or

(C) other property types exempted from parts of Internal Revenue Code §47(c)(2) as described in Chapter 172 of the Texas Tax Code.

(b) Eligible costs and expenses. Eligible costs and expenses means those costs and expenses allowed pursuant to Internal Revenue Code §47(c)(2) or as exempted by Chapter 172 of the Texas Tax Code. Such eligible costs and expenses, include, but are not limited to:

(1) expenditures associated with structural components as defined by United States Treasury Regulation §1.48-1(e)(2) including walls, partitions, floors, ceilings, windows and doors, stairs, elevators, escalators, sprinkler systems, fire escapes, components of central air conditioning, heating, plumbing, and electrical systems, and other components related to the operation or maintenance of the building;

(2) architectural services;

(3) engineering services;

(4) construction management and labor, materials, and reasonable overhead;

(5) subcontracted services;

(6) development fees;

(7) construction period interest and taxes; and

(8) other items referenced in Internal Revenue Code §47(c)(2).

(c) Ineligible costs and expenses. Eligible costs and expenses as defined in Internal Revenue Code §47(c)(2) do not include the following:

(1) the cost of acquiring any interest in the property;

(2) the personal labor by the applicant;

(3) any cost associated with the enlargement of an existing building;

(4) site work expenditures, including any landscaping, sidewalks, paving, decks, outdoor lighting remote from the building, fencing, retaining walls or similar expenditures; or

(5) any cost associated with the rehabilitation of an out-building or ancillary structure unless it is certified by the Commission to contribute to the historical significance of the property.

(d) Eligibility date for costs and expenses.

(1) Part A of the Texas Historic Preservation Tax Credit Certification Application must be submitted prior to the building being placed in service per §13.1(21) of this title (relating to Definitions). Projects that have been placed in service prior to submission of Part A of the application do not qualify for the program.

(2) While the credit may be claimed for eligible costs and expenses incurred prior to the filing of an application, potential applicants are urged to file Parts A and B of the application at the earliest possible date. This will allow the Commission to review the application and provide guidance to the applicant that will increase the chances that the application will ultimately be approved and the credit received.

(3) In certain cases, an applicant may seek to demonstrate that a scope of recently completed work is part of an ongoing project, to be considered cumulatively for qualification for the program. In such cases, the applicant must provide documentation that the previous work is part of a cohesive, ongoing project that has not yet been placed in service, and the Commission will determine whether the prior work is eligible for consideration.

(4) [(3)] For an institution of higher education or university system as defined by Section 61.003, Education Code, eligible costs and expenditures may only be incurred on or after January 1, 2026, and before January 1, 2035, in accordance with Section 172.102(b) of the Tax Code.

(e) Phased development. Part B applications for rehabilitation of the same certified historic structure may be submitted by the same owner only if they describe clearly defined phases of work that align with a cost report that separates the eligible costs and expenses by phase. Each phase of a phased development can independently support an Application for a credit as though it was a standalone rehabilitation, as long as each phase meets the definition of a Project. Separate Part B and C applications shall be submitted for review by the Commission prior to issuance of a certificate of eligibility for each phase.

(f) Amount of credit. The total amount of credit available is twenty-five percent (25%) of the aggregate eligible costs and expenses incurred in the certified rehabilitation of the certified historic structure.

§13.3. Evaluation of Significance.

(a) Application Part A - Evaluation of Significance. Part A of the application requires information to allow the Commission to evaluate whether a building is a certified historic structure and shall be completed for all buildings to be included in the project. Part A of the application is evaluated against criteria for significance and integrity issued by the National Park Service.

(b) Application Requirements. Information to be submitted in Part A of the application includes:

(1) Name, mailing address, telephone number, and email address of the property owner(s) and Applicant if different from the Owner;

(2) Name and address of the property;

(3) Name of the historic district, if applicable;

(4) Current photographs of the building and its site, showing exterior and interior features and spaces adequate to document the property's significance. Photographs must be formatted as directed by the Commission in published program guidance materials on the Commission's online Texas Historic Preservation Tax Credit Application Guide available by accessing thc.texas.gov;

(5) Date of construction of the property;

(6) Brief description of the appearance of the property, including alterations, characteristic features, and estimated date or dates of construction and alterations;

(7) Brief statement of significance summarizing why a property is:

(A) eligible for individual listing in the National Register of Historic Places;

(B) contributes to a historic district listed in the National Register of Historic Places or a certified local district; or

(C) contributes to a potential historic district, accompanied by:

(i) a map showing the boundary of the potential historic district and the location of the property within the district;

(ii) photographs of other properties in the district; and

(iii) justification for the district's eligibility for listing in the National Register of Historic Places;

(8) A map showing the location of the historic property;

(9) Signature of the Owner, and Applicant if different from the Owner, requesting the determination; and

(10) Other information required on the application by the Commission.

(c) Consultation with Commission. Any person may informally consult with the Commission to determine whether a property is:

(1) listed individually in the National Register of Historic Places;

(2) designated as a Recorded Texas Historic Landmark or State Antiquities Landmark; or

(3) certified by the Commission as contributing to the historic significance of a historic district listed in the National Register of Historic Places or a certified local district.

(d) Automatic qualification as certified historic structure. If a property is individually listed in the National Register of Historic Places or designated as a Recorded Texas Historic Landmark or State Antiquities Landmark, then it is a certified historic structure and should be indicated as such on Part A of the application.

(e) Preliminary determination of significance. An Applicant for a property not listed in the National Register of Historic Places, neither individually nor as a contributing element to a historic district; not designated a Recorded Texas Historic Landmark nor State Antiquities Landmark; and not listed in a certified local district may obtain a preliminary determination from the Commission as to whether the property is individually eligible to become a certified historic structure or is eligible as a contributing structure in a potential existing historic district by submitting Part A of the application.

(1) Determination of eligibility for designation in the National Register of Historic Places, either individually or as part of a

historic district, will be based on criteria for listing in the National Register of Historic Places. Applications for a preliminary determination of significance must show how the property meets one of the following criteria for listing in the National Register of Historic Places and any applicable criteria considerations from the National Park Service.

(A) [4] National Register of Historic Places criteria. The quality of significance in American history, architecture, archeology, engineering, and culture is present in districts, sites, buildings, structures, and objects that possess integrity of location, design, setting, materials, workmanship, feeling, and association and one or more of clauses (i) - (iv) of this subparagraph [subparagraphs (A) - (D) of this paragraph]:

(i) [A] Properties that are associated with events that have made a significant contribution to the broad patterns of our history; or

(ii) [B] that are associated with the lives of persons significant in our past; or

(iii) [C] that embody distinctive characteristics of a type, period, or method of construction, or that represent the work of a master, or that possess high artistic values, or that represent a significant and distinguishable entity whose components may lack individual distinction; or

(iv) [D] that have yielded, or may be likely to yield, information important in prehistory or history.

(B) [2] Criteria considerations. Ordinarily cemeteries, birthplaces, or graves of historical figures, properties owned by religious institutions or used for religious purposes, structures that have been moved from their original locations, reconstructed historic buildings, properties primarily commemorative in nature, and properties that have achieved significance within the past 50 years shall not be considered eligible for the National Register. However, such properties will qualify if they are integral parts of districts that do meet the criteria or if they fall within the following categories:

(i) [A] A religious property deriving primary significance from architectural or artistic distinction or historical importance; or

(ii) [B] A building or structure removed from its original location but which is significant primarily for architectural value, or which is the surviving structure most importantly associated with a historic person or event; or

(iii) [C] A birthplace or grave of a historical figure of outstanding importance if there is no appropriate site or building directly associated with his or her productive life; or

(iv) [D] A cemetery which derives its primary significance from graves of persons of transcendent importance, from age, from distinctive design features, or from association with historic events; or

(v) [E] A reconstructed building when accurately executed in a suitable environment and presented in a dignified manner as part of a restoration master plan, and when no other building or structure with the same association has survived; or

(vi) [F] A property primarily commemorative in intent if design, age, tradition, or symbolic value has invested it with its own exceptional significance; or

(vii) [G] A property achieving significance within the past 50 years if it is of exceptional importance.

(2) Determination of eligibility for designation as a Recorded Texas Historic Landmark will be based on criteria for evaluation described in §442.006, Texas Government Code; §21.9 of this title (relating to Application Evaluation Procedures).

(3) Issuance of a preliminary determination of significance does not bind the Commission to the designation of an individual historic structure or district. Applicants proceed with rehabilitation projects at their own risk. If a structure is ultimately not listed in the National Register of Historic Places, designated as a Recorded Texas Historic Landmark, or certified as a contributing element to a local district pursuant to 36 CFR §67.9, the preliminary determination does not become final, and the owner will not be eligible for the credit. The Commission shall not issue a certificate of eligibility until or unless the designation is final.

(f) Determination of contributing structures in existing historic districts. If a property is located in a district listed in the National Register of Historic Places or in a certified local district, an Applicant or an Owner of the property shall request that the Commission determine whether the property is of historic significance contributing to the district by submitting Part A of the application. The Commission evaluates properties located within historic districts listed in the National Register of Historic Places or certified local districts to determine whether they contribute to the historic significance of the district by applying the following standards:

(1) A property contributing to the historic significance of a district is one which by location, design, setting, materials, workmanship, feeling, and association adds to the district's sense of time and place and historical development.

(2) A property does not contribute to the historic significance of a district if it does not add to the district's sense of time and place and historical development, or if its location, design, setting, materials, workmanship, feeling, and association have been so altered or have so deteriorated that the overall integrity of the building has been irretrievably lost.

(3) Generally, buildings that have been built within the past 50 years shall not be considered to contribute to the significance of a district unless a strong justification concerning their historical or architectural merit is given or the historical attributes of the district are considered to be less than 50 years old at the date of application.

(4) Certification of significance will be made on the basis of the appearance and condition of the property before beginning the rehabilitation work.

(5) If a nonhistoric surface material obscures a building's facade [faA/§ade], it may be necessary for the owner to remove some or all [a portion] of the surface material so that a determination of significance can be made. After the material has been removed, if the obscured facade [faA/§ade] has retained substantial historic integrity and the property otherwise contributes to the significance of the historic district, it will be considered eligible to be a certified historic structure.

(g) Subsequent Designation. A building must be a certified historic structure prior to the issuance of the certificate of eligibility by the Commission as required by §172.105 (b)(1)(A) of the Texas Tax Code. If a property is not automatically qualified as a certified historic structure, an owner of a property shall request that the Commission determine whether the property is of historic significance by submitting Part A of the application in accordance with subsections (e) and (f) of this section. Upon listing in the National Register of Historic Places, designation as a Recorded Texas Historic Landmark, or certification as a contributing element to a local district pursuant to 36 CFR §67.9, Commission staff overseeing the National Register program and the

Official Texas Historical Marker program (as applicable), shall prepare a notification, to be filed with the tax credit application, indicating that the designation process required by Part A has been fulfilled.

(h) Multiple buildings. If a property owned by one entity contains more than one building and the Commission determines that the buildings have been functionally related historically, per §13.1(17) of this title (relating to Definitions), to serve an overall purpose (such as a residence and a carriage house), then the functionally related buildings will be treated as a single certified historic structure, regardless of whether one of the buildings is separately listed in the National Register of Historic Places or as a Recorded Texas Historic Landmark or is located within a historic district. Buildings owned by the same applicant that were not functionally related historically must be submitted as individual buildings on separate applications.

(i) Portions of buildings. Portions of buildings, such as single condominium apartment units, are not independently eligible for certification as an individual space without assessment of any work undertaken elsewhere in the building within the last 24 months, as described in §13.6(f) of this title (relating to Application Review Process). This rule applies even when a building has multiple owners. A full description of all work at the building must be provided with the application.

(j) Relocation of historic buildings. Relocation of a historic building from its original site may disqualify the building from eligibility or result in removal of designation as a certified historic structure. Applications involving buildings that have been moved or are to be moved will be evaluated on a case-by-case basis under the applicable criteria for designation as provided in this section. For a building listed in the National Register of Historic Places, the applicant will be responsible for updating the National Register of Historic Places nomination for the property or district, or the relocated building will not be considered a certified historic structure for the purpose of this credit. For a building designated as a Recorded Texas Historic Landmark, the applicant will be responsible for notifying the Commission and otherwise complying with the requirements of §21.11 of this title (relating to Review of Work on Recorded Texas Historic Landmarks) prior to undertaking any relocation.

§13.4. Description of Rehabilitation.

(a) Application Part B - Description of Rehabilitation. Part B of the application requires information to allow the Commission to determine whether the proposed rehabilitation work is consistent with the Standards for Rehabilitation and shall be completed for all projects and phases of projects. Part B may only be submitted with Part A of the application or after the Part A of the application has been submitted to the Commission.

(b) Application Requirements. If a property is a certified historic structure or receives a preliminary determination of significance, an Applicant or Owner of the property shall request that the Commission determine whether the rehabilitation plan is in conformance with the Standards for Rehabilitation. Information to be submitted in the Part B includes:

- (1) Name, mailing address, telephone number, and email address of the Owner and Applicant if different from the Owner;
- (2) Name and address of the property;
- (3) Current photographs of the building and its site, showing exterior and interior features and spaces adequate to document the property's significance. Photographs must be formatted as directed by the Commission in published program guidance materials on the Commission's online Texas Historic Preservation Tax Credit Application Guide available by accessing thc.texas.gov;

(4) A rehabilitation plan including a detailed description of work, drawings of the site plan and the building floor plans showing existing conditions and all proposed work, with elevation drawings if applicable to illustrate any new construction, alterations, or additions. Drawings of the existing building condition and drawings of the proposed project are generally required to substantiate the scope of the project. If there are inconsistencies between the description of work and architectural plans or other ancillary documents, the information in the description of work will take precedence. If the project is a phased development, a description of all phases of work with the associated timelines shall be provided;

(5) Additional photos as necessary to completely illustrate all areas of the building that will be affected by the rehabilitation;

(6) A timeframe by which all work included in the project will be completed with a projected starting date and completion or placed in service date;

(7) An estimate of the aggregate eligible costs and expenses;

(8) Signature of the Owner, and Applicant if different from the Owner, requesting the review; and

(9) Other information required on the application by the Commission.

(c) Amendment Form. Changes to the project not previously documented in Part B of the application must be submitted for formal review using an Amendment Form. Such changes may include additions or deletions to the scope of work, and/or revisions to the proposed rehabilitation plan. Amendment submissions must include a detailed description of proposed changes to the work, together with supporting documents such as plans, as needed to present the proposed changes to the work. The Amendment Form may also be used to notify the Commission of updated contact information or other project updates.

(d) [(e)] Determination of certified rehabilitation. Part B rehabilitation plans and amendments are reviewed by staff of the Commission for consistency with the Standards for Rehabilitation as set forth below:

(1) A property shall be used for its historic purpose or be placed in a new use that requires minimal change to the defining characteristics of the building and its site and environment.

(2) The historic character of a property shall be retained and preserved. The removal of historic materials or alteration of features and spaces that characterize a property shall be avoided.

(3) Each property shall be recognized as a physical record of its time, place, and use. Changes that create a false sense of historical development, such as adding conjectural features or architectural elements from other buildings, shall not be undertaken.

(4) Most properties change over time; those changes that have acquired historic significance in their own right shall be retained and preserved.

(5) Distinctive features, finishes, and construction techniques or examples of craftsmanship that characterize a historic property shall be preserved.

(6) Deteriorated historic features shall be repaired rather than replaced. Where the severity of deterioration requires replacement of a distinctive feature, the new feature shall match the old in design, color, texture, and other visual qualities and, where possible, materials. Replacement of missing features shall be substantiated by documentary, physical, or pictorial evidence.

(7) Chemical or physical treatments, such as sandblasting, that cause damage to historic materials shall not be used. The surface cleaning of structures, if appropriate, shall be undertaken using the gentlest means possible.

(8) Significant archeological resources affected by a project shall be protected and preserved. If such resources must be disturbed, mitigation measures shall be undertaken.

(9) New additions, exterior alterations, or related new construction shall not destroy historic materials that characterize the property. The new work shall be differentiated from the old and shall be compatible with the massing, size, scale, and architectural features to protect the historic integrity of the property and its environment.

(10) New additions and adjacent or related new construction shall be undertaken in such a manner that if removed in the future, the essential form and integrity of the historic property and its environment would be unimpaired.

§13.5. Request for Certification of Completed Work.

(a) Application Part C - Request for Certification of Completed Work. Part C of the application requires information to allow the Commission to certify the completed work follows the Standards for Rehabilitation and the rehabilitation plan as approved by the Commission in the Part B review, together with any subsequent conditions and amendments. Part C may be submitted when the project is placed in service.

(b) Application requirements. Information to be submitted in the Part C includes:

(1) Name, mailing address, telephone number, and email address of the property owner(s);

(2) Name and address of the property;

(3) Photographs of the completed work showing similar views of the photographs provided in Parts A and B. Photographs must be formatted as directed by the Commission in published program guidance materials on the Commission's online Texas Historic Preservation Tax Credit Application Guide available by accessing thc.texas.gov;

(4) Evidence of the placed in service date. Evidence of the date a property is placed in service includes[; such as] a certificate of occupancy issued by the local building official and/or an architect[s]; certificate of substantial completion. Other documents will suffice when certificates of occupancy and/or substantial completion are not available for a specific project and may include[;] final invoices [invoice] issued by a contractor or other verifiable statements of completion. [; or] Alternative [alternative] documentation should be approved by the Commission before submission. Placed in service documentation must indicate the date that work was completed; and

(5) Other information required on the application by the Commission.

§13.6. Application Review Process.

(a) Application form. The Commission staff will develop the application and may modify it as needed over time. All required forms, including application Parts A, B, C, and amendment forms, are available from the Commission at no cost.

(b) Delivery. Applications will be accepted beginning on January 1, 2015 and continuously thereafter. Applications should be submitted to the Commission in the manner and format directed by the Commission in published program guidance materials on the Commission's online Texas Historic Preservation Tax Credit Application Guide available by accessing thc.texas.gov.

(c) Application Part A - Evaluation of Significance. Part A of the application will be used by the Commission to confirm historic designation or to determine if the property is eligible for qualification as a certified historic structure.

(1) If a property is individually listed in the National Register of Historic Places or designated as a Recorded Texas Historic Landmark or State Antiquities Landmark, the property is qualified as a certified historic structure.

(2) The applicant will be responsible for providing sufficient information to the Commission with which the Commission staff may make a determination. If all requested information is not provided to make a determination that a building is eligible for designation as a certified historic structure, the staff may request additional information from the applicant. If the additional information requested is not provided in a timely manner, the application will be considered incomplete and review of the application will be placed on hold until sufficient information is received.

(3) The Commission staff review Part A of a complete application, unless otherwise provided in §13.8 of this title (relating to Relationship with the Federal Rehabilitation Tax Credit Program), and shall notify the applicant in writing of any determination it makes upon completing the review of Part A of the application.

(4) There is no fee to review Part A of the application.

(d) Application Part B - Description of Rehabilitation. Part B of the application will be used by the Commission to review proposed projects for compliance with the Standards for Rehabilitation.

(1) The applicant will be responsible for providing sufficient information, including photographs taken prior to the project, to the Commission with which the Commission staff may make a determination. If all requested information is not provided to make a determination that a project is eligible as a certified rehabilitation, staff may request additional information from the applicant[; usually required to be submitted within 30 days]. If the additional information requested is not provided in a timely manner within the review period, the application will be considered incomplete and review of the application will be placed on hold until sufficient information is received.

(2) The Commission staff will review Part B of a complete application, unless otherwise provided in §13.8 of this title (relating to Relationship with the Federal Rehabilitation Tax Credit Program), and shall notify the applicant in writing of any determination it makes upon completing the review of Part B of the application. In reviewing Part B of the application, the Commission shall determine if Part B is approved or not as follows:

(A) Consistent with the Standards for Rehabilitation as determined by the Commission. If all aspects of Part B of the application meet the Standards for Rehabilitation, no additional information is required, and no conditions are imposed on the work, Part B is approved.

(B) Consistent with the Standards for Rehabilitation with specific conditions of work required. The Commission may determine that the work described in the plan must be performed in a specific manner or with specific materials in order to fully comply with the Standards for Rehabilitation. In such cases, Part B may be approved with specific conditions required. For applications found to be consistent with the Standards for Rehabilitation with specific conditions required, the applicant is responsible for making changes to the work to allow the required conditions to be met; it is recommended that the applicant [shall] provide written acceptance to the Commission of all specific conditions required, and the applicant must present any proposed changes to the work for review by the Commission to ensure

the conditions will be successfully met. Otherwise the application will be determined to be not consistent with the Standards for Rehabilitation; applications found to be consistent with the Standards for Rehabilitation with specific conditions required may proceed with the work but will only be eligible for the credit if the conditions listed are met as part of the rehabilitation work. Failure to follow the conditions may result in a determination by the Commission that the project is not consistent with the Standards for Rehabilitation.

(C) Not consistent with the Standards for Rehabilitation. Applications found not to be consistent with the Standards for Rehabilitation will be considered to be ineligible applications and will be denied. If the project can, in the opinion of the Commission, be brought into compliance, [§] the Commission may issue [shall make] recommendations for design revisions to [to the applicant that might] bring the project into conformance with the Standards for Rehabilitation, however no warranty is made that the recommendations will bring the project into compliance with the Standards for Rehabilitation . After a denial, if deniable construction work has not yet been completed,[§] the applicant may reapply with a revised proposal, and it will be treated as a new application and will be subject to a new application fee.

(3) An application fee is required to be received by the Commission before Commission review of Part B of the application. The fee is based on the estimated amount of eligible costs and expenses listed by the applicant on Part B of the application.

(A) Applicants must submit the fee with Part B of their application or the application will be placed on hold until the fee is received. The fee is calculated according to a fee schedule approved by the Commission and included in the application.

(B) The fee is based on the estimated aggregate eligible costs and expenses indicated in Part B of the application and is not refundable. Resubmission of a rejected application or under any other circumstances will require a new fee. Amendments to a pending application or approved project do not require additional fees.

(4) Amendment Form [Sheet]. Changes to the project not anticipated in the original application shall be submitted to the Commission as consistent with the Standards for Rehabilitation before they are included in the project. The Commission shall review the amendment form [sheet] and issue a determination in writing regarding whether or not the proposed change in the project is consistent with the Standards for Rehabilitation.

(e) Application Part C - Request for Certification of Completed Work. Part C of the application will be used by the Commission to review completed projects for compliance with the work approved under Part B.

(1) The applicant shall file Part C of the application after the building is placed in service.

(2) The applicant will be responsible for providing sufficient information, including photographs before and after the project, to the Commission by which the Commission staff may verify compliance with the approved Part B. If all requested information is not provided to make a determination that a project is eligible as a certified rehabilitation, the application is incomplete and review of the application will be placed on hold until sufficient information is received.

(3) The Commission staff will review Part C of a complete application, unless otherwise provided in §13.8 of this title (relating to Relationship with the Federal Rehabilitation Tax Credit Program), and shall notify the applicant in writing of any determination it makes upon completing the review of Part C of the application.

(A) If the completed project is found to be in compliance with the approved Part B and any required conditions; consistent with the Standards for Rehabilitation, and the building is a certified historic structure at the time of the application, the Commission shall approve the project. The Commission then shall issue to the applicant a certificate of eligibility that confirms the property to which the eligible costs and expenses relate is a certified historic structure and the rehabilitation qualifies as a certified rehabilitation and specifies the date the certified historic structure was first placed in service after the rehabilitation.

(B) If the completed project is not consistent with the Standards for Rehabilitation, with the approved Part B, and/or the specific conditions required, and the project cannot, in the opinion of the Commission, be brought into compliance, [or if the building is not a certified historic structure at the time of the application,] then the Commission shall deny Part C of the application and no certificate of eligibility shall be issued.

(C) If the completed project is not consistent with the Standards for Rehabilitation, with the approved Part B, and/or the specific conditions required, and the project can, in the opinion of the Commission, be brought into compliance, the Commission may request remedial work [issue remedial conditions] that will bring the project into compliance. The applicant shall complete the remedial work and file an amended Part C. If the remedial work, in the opinion of the Commission, brings the project into compliance, then the Commission shall issue a certificate of eligibility.

(D) If the completed project is found to be in compliance with the approved Part B and any required conditions, and consistent with the Standards for Rehabilitation, but is not yet a certified historic structure, the Commission shall not issue a certificate of eligibility until such time that the building has become a certified historic structure.

(4) An application fee is charged before Commission review of Part C of the application based on the amount of eligible costs and expenses listed by applicant on Part C of the application.

(A) Applicants must submit the fee with Part C of their application or the application will be placed on hold until the fee is received. The fee is calculated according to a fee schedule approved by the Commission and included in the application.

(B) The fee is based on the eligible costs and expenses as indicated in the audited cost report and is not refundable. Resubmission of a rejected application or under any other circumstances will require a new fee. Amendments do not require additional fees.

(f) Scope of Review. The review encompasses the entire building's site and environment as well as any buildings that were functionally related historically per §13.1(17) and §13.3(h) of this title (relating to Definitions and Evaluation of Significance, respectively). The scope of review for a project is not limited to the work that qualifies as an eligible expense. All work completed by the current applicant twenty-four (24) months before the submission of the application can be considered part of the project, as is the cumulative effect of any work in previously completed or future phases. Any new construction and site improvements occurring on the historic property are considered part of the project. Individual condominiums or commercial spaces within a larger historic building are not considered individual properties apart from the whole. Multiple interior finish-out projects occurring at the same time, for example, whether completed by an owner, multiple owners, or tenants, must all be reviewed to ensure all work to the building meets the Standards for Rehabilitation.

(1) Eligibility for the credit. If a project, including a single phase of work or an overall rehabilitation, does not meet the Standards for Rehabilitation and is denied based on completed construction work, future work on the building or within a set of functionally related buildings, performed by the same owner, shall not be eligible for a credit under this program. If the building is purchased by a new owner, the new owner may apply for tax credits based on a new application and existing conditions at the time of purchase.

(2) An applicant may elect to apply to receive the credit on only the exterior portions of a larger project that includes other work, in which case the scope of review will be limited to the exterior work. For properties that are individually listed on the National Register of Historic Places, are designated as a Recorded Texas Historic Landmark or State Antiquities Landmark, or determined to be eligible for these designations, the scope of review must also include primary interior spaces.

(3) For these projects described in paragraph (2) of this subsection, all work completed by the current owner twenty-four (24) months before the submission of the application, and within the same scope of review (e.g. exterior and/or primary interior) is considered part of the project, as is the cumulative effect of any work in previously completed or future phases within the same scope of review.

(g) Closure of Inactive Applications. The Commission staff may close applications that have been deemed inactive. Closed applications do not qualify as certified rehabilitations and are not eligible for the Texas Historic Preservation Tax Credit unless reopened per paragraph (6) of this subsection.

(1) Applications may be deemed inactive and closed under any of the following circumstances: Part B and Part C application fees have not been received within sixty (60) days of receipt of the application parts; written requests for information necessary to complete the application and provide sufficient documentation to fully review the application are not responded to within sixty (60) days; or, approved application Parts have not progressed to subsequent Parts (for example: Part B has not been submitted following approval of Part A, etc.) and there has been no communication from the applicant to the Commission for a period of twenty-four (24) months or greater.

(2) Applications for projects that are simultaneously applying for federal historic tax credits, per §13.8 of this title (relating to Relationship with the Federal Rehabilitation Tax Credit Program) may also be closed upon closure of the federal application by the National Park Service.

(3) Applicants will be notified in writing of the potential closure and given sixty (60) days to respond, in writing, with a request for the application to remain open; supply missing or requested information; or to request an extension allowing additional time to compile missing or requested information. If no response is received, the application will be closed. Such requests shall not be unreasonably denied but shall not exceed an additional 60 days.

(4) Extensions will be granted, in writing, for a period of time agreed upon by the Commission and the Applicant, based on the status of the project. If an extension is not met, further extensions may be granted if the Applicant documents to the Commission that the project is progressing.

(5) Applications that have been closed will be reopened under the following conditions: the project applicant has not changed; if only Part A of the application has been received, a set of current photos is submitted for review, or if Part B of the application has been received, the overall scope of work presented in Part B of the application has not substantially changed; and the request to reopen the application is made

in writing within twenty-four (24) months from the date the application was closed.

(6) If all conditions in paragraph (5) of this subsection are not met, a new application must be filed, including new Part B and Part C application fees.

§13.8. *Relationship with the Federal Rehabilitation Tax Credit Program.*

(a) Projects seeking federal and state credits. Projects seeking certification for both the federal rehabilitation tax credit and the Texas Historic Preservation Tax Credit must meet eligibility requirements for each program separately.

(1) Applicants for both programs shall submit [the first page of] the Part A, B, and C application forms, accompanied by the Part 1, 2, and 3 application forms for the federal rehabilitation tax credit program, respectively.

(2) A project, or any part or phase of a project, also submitted for the federal rehabilitation tax credit will be reviewed and approved or rejected by the National Park Service before the Commission issues its determinations under this chapter. ~~[Official written determinations from the National Park Service, including Advisory Determinations on phased work, may meet this qualification.]~~ The Commission will consider National Park Service decisions in rendering its determinations. A project that receives certification for the purposes of the federal rehabilitation tax credit will receive a certification of eligibility pursuant to the Texas Historic Preservation Tax Credit, provided that the building is a certified historic structure at the time the credit is taken.

(A) An official written determination from the National Park Service on an analogous application part for the same scope of work, including an Advisory Determination for phased work, may meet this qualification.

(B) When a new project is seeking the Texas Historic Preservation Tax Credit and the application for this program coincides with a post-certification amendment submitted for federal compliance during the federal recapture period, these submissions will not be considered analogous, even if they document the same scope of work. The Commission will treat these applications separately and will carry out review of Parts A, B, and C of the application for the state program as described in subsection (b) of this section.

(3) Applicants may subdivide a phased development [project] submitted for the federal rehabilitation tax credit program into a series of smaller projects submitted for the state program. These smaller projects must be described in the application for the federal credit at the outset of the project, and must correlate to individual phases of the federal phased development [project]. Each project corresponding to a phase of the federal tax credit project may be submitted for the state credit when that phase of work is placed in service. Official determinations from the National Park Service must still be received for each phase of work submitted for the federal program before the Commission issues its determination on each corresponding smaller project submitted for the state program.

(4) The review fees required per §13.6 of this title, Application Review Process, must be paid before the Commission will issue any determinations or certifications pursuant to the Texas Historic Preservation Tax Credit, even if the project has previously received certification by the National Park Service for the federal rehabilitation tax credit.

(b) Projects seeking state credit exclusively. If the applicant is eligible to claim a state credit exclusively, then the application forms for the Texas Historic Preservation Tax Credit provided by Commission shall be used. Determinations by the Commission that a project

includes a certified historic structure and/or a certified rehabilitation apply only to the Texas Historic Preservation Tax Credit Program and are not binding on any other local or federal tax credit program.

§13.9. Appeals.

(a) Denial of Part A of the application cannot be appealed. An applicant may consult with the Commission to identify any available alternative strategies for historic designation. In such a case, the applicant must submit a new Part A application for consideration.

(b) [(a)] An applicant or owner may appeal any determination on a Part B or Part C application that a rehabilitation does not meet the Secretary of the Interior's Standards for Rehabilitation under §13.6(d)(2)(C) or (e)(3)(B) of this chapter (relating to Application Review Process) and is therefore denied credits. A request for an appeal shall be made in writing to the Executive Director of the Texas Historical Commission, 1511 Colorado Street, Austin, Texas 78711, within 30 days of issuance of the decision that is the subject of the appeal.

(c) [(b)] All information that the appellant wishes the Executive Director to consider shall be presented in writing. The Executive Director may request additional information from the appellant if the Executive Director determines such additional information is necessary to make a decision on the appeal.

(d) [(c)] The Executive Director shall consider the appellant's previously submitted application materials, any further written submissions by the appellant, and other available information. The Executive Director may take into account new information not previously available or submitted, alleged errors in professional judgment, alleged prejudicial procedural errors, or other errors related to the previous determination on Part B or Part C of an application.

(e) [(d)] The Executive Director's decision may reverse the appealed decision in whole or in part, affirm the appealed decision in whole or in part, or resubmit the matter to program staff for further consideration.

(f) [(e)] A written decision on the appeal will be provided to the appellant no more than 60 days after the Executive Director receives an appeal under this rule; provided, however, that if the Executive Director requests additional information from the appellant then the written decision on the appeal will be provided within 60 days of the last materials provided in response to the Executive Director's request.

(g) [(f)] The appellant may request that the Executive Director reconsider the Executive Director's decision on appeal. Such requests must be submitted to the address stated above no more than 30 days following issuance of the decision that is the subject of the request for reconsideration. The Executive Director may accept the request and reconsider the decision or deny the request. Appellants are not entitled to further review after the Executive Director's final decision upon a request for reconsideration.

(h) [(g)] The appeals process established by this rule is not a contested case under Texas Government Code Chapter 2001 and does not grant any right to judicial review.

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601793

Joseph Bell
Executive Director
Texas Historical Commission
Earliest possible date of adoption: June 7, 2026
For further information, please call: (512) 463-6100

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CHAPTER 15. ADMINISTRATION OF
FEDERAL PROGRAMS

13 TAC §15.3

The Texas Historical Commission (Commission) proposes amendments to the Texas Administrative Code, Title 13, Part 2, Chapter 15, §15.3, related to the State Board of Review and National Register. The proposed amendments remove references to the Federal Register; they have changed and could change again in the future, so references to specific rules and sections are suggested to be removed entirely to avoid current and future inaccuracies.

FISCAL NOTE. Joseph Bell, Executive Director, has determined that for the first five-year period the amended rules are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering these rules.

PUBLIC BENEFIT. Mr. Bell has also determined that for the first five-year period the amended rules are in effect, the public benefit will be more accurate information in §15.3.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES, MICROBUSINESSES, AND RURAL COMMUNITIES. Mr. Bell has also determined that there will be no impact on rural communities, small businesses, or micro-businesses as a result of implementing these amendments. Accordingly, no regulatory flexibility analysis, as specified in Texas Government Code §2006.002, is required.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT. There are no anticipated economic costs to persons who are required to comply with the amendments to these rules, as proposed. There is no effect on local economy for the first five years that the proposed amendments are in effect; therefore, no local employment impact statement is required under Texas Government Code §2001.022 and 2001.024(a)(6).

GOVERNMENT GROWTH IMPACT STATEMENT. During the first five years that the amendments would be in effect, the proposed amendments: will not create or eliminate a government program; will not result in the addition or reduction of employees; will not require an increase or decrease in future legislative appropriations; will not lead to an increase or decrease in fees paid to a state agency; will not create a new regulation; will not repeal an existing regulation; and will not result in an increase or decrease in the number of individuals subject to the rule. During the first five years that the amendments would be in effect, the proposed amendments will not positively or adversely affect the Texas economy.

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

PUBLIC COMMENT. Comments on the proposal and as to whether the reasons for initially adopting these rules continue to exist may be submitted to Joseph Bell, Executive Director, Texas Historical Commission, P.O. Box 12276, Austin, Texas 78711. Comments will be accepted for 30 days after publication in the *Texas Register*.

STATUTORY AUTHORITY. These amendments are proposed under the authority of Texas Government Code §442.005(q), which provides the Commission with the authority to promulgate rules to reasonably affect the purposes of the Commission.

CROSS REFERENCE TO OTHER LAW. No other statutes, articles, or codes are affected by these amendments.

§15.3. *State Board of Review/National Register.*

(a) Name. The name of this organization shall be the State Board of Review (hereafter referred to as the "board", "review board", or "board of review") for the National Register of Historic Places, Texas.

(b) Purpose. The purpose of this organization is to review and make recommendations to the state historic preservation officer regarding nominations from Texas to the National Register of Historic Places (hereafter referred to as the "National Register"), and to perform other duties and responsibilities as prescribed in the Federal Register.

(c) Membership. The voting membership of the board of review shall consist of 11 Texas residents. The board shall include one professional in the disciplines of history, prehistoric archeology, and historic archeology, and two professionals each in architectural history and architecture. All professional members shall meet the minimum standards of professional qualifications as set forth in the Federal Register [(Part 36 Code of Federal Regulations Part 61, §61.4(e))] and verified by the state historic preservation officer (state liaison officer). Professionals from closely related fields are eligible to serve on the board of review in lieu of the above specified professionals subject to the approval of the National Park Service. Four citizen members with a demonstrated interest, competence, and knowledge in historic preservation will be selected and shall serve as voting members. Whenever possible, one of these members shall be selected from the appointed representatives from Texas serving as advisors to the National Trust for Historic Preservation.

(d) Appointments. Appointments to the board of review shall be upon recommendation of the State Historic Preservation Officer and confirmed by a majority vote of the Texas Historical Commission (hereafter referred to as the "commission"). The term of office for board of review members shall be two years, with five members to be appointed one year and six to be appointed on alternate years. Terms shall begin October 1. Appointments by the commission to fill vacancies may occur at any time during the year. No member of the board shall be appointed to more than three consecutive terms.

(e) Election and duties of officers. A chairperson, vice-chairperson, and secretary will be elected by the review board annually by a majority vote at the first meeting of each federal fiscal year. The chairperson shall perform such duties as are properly required of him or her by the board. He/she shall have general supervision of the affairs of the board, and shall have authority to interpret and carry out all policies established by its members. The vice-chairperson shall perform such duties as the board or chairperson directs, and shall preside in the absence of the chairperson. The secretary shall certify the minutes of all meetings of the board and shall perform other duties as may be prescribed by the chairperson or board. The secretary shall preside in the absence of both the chairperson and the vice-chairperson. The secretary shall complete an evaluation form for each nomination presented by staff at

each board meeting. The form will become a part of the commission's permanent record of opinions and decisions by the board, and will be filed in the National Register programs office of the commission.

(f) Meetings. Meetings of the board of review shall be held as many times per year as prescribed in the Federal Register [(Part 36 Code of Federal Regulations Part 61, §61.4(e))] pertaining to the National Register. Other meetings may be called by the chairperson as needed. The majority of the membership shall constitute a quorum and the chairperson shall vote only to break a tie. The chairperson may appoint members to committees for specific purposes and committee meetings may be required. Committee reports, if any, shall be given to the full board. If the elected secretary is absent from a board meeting, the chairperson shall appoint a member of the board to serve as the secretary.

(g) Rules. The board of review shall adopt these written procedures as required by the federal guidelines for the National Register as published in the Federal Register [(Part 36 Code of Federal Regulations Part 61, §61.4(e))]. The adoption of, and amendments to, these rules shall be subject to approval and adoption as rules by the commission.

(h) Code of conduct.

(1) No member of the board of review may vote upon the consideration of a property for nomination to the National Register if the member has a conflict of interest, real or potential, in that vote.

(2) A member of the board of review has a conflict of interest in such a vote if there is likely to be a financial benefit from the property being considered to any of the following:

(A) the member of the board of review; or

(B) any person of the member's immediate family, which includes spouse and any minor children; or

(C) a business partner of the member; or

(D) any organization for profit in which the member, or any person of subparagraphs (B) and (C) of this paragraph is serving or is about to serve as an officer, director, trustee, partner, or employee.

(3) A financial benefit includes, but is not limited to, grant money, contract, subcontract, royalty, commission, contingency, brokerage fee, gratuity, favor, or any other things of real or potential value.

(4) A member of the board who has a conflict of interest may not participate as a private citizen in the deliberations concerning the property being considered for nomination to the National Register.

(5) Prior to any deliberations concerning the property in which a member of the board has a conflict of interest, the member with a conflict shall announce, for the record, that such a conflict exists and physically recuse himself/herself from the decision-making process and not vote directly, in absentia, or by proxy in that matter. Review board minutes must indicate which member recused himself/herself and the reasons for the recusal.

(i) Conduct of meetings. Parliamentary authority shall be according to Robert's Rules of Order, Newly Revised, except where specifically provided for otherwise in these rules.

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

Filed with the Office of the Secretary of State on April 24, 2026.
TRD-202601794



CHAPTER 21. HISTORY PROGRAMS SUBCHAPTER B. OFFICIAL TEXAS HISTORICAL MARKER PROGRAM

13 TAC §§21.6, 21.7, 21.9, 21.11, 21.12

The Texas Historical Commission (hereafter referred to as the Commission) proposes amendments to the Texas Administrative Code, Title 13, Part 2, Subchapter B, Chapter 21, §§21.6, 21.7, 21.9, 21.11, and 21.12, related to Official Texas Historical Markers and Recorded Texas Historic Landmarks (RTHLs). Pursuant to Texas Government Code §2001.039, the Texas Historical Commission will assess whether the reason(s) for initially adopting these rules continue to exist. The proposed amendments correct an inaccuracy in §21.6; remove overly specific and redundant language already given in Official Texas Historical Marker procedures and adds the new Historic Texas Freedmen's Cemetery designation to §21.7 and §21.9; and make language more accurate and clear in §21.11 and §21.12.

FISCAL NOTE. Joseph Bell, Executive Director, has determined that for the first five-year period the amended rules are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering these rules.

PUBLIC BENEFIT. Mr. Bell has also determined that for the first five-year period the amended rules are in effect, the public benefit will be more accurate information and clarity in §§21.6, 21.7, 21.9, 21.11, and 21.12.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES, MICROBUSINESSES, AND RURAL COMMUNITIES. Mr. Bell has also determined that there will be no impact on rural communities, small businesses, or micro-businesses as a result of implementing these amendments. Accordingly, no regulatory flexibility analysis, as specified in Texas Government Code §2006.002, is required.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT. There are no anticipated economic costs to persons who are required to comply with the amendments to these rules, as proposed. There is no effect on local economy for the first five years that the proposed amendments are in effect; therefore, no local employment impact statement is required under Texas Government Code §2001.022 and 2001.024(a)(6).

GOVERNMENT GROWTH IMPACT STATEMENT. During the first five years that the amendments would be in effect, the proposed amendments: will not create or eliminate a government program; will not result in the addition or reduction of employees; will not require an increase or decrease in future legislative appropriations; will not lead to an increase or decrease in fees paid to a state agency; will not create a new regulation; will not repeal an existing regulation; and will not result in an increase or decrease in the number of individuals subject to the rule. During the first five years that the amendments would be in effect, the proposed amendments will not positively or adversely affect the Texas economy.

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

PUBLIC COMMENT. Comments on the proposed amendments and whether the reasons for initially adopting these rules continue to exist may be submitted to Joseph Bell, Executive Director, Texas Historical Commission, P.O. Box 12276, Austin, Texas 78711. Comments will be accepted for 30 days after publication in the *Texas Register*.

STATUTORY AUTHORITY. These amendments are proposed under the authority of Texas Government Code §442.005(q), which provides the Commission with the authority to adopt rules that it considers proper for the effective administration of Chapter 442, Texas Government Code.

CROSS REFERENCE TO OTHER LAW. No other statutes, articles, or codes are affected by these amendments.

§21.6. *Recorded Texas Historic Landmark Designation.*

(a) Buildings, structures, and objects as defined in Chapter 26 of this code may be designated as Recorded Texas Historic Landmarks (hereafter referred to as "RTHLs"), provided the following conditions are met:

(1) The property is associated with events that have made a significant contribution to the broad patterns of our history or that are associated with the lives of persons significant in our past;

(2) The property embodies the distinctive characteristics of a type, period, or method of construction, represents the work of a master, possesses high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction;

(3) The property retains integrity at the time of the nomination, as determined by the [executive director of the] commission;

(4) The property, including the buildings, structures, and objects subject to the designation per subsection (b) of this section, is at least 50 years of age; and

(5) The owner(s) of the property at the time of nomination consents to this designation, which runs with the land and remains in effect under all future owners.

(b) At the choice of the legal owner(s) at the time of nomination, designation either applies to all buildings, structures, and objects, and their setting within the legal description of the property; or applies only to the specific buildings, structures, or objects that are the subject of the nomination and does not affect any other buildings, structures, or objects within the legal description of the property. Prior to designation, commission staff will evaluate whether each nominated building, structure, and object meets the criteria for designation and may recommend changes, subject to owner approval.

(c) Evidence of RTHL designation shall be recorded by the commission in the deed records for the county where the RTHL property is located. Designation becomes effective upon recording. RTHLs designated prior to 2020 remain valid based on approval by the commission; however, if the designation is not recorded, Texas Government Code, §442.016 shall not apply.

(d) RTHL designation shall be indicated on the Official Texas Historical Marker installed at the site after the designation has been approved by the commission and recorded. However, RTHL designation

shall be effective until removed by the commission, whether or not the marker remains in place.

(e) Once designated, RTHL properties are subject to provisions of the Texas Government Code, §§442.006(f), 442.011, and 442.016; rules of the commission, including §21.11 of this title (relating to Review of Work on Recorded Texas Historic Landmarks); and other applicable administrative rules.

§21.7. Application Requirements.

(a) Any individual, group or county historical commission may apply to the commission for an Official Texas Historical Marker. The application shall include:

(1) a completed current Official Texas Historical Marker application [form];

(2) supporting documentation as provided in program guidelines, criteria and procedures adopted by the commission; and

(3) an application fee approved by the commission [in the amount of \$100].

(b) Historic Texas Cemetery and Historic Texas Freedmen's Cemetery markers. A marker, medallion or plaque may be awarded to a cemetery only if the commission has designated the cemetery as an Historic Texas Cemetery or a Historic Texas Freedmen's Cemetery. See §22.6 of this title (relating to Historic Texas Cemeteries) for information concerning Historic Texas Cemetery and Historic Texas Freedmen's Cemetery designations [designation]. Historic Texas Cemetery and Historic Texas Freedmen's Cemetery name and date plaque applications are accepted year-round. The marker should [must] be located either at or immediately adjacent to the designated cemetery. In cases where the cemetery is not publicly accessible, the commission will coordinate with the County Historical Commission (CHC) and sponsor to determine an appropriate location for the marker.

(c) [The following procedures shall be observed for the marker application process.] Potential sponsors should check the commission web site at www.thc.texas.gov for current information on the Official Texas Historical Marker Program's marker application procedures [Program].

[(1) The sponsor must contact the county historical commission (CHC) to obtain a marker application form, to review basic program requirements and to discuss the county's review process and procedures, which differ from county to county. The commission does not mandate a specific review process at the county level, so the sponsor will need to work closely with the CHC to be sure all local concerns and procedures are addressed properly. The CHCs cannot send the application forward until they can certify that the history and the application have been adequately reviewed. Applications for Recorded Texas Historic Landmarks (RTHL) for sites located on private land must include written owner consent of the landowner.]

[(2) CHC reviews the marker application for accuracy and significance, and either approves the application or works with the sponsor to develop additional information as necessary.]

[(3) CHC-approved applications are forwarded to the History Programs Division of the commission. Once the application is received by the commission, additional notifications and correspondence will be between the CHC contact and the commission staff contact only, unless otherwise noted.]

[(4) Commission staff makes a preliminary assessment to determine if the topic is eligible for review and if all required elements are included. The commission will notify the applicant through the CHC once the application has been received.]

[(5) A \$100 application fee is due within ten days upon notification of receipt.]

[(6) Additional information may be requested via email. Failure to provide all requested materials as instructed will result in cancellation of the application.]

[(7) Commission staff and commissioners review applications and determine:]

[(A) eligibility for approval;]

[(B) size and type of marker for each topic; and]

[(C) priorities for work schedule on the approved applications.]

[(8) CHC and sponsor will be notified via email of approval and provided a payment form for the casting of the marker.]

[(9) The payment must be received in commission offices within 45 days or the application will be cancelled.]

[(10) Commission staff will write the marker inscription. One review copy will be provided via email to the CHC contact only for local distribution as needed. Inscription review is for accuracy of content only; the commission determines the content, wording, punctuation, phrasing, etc.]

[(A) Upon approval of the inscription, the CHC contact provides additional copies as necessary for committee, commission, or sponsor review and conveys a single response to the commission.]

[(B) Upon receipt of emailed approval by the CHC, the commission proceeds with the order.]

[(C) If changes recommended by the CHC are approved by the commission, staff will send a revised copy for content review. Because inscription reviews are for content only, only two reviews should be necessary to complete this step of the process. Additional requests for revisions are subject to approval by the commission, which will be the sole determiner of warranted requests for changes. Excessive requests for change, or delays in response, may, in the determination of the commission, result in cancellation of the order.]

[(D) Only the authorized CHC contact - chair or marker chair - can make the final approval of inscriptions at the county level. Final approval will be construed by the commission to mean concurrence by any interested parties, including the sponsor.]

[(11) After final approval, the order is sent to marker supplier for manufacturing. Subject to the terms of the commission vendor contract, only authorized commission staff may contact the manufacturer relative to any aspect of Official Texas Historical Markers, including those in process or previously approved.]

[(12) Commission staff reviews galley proofs of markers. With commission approval, manufacturing process proceeds. Manufacturer inspects, crates and ships completed markers and notifies commission, which in turn notifies CHC contact.]

[(13) With shipment notice, planning can begin on marker dedication ceremony, as needed, in conjunction with CHC, sponsors and other interested parties.]

[(14) Information on planning and conducting marker ceremonies is provided by the commission through its web site.]

[(15) Once the planning is complete, the CHC posts the information to the commission web site calendar.]

~~[(16) Commission staff enters marker information into the Texas Historic Sites Atlas at website atlas.the.texas.gov, an online inventory of marker information and inscriptions.]~~

(d) Application content.

(1) Each marker application must address the criteria specified in §21.9 of this title (relating to Applications Evaluation Procedures) in sufficient detail to allow the commission to judge the merit of the application.

(2) Documentation. Each marker application must contain sufficient documentation to verify the assertions about the above criteria. If the claims in the application cannot be verified through documentation, the application will be rejected.

(e) Limitation of markers awarded.

(1) The commission will set a numerical limit on the number of markers that will be approved annually.

(2) No markers in excess of the limit may be approved except by vote of the commission to amend the limit.

§21.9. *Application Evaluation Procedures.*

(a) The commission adopts the following criteria governing evaluation for approval or rejection of applications for Official Texas Historical Markers, Recorded Texas Historic Landmark [Landmarks] (RTHL [RTHLs]) designations, or Historic Texas Cemetery (HTC) and Historic Texas Freedmen's Cemetery (HTFC) designations.

(1) Age: Structures eligible for the RTHL designation and marker must be at least 50 years old. Older structures may be awarded additional weight in evaluation and scoring.

(2) Historical significance/Architectural Significance: The Texas Historical Commission's Division of Architecture evaluates applications for RTHL designations, which are awarded to properties which demonstrate architectural and historical significance and architectural and historical integrity. [~~Architectural significance alone is not enough to qualify a structure for the RTHL designation. It must have an equally significant historical association, and that association can come from an event that occurred at the site; through individuals who owned or lived on the property; or, in the case of bridges, industrial plants, schoolhouses and other non-residential properties, through documented significance to the larger community. Structures deemed architecturally significant are outstanding examples of architectural history through design, materials, structural type or construction methods. In all cases, eligible architectural properties must display integrity; that is, the structure should be in a good state of repair, maintain its appearance from its period of significance and be considered an exemplary model of preservation. Architectural significance is often best determined by the relevance of the property to broader contexts, including geography. Any changes over the years should be compatible with original design and reflect compliance with accepted preservation practices, e.g., the Secretary of the Interior's Standards for Rehabilitation.~~]

(3) State of repair/Integrity: Structures not considered by the commission to be in a good state of repair are not eligible for RTHL designation. The commission reserves the sole right to make that determination relative to eligibility for RTHL markers. [~~Subject marker topics placed at the appropriate site help maintain site integrity. Topics properly documented and understood by the public also help maintain a high degree of integrity.~~]

(4) Diversity of topic for addressing gaps in historical marker program. This criterion addresses the extent to which topic relates to an aspect or area of Texas history that has not been well represented by the marker program.

(5) Value of topic as an untold or untold aspect of Texas history. This criterion addresses the extent to which topic addresses untold facets of Texas history and increases the diversity of history and cultures interpreted through the marker program.

(6) Endangerment level of property, site or topic. This criterion addresses the extent to which the property (RTHLs), site or story is in danger of being lost if its history and significance are not documented through the marker program.

(7) Available documentation and resources. This criterion addresses the quality and balance of the research and documentation for the application.

(8) Diversity among this group of candidates. This criterion addresses the extent to which this topic represents an untold story of Texas history among the applications received during that year's marker cycle.

(9) Relevance to other commission programs. This criterion addresses the extent to which the topic coordinates with other significant programs and initiatives of the agency.

(10) Relevance to the commission's current thematic priorities. This criterion addresses the extent to which the topic coordinates with the thematic priorities set by the commission [~~each year (varies by year)~~].

(11) For Historic Texas Cemetery (HTC) and Historic Texas Freedmen's Cemetery (HTFC) markers, cemetery designation must be recorded before submitting the application for an Official Texas Historical Marker (OTHM).

(b) Applications and topics with exceptional significance directly address established statewide themes, promote untold stories of Texas history and have exceptional ability to educate the public on aspects of Texas history not fully addressed by the marker program. Applications and topics with high significance address statewide themes, promote untold stories of Texas history and have some ability to educate the public on aspects of Texas history not fully addressed by the marker program. Applications and topics that meet requirements have been found to fulfill the basic application requirements and guidelines, relate to statewide themes but do not necessarily directly address topics that have not been widely addressed by the marker program. Applications and topics deemed not eligible do not relate to statewide themes and/or do not meet the basic program application requirements and guidelines. All markers must relate to the statewide themes established by the commission. These themes are available on the commission's web site at www.thc.texas.gov. The [~~From time to time the~~] commission may establish thematic priorities for the marker program. Additional points will be awarded to projects falling within these priorities.

(c) The scoring system for ranking applications is provided in the Official Texas Historical Marker Program's marker application procedures, available on the commission web site at www.thc.texas.gov. [as follows:]

~~[(1) Age - 5 pts. max;]~~

~~[(2) Historical Significance/Architectural Significance - 10 pts. max;]~~

~~[(3) State of Repair/Integrity - 10 pts. max;]~~

~~[(4) Diversity of topic for addressing gaps in historical marker program - 10 pts. max;]~~

~~[(5) Value of topic as an untold or untold aspect of Texas history - 15 pts. max;]~~

- max;] {(6) Endangerment level of property, site or topic - 10 pts.
- max;] {(7) Available documentation and resources - 10 pts.
- max;] {(8) Diversity among this group of candidates - 10 pts.
- and] {(9) Relevance to other commission programs - 5 pts.
- max;] {(10) Relevance to the commission's current thematic priorities - 15 pts.

§21.11. *Review of Work on Recorded Texas Historic Landmarks.*

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless context clearly indicates otherwise.

(1) Damage--To alter, in whole or in part. Damage to historical or architectural integrity includes alterations of structural elements, decorative details, fixtures, and other material; construction of additions; relocation; or demolition.

(2) Integrity--Integrity refers to the physical condition and therefore the capacity of the resource to convey a sense of time and place. Integrity is the authenticity of a property's historic identity, evidenced by the survival of physical characteristics that existed during the property's historic or prehistoric period, including the property's location, design, setting, materials, workmanship, feeling, and association. In terms of architectural design, to have integrity means that a building still possesses much of its mass, scale, decoration, and so on, of either the period in which it was conceived and built, or the period in which it was adapted to a later style which has validity in its own rights as an expression of historical character or development. The question of whether or not a building possesses integrity is a question of the building's retention of sufficient fabric to be identifiable as a historic resource. For a building to possess integrity, its principal features must be sufficiently intact for its historic identity to be apparent. A building that is significant because of its historic association(s) must retain sufficient physical integrity to convey such association(s).

(3) Normal maintenance and repair--Work that does not have the potential to cause removal, damage or alteration to the integrity, form, or appearance of the materials, features, or landform of the historic building or structure and its site, is considered to be normal maintenance and repair. Cleaning surfaces with non-corrosive mild solutions and low-pressure water, repainting window frames or doorways with similar paints, or minor repairs such as replacing putty on windows are examples of normal maintenance and repair. Other work, however, may not constitute normal maintenance and repair. For example, permanent masonry damage can result from use of inappropriate cleaning methods, such as sandblasting, high pressure water cleaning, or the use of unsuitable chemicals, or from use of damaging repointing techniques and materials. Replacing historic windows damages the historical integrity of a building, and painting previously unpainted surfaces constitutes alteration. Such work is not considered normal maintenance or repair.

(b) Procedure. As provided for in Texas Government Code, §442.006(f), a person may not damage the historical or architectural integrity of a structure the commission has designated as a Recorded Texas Historic Landmark (landmark) without first notifying the commission. Such notice shall not be required for normal maintenance and repair; for interior work that does not affect the exterior integrity of the property; or for work to the surrounding site unless included as part of the designated landmark.

(1) Notice from the property owner to the commission. At least 60 days prior to the proposed work on a landmark, a written notification from the property owner describing the project shall be submitted to the commission, along with construction documents, sketches, or drawings which adequately describe the full scope of project work and photographs of the areas affected by the proposed changes. Receipt by the commission shall constitute the date notice is given.

(2) Notice from the commission to the property owner. Written notice of the commission's comments pursuant to a review of the proposed work shall be provided by the commission. Comments shall be made based on the Secretary of the Interior's Standards for the Treatment of Historic Properties (1995 and subsequent revisions; codified at 36 Code of Federal Regulations Part 67), which are summarized in subparagraphs (A) - (C) of this paragraph:

(A) Definitions for historic preservation project treatment.

(i) Preservation is defined as the act or process of applying measures necessary to sustain the existing form, integrity, and materials of an historic property. Work, including preliminary measures to protect and stabilize the property, generally focuses upon the ongoing maintenance and repair of historic materials and features rather than extensive replacement and new construction. New exterior additions are not within the scope of this treatment; however, the limited and sensitive upgrading of mechanical, electrical, and plumbing systems and other code-required work to make properties functional is appropriate within a preservation project.

(ii) Rehabilitation is defined as the act or process of making possible a compatible use for a property through repair, alterations, and additions while preserving those portions or features which convey its historical, cultural, or architectural values.

(iii) Restoration is defined as the act or process of accurately depicting the form, features, and character of a property as it appeared at a particular period of time by means of the removal of features from other periods in its history and reconstruction of missing features from the restoration period. The limited and sensitive upgrading of mechanical, electrical, and plumbing systems and other code-required work to make properties functional is appropriate within a restoration project.

(iv) Reconstruction is defined as the act or process of depicting, by means of new construction, the form features, and detailing of a non-surviving site, landscape, building, structure, or object for the purpose of replicating its appearance at a specific period of time and in its historic location.

(B) General standards for historic preservation projects.

(i) A property shall be used as it was historically, or be given a new use that maximizes the retention of distinctive materials, features, spaces, and spatial relationships. Where a treatment and use have not been identified, a property shall be protected and, if necessary, stabilized until additional work may be undertaken.

(ii) The historic character of a property shall be retained and preserved. The replacement of intact or repairable historic materials or alteration of features, spaces, and spatial relationships that characterize a property shall be avoided.

(iii) Each property shall be recognized as a physical record of its time, place and use. Work needed to stabilize, consolidate, and conserve existing historic materials and features shall be physically and visually compatible, identifiable upon close inspection, and properly documented for future research.

(iv) Changes to a property that have acquired historic significance in their own right shall be retained and preserved.

(v) Distinctive materials, features, finishes, and construction techniques or examples of craftsmanship that characterize a property shall be preserved.

(vi) The existing condition of historic features shall be evaluated to determine the appropriate level of intervention needed. Where the severity of deterioration requires repair or limited replacement of a distinctive feature, the new material shall match the old in composition, design, color, and texture.

(vii) Chemical or physical treatments, if appropriate, shall be undertaken using the gentlest means possible. Treatments that cause damage to historic materials shall not be used.

(viii) Archeological resources shall be protected and preserved in place to the extent possible. If such resources must be disturbed, mitigation measures shall be undertaken.

(C) Specific standards for historic preservation projects. In conjunction with the eight general standards listed in subparagraph (B)(i) - (viii) of this paragraph, specific standards are to be used for each treatment type.

(i) Standards for rehabilitation.

(I) A property shall be used as it was historically or be given a new use that requires minimal change to its distinctive materials, features, spaces, and spatial relationships.

(II) The historic character of a property shall be retained and preserved. The removal of distinctive materials or alteration of features, spaces, and spatial relationships that characterize a property shall be avoided.

(III) Each property shall be recognized as a physical record of its time, place, and use. Changes that create a false sense of historical development, such as adding conjectural features or elements from other historic properties, shall not be undertaken.

(IV) Changes to a property that have acquired historic significance in their own right shall be retained and preserved.

(V) Distinctive materials, features, finishes, and construction techniques or examples of craftsmanship that characterize a property shall be preserved.

(VI) Deteriorated historic features shall be repaired rather than replaced. Where the severity of deterioration requires replacement of a distinctive feature, the new feature shall match the old in design, color, texture, and where possible, materials. Replacement of missing features shall be substantiated by documentary and physical evidence.

(VII) Chemical or physical treatments, if appropriate, shall be undertaken using the gentlest means possible. Treatments that cause damage to historic materials shall not be used.

(VIII) Archeological resources shall be protected and preserved in place to the extent possible. If such resources must be disturbed, mitigation measures shall be undertaken.

(IX) New additions, exterior alterations, or related new construction shall not destroy historic materials, features, and spatial relationships that characterize the property. The new work shall be differentiated from the old and shall be compatible with the historic materials, features, size, scale and proportion, and massing to protect the integrity of the property and its environment.

(X) New additions and adjacent or related new construction shall be undertaken in such a manner that, if removed in the future, the essential form and integrity of the historic property and its environment would be unimpaired.

(ii) Standards for restoration.

(I) A property shall be used as it was historically or be given a new use which reflects the property's restoration period.

(II) Materials and features from the restoration period shall be retained and preserved. The removal of materials or alteration of features, spaces, and spatial relationships that characterize the period shall not be undertaken.

(III) Each property shall be recognized as a physical record of its time, place and use. Work needed to stabilize, consolidate and conserve materials and features from the restoration period shall be physically and visually compatible, identifiable upon close inspection, and properly documented for future research.

(IV) Materials, features, spaces, and finishes that characterize other historical periods shall be documented prior to their alteration or removal.

(V) Distinctive materials, features, finishes, and construction techniques or examples of craftsmanship that characterize the restoration period shall be preserved.

(VI) Deteriorated features from the restoration period shall be repaired rather than replaced. Where the severity of deterioration requires replacement of a distinctive feature, the new feature shall match the old in design, color, texture, and, where possible, materials.

(VII) Replacement of missing features from the restoration period shall be substantiated by documentary and physical evidence. A false sense of history shall not be created by adding conjectural features, features from other properties, or by combining features that never existed together historically.

(VIII) Chemical or physical treatments, if appropriate, shall be undertaken using the gentlest means possible. Treatments that cause damage to historic materials shall not be used.

(IX) Archeological resources affected by a project shall be protected and preserved in place to the extent possible. If such resources must be disturbed, mitigation measures shall be undertaken.

(X) Designs that were never executed historically shall not be constructed.

(iii) Standards for reconstruction.

(I) Reconstruction shall be used to depict vanished or non-surviving portions of a property when documentary and physical evidence is available to permit accurate reconstruction with minimal conjecture, and such reconstruction is essential to the public understanding of the property.

(II) Reconstruction of a landscape, building, structure, or object in its historic location shall be preceded by a thorough archeological investigation to identify and evaluate those features and artifacts which are essential to an accurate reconstruction. If such resources must be disturbed, mitigation measures shall be undertaken.

(III) Reconstruction shall include measures to preserve any remaining historic materials, features, and spatial relationships.

(IV) Reconstruction shall be based on the accurate duplication of historic features and elements substantiated by documentary or physical evidence rather than on conjectural designs or the availability of different features from other historic properties. A reconstructed property shall re-create the appearance of the non-surviving historic property in materials, design, color, and texture.

(V) A reconstruction shall be clearly identified as a contemporary re-creation.

(VI) Designs that were never executed historically shall not be constructed.

(3) If the proposed work meets the Secretary of the Interior's Standards for the Treatment of Historic Properties, the commission may waive the remainder of the 60-day waiting period described in paragraph (1) of this subsection. If the proposed work does not meet these standards or otherwise would damage the integrity of the landmark, the commission may require an additional waiting period of no longer than 30 days, for a total of up to 90 days from the date notice was given. The waiting period is intended to enhance the chance for preservation, and the commission may negotiate with the property owner during this period. On the expiration of the time limits imposed in the commission's response, the work may proceed, but must proceed not later than the 180th day after the date on which notice was given or the notice is considered to have expired.

§21.12. Marker Text Requests.

(a) A request for a review of the text of any Official Texas Historical Marker (OTHM) that is the property of the State of Texas and which falls under the jurisdiction of the Texas Historical Commission ("Commission") may be submitted to dispute the factual accuracy of the OTHM based on verifiable, historical evidence that the marker, at the time of casting:

- (1) Includes the spelling of a name of an individual or organization that was not used historically [is not spelled correctly];
- (2) Includes a date that is not historically accurate; or
- (3) Includes a statement that is not historically accurate.];
or]
- ~~(4) Has been installed at the wrong location.]~~

(b) A request for review of OTHM text shall be submitted on a form provided by the Commission for that purpose, accompanied by no more than 10 single-sided pages of supplemental material printed in a font size no smaller than 11.

(c) OTHM review requests shall be submitted to the Commission at 1511 Colorado St., Austin, Texas 78701; by mail to P.O. Box 12276, Austin, Texas 78711; or by email to thc@thc.texas.gov. The Commission will send a copy of the request and supporting materials to the County Historical Commission (CHC) for the county in which the OTHM is located, return receipt requested. In the absence of a formally established [formally-established] CHC, a copy will be submitted to the county judge, return receipt requested.

(d) The CHC or county judge shall have 10 business days from the date of receipt of the request to submit a response to the Commission if they wish to do so. The CHC's or county judge's response shall consist of not more than 10 single-sided pages of material printed in a font size no smaller than 11 and shall be signed by the chair of the CHC or, in the absence of a formally established CHC, by the county judge.

(e) Within 20 days of receiving the CHC's or county judge's response to the request, or within 30 days of receiving the request itself if there is no CHC or county judge response, the staff at the Commission shall review the information submitted and respond to the requestor and

to the CHC or county judge with the staff recommendation in writing, return receipt requested.

(f) During the period previously referred to in Section (e) of this section, Commission staff may choose to refer the request to a panel of professional historians for a recommendation.

(g) The panel will consist of three professional historians:

(1) the State Historian appointed by the Governor pursuant to Texas Government Code Section 3104.051;

(2) the historian appointed by the Governor to serve on the Commission pursuant to Texas Government Code Section 442.002; and

(3) a professional historian selected by these two historians from the faculty of a public college or university upon receiving the request. If no professional historian has been appointed by the Governor to serve on the Commission, the Governor's appointed chair of the Commission or the chair's designee will serve on the panel in place of that individual.

(h) In reaching its decision, the panel will review the same information reviewed by the staff, as well as any additional information provided by staff, which shall be no more than 10 single-sided pages of supplemental material printed in a font size no smaller than 11. The panel shall be chaired by the State Historian who shall determine whether the panel will meet in person or deliberate through electronic or other means.

(i) The panel shall develop a written recommendation supported by at least two of its members. The written recommendation of the panel will be delivered to the Commission staff no later than 30 days following the panel's receipt of the background materials as provided above. If the panel is unable to develop such a recommendation, the panel chair shall so report in writing to the Commission's staff within the same 30-day period. Commission staff will consider the panel's report and send their final recommendation to the requestor and to the CHC or county judge within 15 days after receiving the panel's report, return receipt requested.

(j) If the requestor, or the County Historical Commission or county judge are not satisfied with the staff recommendation, they may choose to file an objection with the Commission's History Programs Committee ("Committee"). Such objections must be postmarked no later than 5 days following receipt of the staff recommendation. If no such objection is filed, the staff or panel recommendation with accompanying marker text revisions will be placed on the next consent agenda of the Texas Historical Commission for approval.

(k) Review of objections filed with the Committee shall be based on copies of the same information as was initially provided to the panel of historians under section (g) above. If the matter was not submitted to the panel of historians, the objection shall be based on the material previously submitted by the requestor or requestors and CHC or county judge to the marker staff under sections (b) and (d) above, and on any additional information provided by marker staff, which shall be no more than 10 single-sided pages of supplemental material printed in a font size no smaller than 11.

(l) The Committee shall include the objection on the agenda of its next scheduled meeting, assuming said meeting happens at least 20 days after the objection is received by the Commission. If the 20-day deadline is not met, the objection shall be on the agenda of the following meeting of the Committee.

(m) The Committee may choose to take public testimony on the objection, or not. If public testimony is invited, such testimony

may be limited by the Committee chair to a period of time allocated per speaker, per side (pro and con) or both.

(n) The decision of the Committee, along with any recommendation from staff and/or the panel, shall be placed on the consent agenda of the full Commission for approval.

(o) If a request or objection is approved by the Commission, the existing marker will be replaced or another option provided at no cost to the requestor, subject to the availability of funds for that purpose. [~~If such funds are not readily available, a supplemental marker may serve in the interim.~~]

(p) With all approved requests or objections, Commission staff will write the replacement text. Markers will be produced by the contracted foundry and production will be subject to the foundry's schedule.

(q) The Commission will not accept subsequent requests or objections that are substantively similar to a request or objection that is already going through or has already gone through this request process. A decision not to accept a request or objection under this section may be made by the Executive Director.

(r) A request for review may only be filed against a single marker, and no individual or organization may file more than one request for review per calendar year.

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601795

Joseph Bell

Executive Director

Texas Historical Commission

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 463-6100



TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 111. SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

The Texas Department of Licensing and Regulation (Department) proposes amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 111, at Subchapter A, §111.2; Subchapter B, §111.12 and §111.13; Subchapter F, §111.50 and §111.55; Subchapter H, §111.70; and Subchapter W, §111.220, regarding the Speech-Language Pathologist and Audiologist program. These proposed changes are referred to as the "proposed rules."

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 111, implement Texas Occupations Code, Chapter 401, Speech-Language Pathologist and Audiologist.

The proposed rules are necessary to implement the statutory changes made by the 89th Legislature, Regular Session. Specifically, the proposed rules implement Senate Bill (SB) 904, Sec-

tion 1, SB 905, Sections 1, 2, 3, and 4, and SB 2075, Sections 9 and 10, by the 89th Legislature, Regular Session (2025). The proposed rules also include changes suggested by Departmental divisions during the four-year rule review of Chapter 111, including the Licensing division and Compliance division.

The proposed rules remove language that would require the six-year terms of three members of the advisory board to expire on February 1 of each odd-numbered year and change the advisory board's presiding officer's term from one year to two years, allowing the advisory board member to serve their full six-term, regardless of when appointed.

The proposed rules eliminate the definition of "Provisional Licensee," as provisional licenses are no longer needed now that the jurisprudence exam is always available. They also remove requirements for speech-language pathology (SLP) assistant applicants to submit verification of 25 clinical observation hours and 25 clinical assisting hours to the Department, as well as the requirement to complete any missing hours under direct supervision after licensure. Additionally, the rules renumber §111.55(b)(1) - (8).

The proposed rules amend the existing clinical observation and experience requirements for SLP assistants to require that verification of their 25 hours of clinical observation and 25 hours of clinical assisting experience are submitted to the assistant's supervisor upon license issuance. The proposed rules also reorganize the requirements of §111.50(d) and §111.50(e) in a more logical manner.

The proposed rules allow audiology license applicants to qualify with a master's degree in audiology awarded on or before December 31, 2007. Applicants awarded the equivalent of a master's degree in audiology from a foreign university on or before December 31, 2007, must also obtain an evaluation showing their degree is equivalent to a degree from an accredited U.S. program. The rules also repeal the requirement that the Texas Commission of Licensing and Regulation adopt rules for selling hearing instruments with input from both the Speech-Language Pathologist and Audiologist Advisory Board and the Hearing Instrument Fitters and Dispensers Advisory Board.

Advisory Board Recommendations

The proposed rules were presented to and discussed by the Speech-Language Pathologists and Audiologists Advisory Board at its meeting on March 23, 2026. The Advisory Board did not make any changes to the proposed rules. The Advisory Board voted and recommended that the proposed rules be published in the *Texas Register* for public comment.

SECTION-BY-SECTION SUMMARY

Subchapter A. General Provisions

The proposed rules amend §111.2. Definitions. The proposed rules repeal the definition of "Provisional Licensee." Provisional licenses for Speech-Language Pathologists and Audiologists originated when the jurisprudence exam was offered only a few times a year, allowing individuals to work while waiting to take it. Now, the jurisprudence exam is accessible year-round, making such provisional licenses unnecessary.

Subchapter B. Speech-Language Pathologists and Audiologists Advisory Board

The proposed rules amend §111.12, Terms; Vacancies. The proposed rules under subsection (a) remove language that

would require the six-year terms of three members of the advisory board to expire on February 1 of each odd-numbered year.

The proposed rules amend §111.13, Officers. The proposed rules under subsection (a) change the advisory board's presiding officer's term from one year to two years.

Subchapter F. Requirements for Assistant in Speech-Language Pathology License

The proposed rules add new rules to §111.50, Assistant in Speech-Language Pathology License--Licensing Requirements--Education and Clinical Observation and Experience. Specifically, the new rules modify §111.50(d), Clinical Observation and Experience.

The proposed rules add new §111.50(d)(2), which requires that if any of the 25 hours of clinical observation and 25 hours of clinical assisting experience required for licensure as a SLP assistant were earned during training, then this verification must be submitted to the assistant's supervisor after the license is issued.

The proposed rules also amend §111.50, Assistant in Speech-Language Pathology License--Licensing Requirements--Education and Clinical Observation and Experience. Specifically, the proposed rules amend §111.50(d)(1) to clarify that the requirements of §111.50(d)(1) are prescribed by §111.50(d), not §111.50(e).

Also, the proposed rules reorganize the requirements of §111.50(d) and §111.50(e) in a more logical manner. Specifically, the proposed rules move former §111.50(e) to §111.50(d)(3), move former §111.50(e)(1) to §111.50(d)(3)(A), move former §111.50(e)(2) to §111.50(d)(3)(B), and move former §111.50(d)(2) to §111.50(e).

The proposed rules amend §111.55, Assistant in Speech-Language Pathology License--Application and Eligibility Requirements.

The proposed rules repeal subsection (b)(5) and remove the requirement that applicants for licensure as an assistant in speech-language pathology must provide the Department verification from their university program that the applicant completed 25 hours of clinical observation and 25 hours of clinical assisting experience.

The proposed rules repeal subsection (b)(6) and remove the requirement that applicants who did not obtain all 25 hours of clinical observation and 25 hours of clinical assisting experience complete those hours under direct supervision by an approved supervisor after the license is issued.

Finally, the proposed rules renumber §111.55(b)(1) - (8).

Subchapter H. Requirements for Audiology License

The proposed rules amend §111.70, Audiology License--Licensing Requirements. The proposed rules under subsection (b) now authorize an applicant seeking licensure as an audiologist to qualify if the applicant possesses a master's degree in audiology conferred on or before December 31, 2007.

The proposed rule of subsection (d) now require an applicant who earned a master's degree in audiology at a foreign university on or before December 31, 2007 to hire a transcript evaluation service to determine the applicant's degree is the equivalent of a degree obtained from a program accredited by a national accrediting organization approved by the commission or department and recognized by the United States secretary of education

under the Higher Education Act of 1965 (20 U.S.C. Section 1001 et seq.).

Finally, the proposed rules renumber §111.70(e) and (f).

Subchapter W. Joint Rule Regarding the Sale of Hearing Instruments

The proposed rules amend §111.220, Requirements Regarding the Sale of Hearing Instruments. The proposed rules under subsection (a) repeal the requirement that the TDLR Commission adopt rules governing the sale of hearing instruments with the assistance of both the Speech-Language Pathologist and Audiologist Advisory Board and the Hearing Instrument Fitters and Dispensers Advisory Board.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Tony Couvillon, Senior Policy Research and Budget Analyst, has determined that for each year of the first five years the proposed rules are in effect, there are no estimated additional costs or reductions in costs to state or local government as a result of enforcing or administering the proposed rules.

Tony Couvillon, Senior Policy Research and Budget Analyst, has determined that for each year of the first five years the proposed rules are in effect, there is no estimated increase or loss in revenue to the state or local government as a result of enforcing or administering the proposed rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

Because Mr. Couvillon has determined that the proposed rules will not affect a local economy, the agency is not required to prepare a local employment impact statement under Texas Government Code §2001.022.

PUBLIC BENEFITS

Mr. Couvillon also has determined that for each year of the first five-year period the proposed rules are in effect, the proposed rules will benefit speech language pathologists who graduated with a master's degree in audiology before 2008, if they choose to enter the workplace or move to Texas, since there were no doctorate programs available prior to that time. Previously, when individuals would come to the state or re-enter the workforce after an absence, they would have to request TDLR's executive director to approve an individual waiver. The proposed rules also eliminate an obsolete license type and streamline the process for speech-language pathology assistants to gain clinical observation and clinical assisting experience hours once licensed, thereby reducing bureaucracy. These rule changes eliminate confusion, allowing for a more efficient application process for both the applicant and staff.

PROBABLE ECONOMIC COSTS TO PERSONS REQUIRED TO COMPLY WITH PROPOSAL

Mr. Couvillon has determined that for each year of the first five-year period the proposed rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules.

FISCAL IMPACT ON SMALL BUSINESSES, MICRO-BUSINESSES, AND RURAL COMMUNITIES

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities as a result of the proposed rules. Because the agency has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities,

preparation of an Economic Impact Statement and a Regulatory Flexibility Analysis, as detailed under Texas Government Code §2006.002, is not required.

ONE-FOR-ONE REQUIREMENT FOR RULES WITH A FISCAL IMPACT

The proposed rules do not have a fiscal note that imposes a cost on regulated persons, including another state agency, a special district, or a local government. Therefore, the agency is not required to take any further action under Texas Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Texas Government Code §2001.0221, the agency provides the following Government Growth Impact Statement for the proposed rules. For each year of the first five years the proposed rules will be in effect, the agency has determined the following:

1. The proposed rules do not create or eliminate a government program.
2. Implementation of the proposed rules does not require the creation of new employee positions or the elimination of existing employee positions.
3. Implementation of the proposed rules does not require an increase or decrease in future legislative appropriations to the agency.
4. The proposed rules do not require an increase or decrease in fees paid to the agency.
5. The proposed rules do not create a new regulation.
6. The proposed rules expand, limit, or repeal an existing regulation.

Mr. Couvillon has determined that the proposed rules expand an existing regulation by authorizing an applicant for an audiology license who graduated with a master's degree in audiology before 2008 to qualify for licensure and also clarifying the requirements for foreign graduates of that time period.

Mr. Couvillon has also determined that the proposed rules repeal an existing regulation by removing the requirement for speech language pathology assistant applicants to submit a clinical deficiency form under certain conditions, and to submit verification of clinical observation and clinical assisting experience hours to the speech-language pathology assistant's supervisor instead of submitting to TDLR.

Mr. Couvillon has also determined that the proposed rules eliminate an existing regulation by eliminating the provisional license type.

Mr. Couvillon has also determined that the proposed rules limit an existing regulation by removing the requirement that all rulemakings for this chapter be reviewed by the Hearing Instrument Fitters and Dispensers Advisory Board.

7. The proposed rules do not increase or decrease the number of individuals subject to the rules' applicability.
8. The proposed rules do not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

The Department has determined that no private real property interests are affected by the proposed rules and the proposed rules

do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rules do not constitute a taking or require a takings impact assessment under Texas Government Code §2007.043.

PUBLIC COMMENTS AND INFORMATION RELATED TO THE COST, BENEFIT, OR EFFECT OF THE PROPOSED RULES

The Department is requesting public comments on the proposed rules and information related to the cost, benefit, or effect of the proposed rules, including any applicable data, research, or analysis. Any information that is submitted in response to this request must include an explanation of how and why the submitted information is specific to the proposed rules. Please do not submit copyrighted, confidential, or proprietary information.

Comments on the proposed rules and responses to the request for information may be submitted electronically on the Department's website at https://ga.tdlr.texas.gov:1443/form/SLPA_Rule_Making; by facsimile to (512) 475-3032; or by mail to Monica Nuñez, Legal Assistant, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711. The deadline for comments is 30 days after publication in the *Texas Register*.

SUBCHAPTER A. GENERAL PROVISIONS

16 TAC §111.2

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 401, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 401. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), Senate Bill 905, 89th Legislature, Regular Session (2025), and Senate Bill No. 2075, 89th Legislature, Regular Session (2025).

§111.2. Definitions.

Unless the context clearly indicates otherwise, the following words and terms must have the following meanings.

(1) - (30) (No change.)

~~[(31) Provisional Licensee--An individual granted a provisional license under Texas Occupations Code §401.308.]~~

(31) ~~[(32)]~~ Sale--The term includes a lease, rental, or any other purchase or exchange for value. The term does not include a sale at wholesale by a manufacturer to a person licensed under the Act or to a distributor for distribution and sale to a person licensed under the Act.

(32) ~~[(33)]~~ Speech-language pathologist--An individual who holds a license under Texas Occupations Code §401.302 and §401.304, to practice speech-language pathology.

(33) ~~[(34)]~~ Speech-language pathology--The application of nonmedical principles, methods, and procedures for measurement, testing, evaluation, prediction, counseling, habilitation, rehabilitation, or

instruction related to the development and disorders of communication, including speech, voice, language, oral pharyngeal function, or cognitive processes, for the purpose of evaluating, preventing, or modifying or offering to evaluate, prevent, or modify those disorders and conditions in an individual or a group.

(34) [(35)] Supervisor--An individual who holds a license under Texas Occupations Code §401.302 and §401.304 and whom the department has approved to oversee the services provided by the assigned assistant and/or intern. The term "supervisor" and "department-approved supervisor" have the same meaning as used throughout this chapter.

(35) [(36)] Telehealth--See definition(s) in Subchapter V, Telehealth.

(36) [(37)] Tele-supervision--Supervision of interns or assistants that is provided remotely using telecommunications technology.

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601788

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER B. SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS ADVISORY BOARD

16 TAC §111.12, §111.13

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 401, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 401. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), Senate Bill 905, 89th Legislature, Regular Session (2025), and Senate Bill No. 2075, 89th Legislature, Regular Session (2025).

§111.12. *Terms; Vacancies.*

(a) Members are appointed for staggered six-year terms. [The terms of three members expire September 1 of each odd-numbered year.]

(b) - (c) (No change.)

§111.13. *Officers.*

(a) The presiding officer of the commission shall designate a member of the advisory board to serve as the presiding officer of the advisory board for a term of two years [~~one year~~].

(b) (No change.)

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601789

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER F. REQUIREMENTS FOR ASSISTANT IN SPEECH-LANGUAGE PATHOLOGY LICENSE

16 TAC §111.50, §111.55

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 401, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 401. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), Senate Bill 905, 89th Legislature, Regular Session (2025), and Senate Bill No. 2075, 89th Legislature, Regular Session (2025).

§111.50. *Assistant in Speech-Language Pathology License--Licensing Requirements--Education and Clinical Observation and Experience.*

(a) - (c) (No change.)

(d) Clinical Observation and Experience. The applicant must have earned at least 25 hours of clinical observation in the area of speech-language pathology and 25 hours of clinical assisting experience in the area of speech-language pathology.

(1) (No change.)

(2) Verification of 25 hours of clinical observation and 25 hours of clinical assisting experience from the university program director or designee of the college or university training program showing the applicant completed the requirements set out in paragraph (1) of this subsection, if any hours were earned, must be submitted to the assistant's supervisor upon license issuance.

[(2) An applicant who held an assistant license in another state and completed hours for that license does not need to submit proof of completion of the 25 hours of clinical observation and 25 hours of clinical assisting experience.]

(3) An applicant who has not acquired the required hours under this subsection must complete the hours under 100% direct supervision by the approved supervisor once the license is issued and before the assistant may begin to practice.

(A) The licensed speech-language pathologist who will provide the applicant with the training to acquire these hours must meet the requirements set out in the Act and §111.154, must be the approved supervisor of the assistant, and must have the assistant complete any missing hours under 100% direct supervision before allowing the assistant to practice without 100% direct supervision.

(B) If the assistant changes supervisors before completing the missing clinical observation and clinical assisting experience hours, the assistant must complete the missing hours under 100% direct supervision by the new supervisor before being allowed to provide services under the assistant license.

(c) An applicant who held an assistant license in another state and completed hours for that license does not need to submit proof of completion of the 25 hours of clinical observation and 25 hours of clinical assisting experience.

~~[(e) An applicant who has not acquired the required hours under subsection (d) must complete the hours under 100% direct supervision by the approved supervisor once the license is issued and before the assistant may begin to practice.]~~

~~[(1) The licensed speech-language pathologist who will provide the applicant with the training to acquire these hours must meet the requirements set out in the Act and §111.154, must be the approved supervisor of the assistant, and must have the assistant complete any missing hours under 100% direct supervision before allowing the assistant to practice without 100% direct supervision.]~~

~~[(2) If the assistant changes supervisors before completing the missing clinical observation and clinical assisting experience hours, the assistant must complete the missing hours under 100% direct supervision by the new supervisor before being allowed to provide services under the assistant license.]~~

(f) - (g) (No change.)

§111.55. Assistant in Speech-Language Pathology License--Application and Eligibility Requirements.

(a) (No change.)

(b) An applicant for an assistant in speech-language pathology license must submit the following required documentation:

(1) - (4) (No change.)

~~[(5) verification of 25 hours of clinical observation and 25 hours of clinical assisting experience from the university program director or designee of the college or university training program showing the applicant completed the requirements set out in §111.50(d), if any hours were earned;]~~

~~[(6) for an applicant who did not obtain the hours referenced in paragraph (5), the missing hours must be completed under direct supervision by the approved supervisor upon license issuance;]~~

~~[(7)]~~ (5) proof of successfully completing the jurisprudence examination under §111.23; and

~~[(8)]~~ (6) the initial application fee required under §111.160.

(c) - (d) (No change.)

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601790

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Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER H. REQUIREMENTS FOR AUDIOLOGY LICENSE

16 TAC §111.70

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 401, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 401. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), Senate Bill 905, 89th Legislature, Regular Session (2025), and Senate Bill No. 2075, 89th Legislature, Regular Session (2025).

§111.70. Audiology License--Licensing Requirements.

(a) (No change.)

(b) Education. The applicant for an audiology license must possess at least:

(1) a master's degree in audiology conferred on or before December 31, 2007; or

(2) a doctoral degree in audiology or a related hearing science completed at a college or university that has a program accredited by a national accrediting organization that is approved by the department and recognized by the United States Secretary of Education under the Higher Education Act of 1965 (20 U.S.C. §1001 et seq.).

~~[(b) Education. The doctoral degree in audiology or a related hearing science shall be completed at a college or university that has a program accredited by a national accrediting organization that is approved by the department and recognized by the United States Secretary of Education under the Higher Education Act of 1965 (20 U.S.C. §1001 et seq.).]~~

(c) An applicant whose transcript is in a language other than English or whose degree was earned at a foreign university must submit an evaluation form from an ASHA-approved transcript evaluation service. The transcript evaluation service must determine that the applicant's degree is a doctoral degree in audiology or a related hearing science. The applicant must bear all expenses incurred for the evaluation.

(d) If the degree earned at a foreign university is a master's degree in audiology conferred on or before December 31, 2007, the transcript evaluation service must also determine that the applicant's degree is the equivalent of a degree obtained from a program accredited

by a national accrediting organization approved by the commission or department and recognized by the United States secretary of education under the Higher Education Act of 1965 (20 U.S.C. Section 1001 et seq.).

(c) [(d)] An applicant who graduated from a college or university program not accredited by a national accrediting organization that is approved by the department and recognized by the United States Secretary of Education under the Higher Education Act of 1965 (20 U.S.C. §1001 et seq.) must have the ASHA Council for Clinical Certification evaluate the course work to determine whether the applicant qualified for the Certificate of Clinical Competence. The applicant must bear all expenses incurred for the verification.

(f) [(e)] Examination. An applicant must pass the examination referenced under §111.21.

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601791

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER W. JOINT RULE REGARDING THE SALE OF HEARING INSTRUMENTS

16 TAC §111.220

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 401, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 401. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), Senate Bill 905, 89th Legislature, Regular Session (2025), and Senate Bill No. 2075, 89th Legislature, Regular Session (2025).

§111.220. Requirements Regarding the Sale of Hearing Instruments.

(a) This subchapter constitutes the rules required by Texas Occupations Code §401.2021 and §402.1021 to be adopted by the commission with the assistance of the Speech-Language Pathologists and Audiologists Advisory Board [and the Hearing Instrument Fitters and Dispensers Advisory Board]. The requirements of this subchapter shall be repealed or amended only through consultation with the Speech-Language Pathologists and Audiologists Advisory Board [and mutual action by, both advisory boards].

(b) - (c) (No change.)

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601792

Deanne Rienstra

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Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



CHAPTER 112. HEARING INSTRUMENT FITTERS AND DISPENSERS

The Texas Department of Licensing and Regulation (Department) proposes amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 112, Subchapter B, §112.12 and §112.13; Subchapter D, §112.32; Subchapter H, §112.70; and Subchapter O, §112.140; regarding the Hearing Instrument Fitters and Dispensers program. These proposed changes are referred to as the "proposed rules."

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 112, implement Texas Occupations Code, Chapter 402, Hearing Instrument Fitters and Dispensers.

The proposed rules are necessary to implement Senate Bill (SB) 904 89th Legislature, Regular Session (2025), specifically, Sections 2, 3, and 4, and SB 2075 (2025), specifically, Sections 11 and 12. The proposed rules remove language that would require the six-year terms of three members of the advisory board to expire on February 1 of each odd-numbered year, allowing each advisory board member to serve their full six-year term, regardless of when appointed. The proposed rules also change the advisory board's presiding officer's term from one year to two years.

The proposed rules require applicants seeking their initial renewal of their hearing instrument fitter and dispenser license to complete 20 hours of continuing education; remove the requirement that the Commission adopt rules governing the sale of hearing instruments with the assistance of both the Hearing Instrument Fitters and Dispensers Advisory Board and the Speech-Language Pathologist and Audiologist Advisory Board; remove the exception that allowed the Department to renew a license of a licensee who does not comply with the applicable continuing education requirements if the applicant is within the first 24 months of licensure; and allow hearing instruments to be sold to a minor with a written statement signed by a licensed physician, rather than requiring the statement to be signed by a licensed physician specializing in diseases of the ear.

Advisory Board Recommendations

The proposed rules were presented to and discussed by the Hearing Instrument Fitters and Dispensers Advisory Board at its meeting on March 11, 2026. The Advisory Board did not make any changes to the proposed rules. The Advisory Board voted and recommended that the proposed rules be published in the *Texas Register* for public comment.

SECTION-BY-SECTION SUMMARY

Subchapter B. Hearing Instrument Fitters and Dispensers Advisory Board

The proposed rules amend §112.12, Terms; Vacancies. The proposed rules under subsection (a) remove language that would require the six-year terms of three members of the advisory board to expire on February 1 of each odd-numbered year, allowing each advisory board member to serve their full six-year term, regardless of when appointed.

The proposed rules amend §112.13, Officers. The proposed rules under subsection (a) change the advisory board's presiding officer's term from one year to two years.

Subchapter D. Hearing Instrument Fitter and Dispenser License

The proposed rules amend §112.32, Hearing Instrument Fitter and Dispenser License--License Term; Renewals. The proposed rules under subsection (c) now require applicants seeking their initial renewal of their hearing instrument fitter and dispenser license to complete 20 hours of continuing education.

Subchapter H. Continuing Education Requirements

The proposed rules amend §112.70, Continuing Education--Hours, Courses, and Methods of Delivery. The proposed rules under subsection (i) remove the exception that allowed the Department to renew a license of a licensee who does not comply with the applicable continuing education requirements if the applicant is within the first 24 months of licensure.

Subchapter O. Joint Rule Regarding the Sale of Hearing Instruments.

The proposed rules amend §112.140, Requirements Regarding the Sale of Hearing Instruments. The proposed rules under subsection (a) remove the requirement that the TDLR Commission adopt rules governing hearing instruments with the assistance of both the Hearing Instrument Fitters and Dispensers Advisory Board and the Speech-Language Pathologist and Audiologist Advisory Board.

The proposed rules add new subsection (f). The proposed rule allows hearing instruments to be sold to a minor with a written statement signed by a licensed physician, rather than requiring the statement to be signed by a licensed physician specializing in diseases of the ear.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Tony Couvillon, Senior Policy Research and Budget Analyst, has determined that for each year of the first five years the proposed rules are in effect, there are no estimated additional costs or reductions in costs to state or local government as a result of enforcing or administering the proposed rules.

Mr. Couvillon has determined that for each year of the first five years the proposed rules are in effect, there is no estimated increase or loss in revenue to the state or local government as a result of enforcing or administering the proposed rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

Because Mr. Couvillon has determined that the proposed rules will not affect a local economy, the agency is not required to prepare a local employment impact statement under Texas Government Code §2001.022.

PUBLIC BENEFITS

Mr. Couvillon also has determined that for each year of the first five-year period the proposed rules are in effect, the public will re-

ceive a benefit. Specifically, the proposed changes would result in increased access to hearing instruments for minors because they are no longer required to see a physician who specializes in ear diseases. The proposed changes also improve government efficiency by eliminating the need for the speech-language pathology advisory board and hearing-instrument fitters and dispensers advisory board to consult one another before making decisions regarding the sale of hearing instruments. Finally, required continuing education for new licensees would result in them being better educated after completing their first license term, strengthening overall professional standards and competence.

PROBABLE ECONOMIC COSTS TO PERSONS REQUIRED TO COMPLY WITH PROPOSAL

Mr. Couvillon has determined that for each year of the first five-year period the proposed rules are in effect, there will be additional costs to persons who are required to comply with the proposed rules. The proposed rules require first-time licensees to complete continuing education, which is now required by statute. While there is a new potential cost of \$129 for licensees completing their first license term who choose continuing education through the unlimited access providers, several approved options are available at no cost. The \$129 amount reflects the average cost among 15 TDLR-registered continuing education providers offering online, live, virtual, or recorded courses.

FISCAL IMPACT ON SMALL BUSINESSES, MICRO-BUSINESSES, AND RURAL COMMUNITIES

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities as a result of the proposed rules. Because the agency has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities, preparation of an Economic Impact Statement and a Regulatory Flexibility Analysis, as detailed under Texas Government Code §2006.002, is not required.

ONE-FOR-ONE REQUIREMENT FOR RULES WITH A FISCAL IMPACT

The proposed rules have a fiscal note that imposes a cost on regulated persons, including another state agency, a special district, or a local government; however, the proposed rules fall under the exception for rules that are necessary to implement legislation under §2001.0045(c)(9). Therefore, the agency is not required to take any further action under Texas Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Texas Government Code §2001.0221, the agency provides the following Government Growth Impact Statement for the proposed rules. For each year of the first five years the proposed rules will be in effect, the agency has determined the following:

1. The proposed rules do not create or eliminate a government program.
2. Implementation of the proposed rules does not require the creation of new employee positions or the elimination of existing employee positions.
3. Implementation of the proposed rules does not require an increase or decrease in future legislative appropriations to the agency.

4. The proposed rules do not require an increase or decrease in fees paid to the agency.

5. The proposed rules create a new regulation.

The proposed rules add a new regulation by allowing hearing instruments to be sold to a minor with a written statement from a licensed physician.

6. The proposed rules expand, limit, or repeal an existing regulation.

The proposed rules expand an existing regulation by requiring new permit holders to complete continuing education after their first license term in order to renew the license.

7. The proposed rules increase or decrease the number of individuals subject to the rules' applicability.

The proposed rules limit an existing regulation by removing the requirement that all rulemakings for this chapter be reviewed by the Speech-Language Pathology and Audiology Advisory Board.

8. The proposed rules do not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

The Department has determined that no private real property interests are affected by the proposed rules and the proposed rules do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rules do not constitute a taking or require a takings impact assessment under Texas Government Code §2007.043.

PUBLIC COMMENTS AND INFORMATION RELATED TO THE COST, BENEFIT, OR EFFECT OF THE PROPOSED RULES

The Department is requesting public comments on the proposed rules and information related to the cost, benefit, or effect of the proposed rules, including any applicable data, research, or analysis. Any information that is submitted in response to this request must include an explanation of how and why the submitted information is specific to the proposed rules. Please do not submit copyrighted, confidential, or proprietary information.

Comments on the proposed rules and responses to the request for information may be submitted electronically on the Department's website at https://ga.tdlr.texas.gov:1443/form/HEAR_Rule_Making; by facsimile to (512) 475-3032; or by mail to Monica Nuñez, Legal Assistant, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711. The deadline for comments is 30 days after publication in the *Texas Register*.

SUBCHAPTER B. HEARING INSTRUMENT FITTERS AND DISPENSERS ADVISORY BOARD

16 TAC §112.12, §112.13

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 402, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 402. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), and Senate Bill 2075, (2025).

§112.12. Terms; Vacancies.

(a) Members of the advisory board serve staggered six-year terms. [The terms of three members expire on February 1 of each odd-numbered year.]

(b) - (c) (No change.)

§112.13. Officers.

(a) The presiding officer of the commission shall designate a member of the advisory board to serve as the presiding officer of the advisory board for a term of two years [~~one year~~]. The presiding officer of the advisory board may vote on any matter before the advisory board.

(b) (No change.)

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601784

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER D. HEARING INSTRUMENT FITTER AND DISPENSER LICENSE

16 TAC §112.32

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 402, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 402. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), and Senate Bill 2075, (2025).

§112.32. Hearing Instrument Fitter and Dispenser License--License Term; Renewals.

(a) - (b) (No change.)

(c) To renew a hearing instrument fitter and dispenser license, a license holder must:

(1) (No change.)

(2) [except for the first renewal,] complete 20 [twenty (20)] hours of continuing education as required under §112.70;

(3) - (5) (No change.)

(d) - (j) (No change.)

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601785

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER H. CONTINUING EDUCATION REQUIREMENTS

16 TAC §112.70

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 402, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 402. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), and Senate Bill 2075, (2025).

§112.70. *Continuing Education--Hours, Courses, and Methods of Delivery.*

(a) - (h) (No change.)

(i) Pursuant to Texas Occupations Code §402.305, the department may renew the license of a license holder who has not complied with the continuing education requirements if the license holder submits proof from an attending physician that the license holder suffered a serious disabling illness or physical disability that prevented compliance with the continuing education requirements during the 24 months before the end of the license term. [;]

[(1) submits proof from an attending physician that the license holder suffered a serious disabling illness or physical disability that prevented compliance with the continuing education requirements during the 24 months before the end of the license term; or]

[(2) was licensed for the first time during the 24 months before the end of the license term.]

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601786

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879



SUBCHAPTER O. JOINT RULE REGARDING THE SALE OF HEARING INSTRUMENTS

16 TAC §112.140

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 402, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 402. No other statutes, articles, or codes are affected by the proposed rules.

The legislation that enacted the statutory authority under which the proposed rules are proposed to be adopted is Senate Bill 904, 89th Legislature, Regular Session (2025), and Senate Bill 2075, (2025).

§112.140. *Requirements Regarding the Sale of Hearing Instruments.*

(a) This subchapter constitutes the rules required by Texas Occupations Code §401.2021 and §402.1021 to be adopted by the commission with the assistance of [~~the Speech Language Pathology and Audiology Advisory Board and~~] the Hearing Instrument Fitters and Dispensers Advisory Board. The requirements of this subchapter shall be repealed or amended only through consultation with the Hearing Instrument Fitters and Dispensers Advisory Board [~~and mutual action by both advisory boards~~].

(b) - (e) (No change.)

(f) A licensed hearing instrument fitter and dispenser may not sell a hearing instrument to a person under 18 years of age unless the prospective user or a parent or guardian of the prospective user has presented to the hearing instrument fitter and dispenser a written statement, signed by a licensed physician, that states that the patient's hearing loss has been medically evaluated and that the patient may be considered a candidate for a hearing instrument. Whenever practicable, the medical evaluation described should be performed by a licensed physician who specializes in diseases of the ear.

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

Filed with the Office of the Secretary of State on April 24, 2026.

TRD-202601787

Deanne Rienstra

General Counsel

Texas Department of Licensing and Regulation

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-4879

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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 89. ADAPTATIONS FOR SPECIAL POPULATIONS

SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING SPECIAL EDUCATION SERVICES

DIVISION 2. CLARIFICATION OF PROVISIONS IN FEDERAL REGULATIONS

19 TAC §89.1053

The Texas Education Agency (TEA) proposes an amendment to §89.1053, concerning procedures for use of restraint and time-out. The proposed amendment would revise, expand, and align existing definitions; clarify procedural requirements; and establish a crisis prevention and intervention training requirement for school systems consistent with Senate Bill (SB) 133, 88th Texas Legislature, Regular Session, 2023, and House Bill (HB) 2 and SB 568, 89th Texas Legislature, Regular Session, 2025.

BACKGROUND INFORMATION AND JUSTIFICATION: Section 89.1053 establishes the procedures governing the use of restraint and time-out for students receiving special education and related services. The proposed amendment to the section title would align the rule with state statute.

The proposed amendment to subsection (a) would add a requirement for crisis prevention and intervention training to align with HB 2 and SB 568 and would further clarify practices that constitute prohibited forms of confinement.

The proposed amendment to subsection (b) would add definitions for the terms crisis, crisis prevention and intervention training, imminent, law enforcement duties, seclusion, and taser and expand the existing definitions for emergency and restraint to promote clarity and consistency in implementation in alignment with SB 133, HB 2, and SB 568.

Proposed new subsection (d)(5) would clarify training requirements to emphasize instruction on disability-related behaviors and evidence-based, individualized positive behavioral interventions in alignment with SB 133, HB 2, and SB 568.

The proposed amendment to subsection (e) would clarify documentation and notification requirements for each use of restraint, including establishing a uniform timeline for placement of written documentation in a student's special education eligibility folder to support admission, review, and dismissal (ARD) committee review.

The proposed amendment to subsection (f) would align with HB 2 and SB 568 by reaffirming that restraint may not be used as a disciplinary or behavior management technique or as a method to gain student compliance.

The proposed amendment to subsection (g) would clarify that the ARD committee is responsible for reviewing, at least annually, the use, amount, and effectiveness of time-out as a behavioral intervention and for considering any necessary revisions to the student's individualized education plan, behavioral intervention

plan, or positive behavior supports to align with HB 2 and SB 568.

The proposed amendment to subsection (i) would clarify documentation requirements for time-out to ensure consistent data collection that enables ARD committees and TEA to monitor use, evaluate effectiveness, and verify compliance with individualized planning requirements.

New subsection (j) would add requirements and criteria for crisis prevention and intervention training to align with HB 2 and SB 568.

FISCAL IMPACT: Jennifer Alexander, associate commissioner for special populations and student supports, has determined that for the first five-year period the proposal is in effect, there are no additional costs to state or local government, including school districts and open-enrollment charter schools, required to comply with the proposal.

LOCAL EMPLOYMENT IMPACT: The proposal has no effect on local economy; therefore, no local employment impact statement is required under Texas Government Code, §2001.022.

SMALL BUSINESS, MICROBUSINESS, AND RURAL COMMUNITY IMPACT: The proposal has no direct adverse economic impact for small businesses, microbusinesses, or rural communities; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

COST INCREASE TO REGULATED PERSONS: The proposal does not impose a cost on regulated persons, another state agency, a special district, or a local government and, therefore, is not subject to Texas Government Code, §2001.0045.

TAKINGS IMPACT ASSESSMENT: The proposal does not impose a burden on private real property and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

GOVERNMENT GROWTH IMPACT: TEA staff prepared a Government Growth Impact Statement assessment for this proposed rulemaking. During the first five years the proposed rulemaking would be in effect, it would expand an existing regulation by updating and aligning definitions, clarifying procedural requirements, and establishing a crisis prevention and intervention training mandate for school systems in accordance with SB 133, HB 2, and SB 568.

The proposed rulemaking would not create or eliminate a government program; would not require the creation of new employee positions or elimination of existing employee positions; would not require an increase or decrease in future legislative appropriations to the agency; would not require an increase or decrease in fees paid to the agency; would not create a new regulation; would not limit or repeal an existing regulation; would not increase or decrease the number of individuals subject to its applicability; and would not positively or adversely affect the state's economy.

PUBLIC BENEFIT AND COST TO PERSONS: Ms. Alexander has determined that for each year of the first five years the proposal is in effect, the public benefit anticipated as a result of enforcing the proposal would be to clarify and standardize requirements for the use of confinement, restraint, seclusion, and time-out for students with disabilities who receive special education and related services. It would reinforce the use of crisis prevention and de-escalation practices and add training requirements, strengthen student protections, and enhance compliance with state and federal law. In addition, the amendment would

provide clear guidance for school personnel regarding permissible and prohibited interventions and promote consistent implementation and documentation across school systems.

DATA AND REPORTING IMPACT: The proposal would have no data and reporting impact.

PRINCIPAL AND CLASSROOM TEACHER PAPERWORK REQUIREMENTS: TEA has determined that the proposal would not require a written report or other paperwork to be completed by a principal or classroom teacher.

PUBLIC COMMENTS: TEA requests public comments on the proposal, including, per Texas Government Code, §2001.024(a)(8), information related to the cost, benefit, or effect of the proposed rule and any applicable data, research, or analysis, from any person required to comply with the proposed rule or any other interested person. The public comment period on the proposal begins May 8, 2026, and ends June 8, 2026. Public hearings will be conducted to solicit testimony and input on the proposed amendment at 9:30 a.m. on May 28 and May 29, 2026. The public may participate in either hearing virtually by linking to the hearing at <https://us02web.zoom.us/j/83304675292>. Anyone wishing to testify must be present at 9:30 a.m. and indicate to TEA staff their intent to comment and are encouraged to also send written testimony to sped@tea.texas.gov. Each hearing will conclude once all who have signed in have been given the opportunity to comment. Questions about the hearing should be directed to Derek Hollingsworth, Special Populations Policy and Compliance, Derek.Hollingsworth@tea.texas.gov.

STATUTORY AUTHORITY. The amendment is proposed under Texas Education Code (TEC), §29.001, as amended by HB 2 and SB 568, 89th Texas Legislature, Regular Session, 2025, which establishes criteria for the implementation of special education law; TEC, §29.026, as added by HB 2 and SB 568, 89th Texas Legislature, Regular Session, 2025, which establishes rulemaking authority for the commissioner of education as necessary to implement TEC, Chapter 29, Subchapter A; TEC, §37.0021, as amended by SB 133, 88th Texas Legislature, Regular Session, 2023, and HB 2, 89th Texas Legislature, Regular Session, 2025, which establishes rulemaking authority for the adoption of procedures governing the use of restraint and time-out for a student with a disability; and TEC, §37.0023, which prohibits aversive techniques that are intended to reduce the likelihood of a behavior recurring and requires the commissioner to adopt procedures under this section.

CROSS REFERENCE TO STATUTE. The amendment implements TEC, §29.001, as amended by HB 2 and SB 568, 89th Texas Legislature, Regular Session, 2025; §29.026, as added by HB 2 and SB 568, 89th Texas Legislature, Regular Session, 2025; §37.0021, as amended by SB 133, 88th Texas Legislature, Regular Session, 2023, and HB 2, 89th Texas Legislature, Regular Session, 2025; and §37.0023.

§89.1053. Procedures for the Use of Confinement, Restraint, Seclusion, and Time-Out.

(a) Requirement to implement. In addition to the requirements of 34 Code of Federal Regulations (CFR), §300.324(a)(2)(i), school districts and charter schools must implement the provisions of this section regarding the use of restraint, [and] time-out, and crisis prevention and intervention training. In accordance with the provisions of Texas Education Code (TEC), §37.0021 (Use of Confinement, Restraint, Seclusion, and Time-Out), it is the policy of the state to treat with dignity and respect all students, including students with disabili-

ties who receive special education services under TEC, Chapter 29, Subchapter A. In accordance with this policy, students may not be confined in a locked box, locked closet, or other specially designed locked space as either a discipline management practice or a behavior management technique.

(b) Definitions.

(1) "Crisis" means a situation in which a student is experiencing a state of dysregulation that overwhelms the student's baseline coping mechanisms and:

(A) may cause impaired logical thinking, potential risk of serious physical harm to self or others, functional impairment, or involuntary physiological responses; and

(B) is best addressed by crisis prevention and intervention to return the student's behavior to a regulated state and avoid an emergency as defined in this section.

(2) "Crisis prevention and intervention training" means evidence-based strategies, including proactive ongoing use of best practices, that are designed to equip individuals to recognize, respond to, and de-escalate crises and emergencies through individualized, developmentally and neurologically responsive supports and to use, only when necessary and appropriate, safely applied physical interventions.

(3) [(+)] "Emergency" [Emergency] means a situation in which a student's behavior poses a threat of:

(A) imminent, serious physical harm to the student or others; or

(B) imminent, serious property destruction.

(4) "Imminent" means likely to occur immediately or without delay, leaving no reasonable opportunity to prevent serious physical harm through less restrictive interventions. Imminent does not include situations where there is time to safely use de-escalation, redirection, or other less restrictive interventions.

(5) "Law enforcement duties" means activities of a peace officer relating to the investigation and enforcement of state criminal laws and other duties authorized by the Code of Criminal Procedure, subject to any limitations as determined by the board of trustees of a school district under TEC §37.081(d).

(6) [(2)] "Restraint" [Restraint] means the use of physical force or a mechanical device to significantly restrict the free movement of all or a portion of the student's body.

(A) "Physical restraint" means a personal restriction that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely.

(B) "Mechanical restraint" refers to the use of any device or equipment to restrict a student's freedom of movement. The term does not include devices implemented by trained school personnel or utilized by a student that have been prescribed by an appropriate medical or related services provider.

(7) "Seclusion" means a behavior management technique in which a student is confined in a locked box, locked closet, or locked room that:

(A) is designed solely to seclude a person; and

(B) contains less than 50 square feet of space.

(8) "Taser" means a device manufactured, sold, or distributed by Axon Enterprises (formally known as Taser International, Incorporated) that is intended, designed, made, or adapted to incapacitate a person by inflicting an electrical charge through the emission

of a projectile or conductive stream. The term, for purposes of this section, includes a similar device manufactured, sold, or distributed by another person.

(9) ~~[(3)]~~ "Time-out" [Time-out] means a behavior management technique in which, to provide a student with an opportunity to regain self-control, the student is separated from other students for a limited period in a setting:

(A) that is not locked; and

(B) from which the exit is not physically blocked by furniture, a closed door held shut from the outside, or another inanimate object.

(c) Use of restraint. A school employee, volunteer, or independent contractor may use restraint only in an emergency as defined in subsection (b) of this section and with the following limitations.

(1) Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

(2) Restraint must be discontinued at the point at which the emergency no longer exists.

(3) Restraint must be implemented in such a way as to protect the health and safety of the student and others.

(4) Restraint must not deprive the student of basic human necessities.

(d) Training on use of restraint. Training for school employees, volunteers, or independent contractors must be provided according to the following requirements.

(1) A core team of personnel on each campus must be trained in the use of restraint, and the team must include a campus administrator or designee and any general or special education personnel whose job duties may place them at high risk of utilizing [likely to use] restraint.

(2) Personnel called upon to use restraint in an emergency and who have not received prior training must receive training within 30 school days following the use of restraint.

(3) Training on use of restraint must include prevention and de-escalation techniques and provide alternatives to the use of restraint.

(4) All trained personnel must receive instruction in current professionally accepted practices and standards regarding behavior management and the use of restraint.

(5) Training on the use of restraint must include instruction on disability-related behaviors, including behaviors associated with neurological, developmental, or emotional disabilities, and evidence-based strategies to prevent, reduce, or respond to such behaviors. This training must emphasize individualized and developmentally appropriate approaches and the use of positive behavioral interventions and supports as alternatives to physical intervention and restraint.

(e) Documentation and notification on use of restraint. In a case in which restraint is used, school employees, volunteers, or independent contractors must implement the following documentation requirements.

(1) On the day restraint is utilized, the campus administrator or designee must be notified verbally or in writing regarding the use of restraint.

(2) On the day restraint is utilized, a good faith effort must be made to verbally notify the parent(s) or person standing in a parental relation to the student regarding the use of restraint.

(3) Written notification of the use of restraint must be placed in the mail or otherwise provided to the parent(s) or person standing in parental relation to the student [parent] within one school day of the use of restraint. In the case of residential placements, written notification must be provided to the parent(s) or person standing in parental relation to the student within 24 hours of the restraint, regardless of whether the day is a school day, weekend, or holiday.

(4) Written documentation regarding the use of restraint must be placed in the student's special education eligibility folder no later than the third school day after the restraint [in a timely manner] so the information is available to the admission, review, and dismissal (ARD) committee when it considers the impact of the student's behavior on the student's learning and/or the creation or revision of a behavior improvement plan or a behavioral intervention plan.

(5) Written notification must be provided to the student's parent(s) or person standing in parental relation to the student for each use of restraint, and documentation of each restraint must be placed in the student's special education eligibility folder. For purposes of this subsection, "each restraint" refers to each time the student is restrained by either physical force or mechanical device and released, regardless of the length of time of the restraint or the time between the release and the restart of the restraint. Multiple restraints may not be combined into a single restraint notification form, reported to the campus administrator or the parent(s) or person standing in parental relation to the student as a single restraint, or reported to the Texas Education Agency (TEA) as a single restraint. The written notification of each restraint must include the following:

(A) name of the student;

(B) name of the individual administering the restraint;

(C) date of the restraint and the time the restraint began and ended;

(D) location of the restraint;

(E) nature of the restraint;

(F) a description of the activity in which the student was engaged immediately preceding the use of restraint;

(G) the behavior of the student that prompted the restraint;

(H) the efforts made to de-escalate the situation and any alternatives to restraint that were attempted;

(I) observation of the student at the end of the restraint;

(J) contact information for the parent(s) or person standing in parental relation to the student to whom the school district sent the required [documenting parent contact and] notification of restraint; and

(K) one of the following:

(i) if the student has a behavior improvement plan or behavioral intervention plan, whether the behavior improvement plan or behavioral intervention plan may need to be revised as a result of the behavior that led to the restraint and, if so, identification of the staff member responsible for scheduling an ARD committee meeting to discuss any potential revisions; or

(ii) if the student does not have a behavior improvement plan or a behavioral intervention plan, information on the procedure for the student's parent or person standing in parental relation to the student to request an ARD committee meeting to discuss the possibility of conducting a functional behavioral assessment of the student and developing a plan for the student.

(f) Clarification regarding restraint. Restraint may not be used as a disciplinary or behavior management technique or as a method to gain student compliance. The provisions adopted under this section do not apply to the use of physical force or a mechanical device that does not significantly restrict the free movement of all or a portion of the student's body. Restraint that involves significant restriction as referenced in subsection (b)(6) [(b)(2)] of this section does not include:

(1) physical contact or appropriately prescribed adaptive equipment to promote normative body positioning and/or physical functioning;

(2) limited physical contact with a student to promote safety (e.g., holding a student's hand), prevent a potentially harmful action (e.g., running into the street), teach a skill, redirect attention, provide guidance to a location, or provide comfort;

(3) limited physical contact or appropriately prescribed adaptive equipment to prevent a student from engaging in ongoing, repetitive self-injurious behaviors, with the expectation that instruction will be reflected in the individualized education program (IEP) as required by 34 CFR, §300.324(a)(2)(i), to promote student learning and reduce and/or prevent the need for ongoing intervention; or

(4) seat belts and other safety equipment used to secure students during transportation.

(g) Use of time-out. A school employee, volunteer, or independent contractor may use time-out in accordance with subsection (b)(9) [(b)(3)] of this section with the following limitations.

(1) Physical force or threat of physical force must not be used to place, maintain, or keep a student in time-out.

(2) Time-out may only be used in conjunction with an array of positive behavior intervention strategies and techniques and must be included in the student's IEP and/or behavior improvement plan or behavioral intervention plan if it is utilized on a recurrent basis to increase or decrease a targeted behavior. The student's ARD committee must review, at least annually, the use, amount, and effectiveness of time-out as a behavioral intervention and consider whether revisions to the student's IEP, behavioral intervention plan, or positive behavior supports are necessary to reduce or eliminate the need for time-out.

(3) Use of time-out must not be implemented in a fashion that precludes the ability of the student to be involved in and progress in the general curriculum and advance appropriately toward attaining the annual goals specified in the student's IEP.

(h) Training on use of time-out. Training for school employees, volunteers, or independent contractors must be provided according to the following requirements.

(1) General or special education personnel who implement time-out based on requirements established in a student's IEP and/or behavior improvement plan or behavioral intervention plan must be trained in the use of time-out.

(2) Newly-identified personnel called upon to implement time-out based on requirements established in a student's IEP and/or behavior improvement plan or behavioral intervention plan must receive training in the use of time-out within 30 school days of being assigned the responsibility for implementing time-out.

(3) Training on the use of time-out must be provided as part of a program which addresses a full continuum of positive behavioral intervention strategies and must address the impact of time-out on the ability of the student to be involved in and progress in the general curriculum and advance appropriately toward attaining the annual goals specified in the student's IEP.

(4) All trained personnel must receive instruction in current professionally accepted practices and standards regarding behavior management and the use of time-out.

(i) Documentation on use of time-out. Necessary documentation or data collection regarding the use of time-out, if any, must be addressed in the IEP and/or behavior improvement plan or behavioral intervention plan. If a student has a behavior improvement plan or behavioral intervention plan, the school district must document each use of time-out prompted by a behavior of the student specified in the student's behavior improvement plan or behavioral intervention plan, including a description of the behavior that prompted the time-out. Documentation of each use of time-out must include:

(1) a description of the behavior specified in the student's behavior improvement plan or behavioral intervention plan that prompted the use of time out; and

(2) any data collected regarding the use of time out, as addressed in the student's IEP, behavior improvement plan, or behavioral intervention plan. The ARD committee must use any collected data to evaluate [judge] the effectiveness of the intervention and provide a basis for making determinations regarding its continued use.

(j) Crisis prevention and intervention training. Training for school employees, volunteers, or independent contractors must be provided in accordance with the following requirements.

(1) School districts must create, document, and use risk criteria based on job role, campus assignments, or incident history to determine which personnel, including support staff and law enforcement, require training and the extent of training needed.

(2) Personnel who are designated as high risk must receive training that includes non-violent crisis intervention techniques, verbal de-escalation strategies, and safe physical intervention procedures.

(3) School districts shall require training using standards from the State Board for Educator Certification's continuing education clearinghouse in accordance with TEC, §21.4514.

(4) Minimum recommended training intervals include:

(A) annually for personnel determined to have a high risk of crisis involvement; and

(B) every two years for other campus-based personnel.

(5) Crisis prevention and intervention training may be combined with, or substituted by, other required training when 51% or more of the training content addresses the requirements of this subsection, including:

(A) trauma-informed care training in accordance with TEC, §38.036; and

(B) conflict resolution and positive student relationships training in accordance with TEC, §21.451(d)(3).

(k) [(j)] Student safety. Any behavior management technique and/or discipline management practice must be implemented in such a way as to protect the health, [and] safety, and dignity of the student and others. No discipline management practice may be calculated to inflict injury, cause harm, demean, or deprive the student of basic human necessities.

(l) [(k)] Data reporting. With the exception of actions covered by subsection (f) of this section, data regarding the use of restraint must be electronically reported to TEA [the Texas Education Agency (TEA)] in accordance with reporting standards specified by TEA.

(m) [(4)] Restrictions on peace officers and security personnel. In accordance with TEC, §37.0021(j), a peace officer performing law enforcement duties or school security personnel performing security-related duties on school property or at a school-sponsored or school-related activity must not restrain or use a chemical irritant spray or Taser on a student enrolled in Grade 5 or below, unless the student poses a serious risk of harm to the student or another person.

(n) [(m)] Provisions applicable to peace officers. The provisions adopted under this section apply to a peace officer only if the peace officer is employed or commissioned by the school district or provides, as a school resource officer, a regular police presence on a school district campus under a memorandum of understanding between the school district and a local law enforcement agency, except that the data reporting requirements in subsection (l) [(k)] of this section apply to the use of restraint by any peace officer performing law enforcement duties on school property or during a school-sponsored or school-related activity.

(o) [(n)] The provisions adopted under this section do not apply to:

(1) juvenile probation, criminal detention, or corrections personnel; or

(2) an educational services provider with whom a student is placed by a judicial authority, unless the services are provided in an educational program of a school district.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601797

Cristina De La Fuente-Valadez

Director, Rulemaking

Texas Education Agency

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 475-1497



TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§3.205, 3.3403, 3.3703, 3.9208, and 3.9210, concerning certain participating policy forms, health coverage of newborn children, and preferred and exclusive provider benefit plans. The amendments implement House Bill 4611, 88th Legislature, 2023; House Bills 388, 1620, and 2221, 89th Legislature, 2025; and Senate Bills 493, 896, and 1236, 89th Legislature, 2025.

EXPLANATION.

Amendments to §§3.205, 3.3403, 3.3703, 3.9208, and 3.9210 are necessary to implement the following legislation.

- HB 388 requires health benefit plans to use a uniform coordination of benefits questionnaire that is adopted by TDI.

- HB 1620 revises Government Code references throughout the Insurance Code to reflect statutory amendments relating to Medicaid enacted in HB 4611, which made nonsubstantive revisions to various health and human services laws.

- HB 2221 moves requirements concerning unlawful rebates and inducements to new Insurance Code Chapter 1702.

- SB 493 prohibits certain pharmacy benefit manager contract provisions.

- SB 896 extends the enrollment period for newborn children from 31 days to 60 days.

- SB 1236 expands requirements for pharmacy benefit network contracts.

In separate proposals also published in this issue of the *Texas Register*, TDI proposes amendments to 28 TAC Chapters 11 and 26 to implement the previously referenced legislation. In a separate proposal published October 24, 2025 (50 TexReg 6976), TDI proposed a uniform coordination of benefits questionnaire in 28 TAC Chapter 3, Subchapter V, to implement HB 388. At a later date, TDI also plans to propose amendments to 28 TAC Chapter 21 to implement provisions in HB 2221 and SB 1236.

Descriptions of the sections' proposed amendments follow.

Section 3.205.

A proposed amendment to §3.205 replaces the reference to Insurance Code §541.056(c), which was repealed by HB 2221, with new Insurance Code §1702.102(c), which was added by HB 2221.

Section 3.3403.

The proposed amendments to §3.3403 implement SB 896. Subsections (a), (b), and (d) are amended by striking general references to "a period of time" for newborn coverage and replacing them with the concrete time period of "before the 61st day after the child's birth." Subsection (e) is amended by replacing references to a 31-day initial coverage period with a 60-day initial coverage period.

Subsections (f) - (h), addressing the original implementation period of Insurance Code §1367.003, are deleted because they are no longer relevant. Subsection (i) is redesignated as subsection (f), and a title is added to the statutory reference in the subsection to conform to agency style.

Section 3.3703.

The proposed amendments to §3.3703 implement HB 388, HB 493, and SB 1236. Subsection (a)(21) is amended by adding a reference to Insurance Code §1203.153. Consistent with SB 1236, new subsection (a)(31) requires a contract between an insurer and a pharmacy or pharmacist to comply with Insurance Code Chapter 1369. New subsection (a)(32) prohibits certain contract provisions in a contract between an insurer and a pharmacy or pharmacist, consistent with Insurance Code §4151.155 as added by SB 493. Although §4151.155 affects contracts involving a pharmacy benefit manager, subsection (a)(32) applies to contracts involving an insurer to ensure requirements for insurers and their pharmacy benefit managers are consistent. New subsection (a)(33) is added to cross-reference 28 TAC §7.1613, which addresses requirements for a contract between an issuer and a third-party administrator (TPA), including a requirement for a TPA to be contractually obligated to comply with all statutory and regulatory requirements related to a function carried out by the TPA. This makes clear that the requirements of §3.3703 ap-

ply to health plan contracts with physicians or providers, whether the plan contracts directly or relies on a TPA such as a pharmacy benefit manager to contract.

Section 3.9208.

The proposed amendment to §3.9208 replaces the reference to Government Code Chapter 533 with Government Code Chapter 540, as repealed and replaced by HB 4611, and consistent with HB 1620.

Section 3.9210. The proposed amendment to §3.9210(a) replaces the reference to Government Code Chapter 533 with Government Code Chapter 540, as repealed and replaced by HB 4611 and consistent with HB 1620.

In addition, proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to TDI's current drafting style and plain language preferences, and to improve the rule's clarity. These changes appear throughout the amended sections and include adding titles to cited statutes; nonsubstantive text edits, including the addition of necessary words such as "to" and replacing the word "which" with "that"; and other grammatical, punctuational, and format changes.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT.

Rachel Bowden, director of the Regulatory Initiatives Office in the Life and Health Division, 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 proposed 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.

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 and enforcing the proposed amendments will have the public benefit of ensuring that TDI's rules conform to House Bills 388, 1620, 2221, and 4611, and Senate Bills 493, 896, and 1236.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance. Any costs for those required to comply with the proposed amendments are attributable to House Bills 388, 1620, 2221, and 4611; and Senate Bills 493, 896, and 1236 because the proposed amendments do not impose requirements beyond those in statute.

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. Even if it did, no additional rule amendments would be required under Government Code §2001.0045 because the proposed amendments

are necessary to implement legislation. The proposed rule implements: HB 388, HB 1620, HB 2221, HB 4611, SB 493, SB 896, and SB 1236.

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 not increase or decrease 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 TDI no later than 5:00 p.m., central time, on June 8, 2026. 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. 2864. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing both remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.034. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

SUBCHAPTER C. APPROVAL, DISAPPROVAL, AND WITHDRAWAL OF APPROVAL OF CERTAIN PARTICIPATING POLICY FORMS

28 TAC §3.205

STATUTORY AUTHORITY. TDI proposes amendments to §3.205 under Insurance Code §1702.006 and §36.001.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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 3.205 implements Insurance Code §1702.102.

§3.205. *Construction of Rules.*

This subchapter may not be construed to prohibit the use of any provision authorized by Insurance Code §1702.102(c), concerning Prohibited Rebates and Inducements, [§541.056(e)] or other applicable statute.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601807

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER U. NEWBORN CHILDREN COVERAGE

28 TAC §3.3403

STATUTORY AUTHORITY. TDI proposes amendments to §3.3403 under Insurance Code §1367.002 and §36.001.

Insurance Code §1367.002 states that certain provisions of Insurance Code Chapter 1201, including provisions relating to rulemaking under Insurance Code Chapter 1201, apply to Insurance Code Chapter 1367, Subchapter A.

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 3.3403 implements Insurance Code §1367.003.

§3.3403. *General Rules of Application.*

(a) No individual policy or group policy of accident and sickness insurance that [which] provides for accident and sickness coverage of additional newborn children may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant before the 61st day after the date of the child's birth, [for a period of time,] or limitations or exclusions for congenital defects of a newborn child.

(b) No individual policy or group policy of accident and sickness insurance that [which] provides for maternity benefits may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant before the 61st day after the date of the child's birth, [for a period of time,] or limitations or exclusions for congenital defects of a newborn child.

(c) If the policy provides accident and sickness coverage for newborn children, the [such] coverage must be at least as comprehensive as the coverage provided under the policy for other children for loss as a result of an accident or sickness.

(d) If the policy provides maternity benefits, and included in those [such] benefits are coverages for newborn infants, the [such] policy may not contain any provision excluding or limiting initial coverage of newborn infants before the 61st day after the date of the child's birth, [for a period of time,] or limit or exclude coverage for congenital defects of a newborn child.

(e) The initial coverage provided to newborn children must continue for a period of at least 60 [31] days. The insurer may require that before the coverage continues beyond this initial 60 [31]-day period, the policyholder must notify the insurer of the birth of the newborn child and pay any additional premium required to maintain the coverage in force. Any additional premium required for the initial period of coverage may be charged.

~~[(f) Insurance Code §1367.003 applies to all accident and sickness policies issued or issued for delivery, renewed, extended, or amended in the State of Texas on and after January 1, 1974. The insurer, upon a renewal, extension, or amendment, may charge such additional premiums as are just and reasonable for the additional risk incurred by compliance with Insurance Code §1367.003. With respect to any policy forms approved by the Texas Department of Insurance prior to the effective date of §1367.003, an insurer is authorized to achieve compliance with §1367.003 by the use of endorsements or riders provided such endorsements or riders are approved by the Texas Department of Insurance as being in compliance with Insurance Code §1367.003 and other provisions of the Texas Insurance Code.]~~

~~[(g) Insurance Code §1367.003 applies to policies written before January 1, 1974, if and when such a policy is "renewed, extended or amended" after January 1, 1974. If the provisions of a policy written before January 1, 1974, allow the insurer to renegotiate the terms of the policy after January 1, 1974, or allow the insurer to adjust the premiums charged under the policy after January 1, 1974, and if at the time such renegotiation or adjustment could be accomplished and is accomplished, the policy continues in force or a policy with substantially similar coverage is agreed to by the insured and insurer, then the policy will be said to have been "renewed, extended or amended" for purposes of Insurance Code §1367.003, and the requirements of §1367.003 will attach to the policy.]~~

~~[(h) Insurance Code §1367.003 applies to any policy except a "non-cancellable and guaranteed renewable" policy written before January 1, 1974, if such policy is "renewed, extended or amended" or a rate adjustment could be made after January 1, 1974. If a group policy is written in conjunction with a collective bargaining agreement, such policy will be considered "renewed, extended or amended" upon the expiration of any applicable collective bargaining agreement.]~~

(f) ~~[(f)]~~ Nothing in this subchapter will be deemed to extend the provisions of Insurance Code §1367.003, concerning Certain Limitations on Coverage for Newborn Children Prohibited, to insurance contracts providing benefits only for specified diseases, pure accident policies, disability only policies, or loss of time only policies.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601809



**SUBCHAPTER X. PREFERRED AND
EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS**

28 TAC §3.3703

STATUTORY AUTHORITY. TDI proposes amendments to §3.3703 under Insurance Code §§1203.152, 1301.007, 4151.006, and 36.001.

Insurance Code §1203.152 requires the commissioner to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers in Texas.

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

Insurance Code §4151.006 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 4151.

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 3.3703 implements Insurance Code §1203.153 and §4151.155, and Chapter 1369.

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that ensures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements. [:]

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers

privileges to members of a class of physicians or practitioners, then the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to the [sueh] physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider must not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, X-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider that [whieh] act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process, including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider that [who] is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 - 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in Insurance Code §1301.067, concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited, about any of the matters set forth in the contract.

(14) A contract between a preferred provider and an insurer conducting, using, or relying on ~~upon~~ economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with Insurance Code §1301.058, concerning Economic Profiling.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of Insurance Code §1301.059(b), concerning Quality Assessment.

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if they are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, and implementing rules.

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in Insurance Code §1301.160(b), concerning Notification of Termination of Participation of Preferred Provider.

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider on ~~upon~~ request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including email, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided in accordance with this paragraph are required to be made under subparagraph (D) of this paragraph and, when applicable subparagraph (J) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methods that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers;

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided under this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days' written notice to the preferred provider identifying with specificity the amendment, revision, or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this paragraph, the written

notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely on ~~upon~~ information provided in accordance with this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(J) No adverse material change to a preferred provider contract will be effective as to the preferred provider unless the adverse material change is made in accordance with Insurance Code §1301.0642, concerning Contract Provisions Allowing Certain Adverse Material Changes Prohibited, to the extent applicable.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage, consistent with Insurance Code §1203.153, concerning Uniform Coordination of Benefits Questionnaire Required.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identi-

fied by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to which ~~whom~~ the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility ~~to which~~ the insured is being referred to.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of Insurance Code §1661.005, concerning Refund of Overpayment.

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician or provider group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care and §1301.155(a), concerning Emergency Care, that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.0053 and §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contract Requirements, to the extent applicable.

(30) A contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist must comply with Insurance Code Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan.

(31) A contract between an insurer and a pharmacy or pharmacist must comply with Insurance Code Chapter 1369, concerning

Benefits Related to Prescription Drugs and Devices and Related Services.

(32) A contract between an insurer and a pharmacy or pharmacist may not include a provision that is prohibited under Insurance Code §4151.155, concerning Certain Disclosures and Communications by Pharmacist of Pharmacy Protected.

(33) A contract between an insurer and a third-party administrator, including a pharmacy benefit manager, must comply with §7.1613 of this title (relating to Written Agreements Between Administrators and Insurers).

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, and the provisions of that subchapter will be employed to the extent practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601812

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Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER KK. EXCLUSIVE PROVIDER BENEFIT PLAN

28 TAC §3.9208, §3.9210

STATUTORY AUTHORITY. TDI proposes amendments to §3.9208 and §3.9210 under Insurance Code §36.001.

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 3.9208 and 3.9210 implement HB 1620 and HB 4611.

§3.9208. *Provider Network: Accessibility and Availability.*

An issuer is subject to the same network accessibility and availability requirements as outlined in §11.1607 of this title (relating to Accessibility and Availability Requirements). Issuers must comply with this section; any requirements under a Medicaid contract, subject to

Government Code[.] Chapter 540, concerning Medicaid Managed Care Program [§33]; and any other applicable law.

§3.9210. *Complaints System.*

(a) Complaints System. Issuers must comply with this section; any requirements under a Medicaid contract, subject to Government Code[.] Chapter 540, concerning Medicaid Managed Care Program [§33]; and any other applicable law. The complaint system must provide reasonable procedures for the resolution of oral and written complaints initiated by insureds or providers concerning health care services, including a process for the notice and appeal of complaints.

(1) If a complainant notifies the issuer orally or in writing of a complaint, the issuer, not later than the fifth business day after the date of the receipt of the complaint, must [shalt] send to the complainant a letter acknowledging the date of receipt of the complaint that includes a description of the organization's complaint procedures and time frames. If the complaint is received orally, the issuer must [shalt] also enclose a one-page complaint form. The one-page complaint form must prominently and clearly state that the complaint form must be returned to the issuer for prompt resolution of the complaint.

(A) The issuer must [shalt] investigate each oral and written complaint received in accordance with its policies and in compliance with this subchapter.

(B) Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization must [shalt] be concluded in accordance with the medical or dental immediacy of the case and may not exceed one business day from receipt of the complaint.

(C) For all other complaints, the total time for acknowledgment, investigation, and resolution of the complaint by the issuer may not exceed 30 calendar days after the date the issuer receives the written complaint or one-page complaint form from the complainant.

(D) After the issuer has investigated a complaint, the issuer must [shalt] send a response letter to the complainant explaining the issuer's resolution of the complaint within the time frame as set forth in this section. The letter must include a statement of the specific medical and contractual reasons for the resolution and the specialization of any health care provider consulted. The response letter must contain a full description of the process for appeal, including the time frames for the appeal process and the time frames for the final decision on the appeal.

(2) If the complaint is not resolved to the satisfaction of the complainant, the issuer must [shalt] provide an appeals process that includes the right of the complainant to either [tø] appear in person before a complaint appeal panel at a location where the insured normally receives health care services, unless another site is agreed to by the complainant, or to address a written appeal to the complaint appeal panel. The issuer must [shalt] complete the appeals process under this section not later than the 30th calendar day after the date of the receipt of the written request for appeal.

(A) The issuer must [shalt] send an acknowledgment letter to the complainant not later than the fifth business day after the date of receipt of the written request for appeal.

(B) The issuer must [shalt] appoint members to the complaint appeal panel, which must [shalt] advise the issuer on the dispute's resolution [of the dispute]. The complaint appeal panel must [shalt] be composed of equal numbers of issuer staff, physicians or [øther] providers, and insureds. Each member on the complaint appeal panel must not have been previously involved in the disputed decision. The health care providers must have experience in the area of care that is in dispute and must be independent of any health care provider that

[who] made any prior determination. If specialty care is in dispute, then the appeal panel must include a person who is a specialist in the field, or related field, of care [to which] the appeal relates to. Panel members who [that] are insureds may not be the issuer's employees [of the issuer].

(C) Not later than the fifth business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, the issuer must [shall] provide to the complainant or the complainant's designated representative:

(i) any documentation to be presented to the panel by the issuer staff;

(ii) the specialization of any health care providers consulted during the investigation; and

(iii) the name and affiliation of each issuer representative on the panel.

(D) The complainant, or designated representative if the insured is a minor or disabled, is entitled to:

(i) appear in person before the complaint appeal panel;

(ii) present alternative expert testimony; and

(iii) request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

(b) Notice of the final decision of the issuer on the appeal must include a statement of the specific contractual and clinical criteria used to reach the final decision. The notice must also include the toll-free telephone number and the address of the Texas Department of Insurance.

(c) In compliance with Chapter 21, Subchapter Q₂ of this Title (relating to Complaint Records to be Maintained), the issuer shall maintain a record of each complaint and any complaint proceeding and any actions taken on a complaint for three years from the date of the receipt of the complaint. The record must include complaints relating to limited provider networks. A complainant is entitled to a copy of the record on the applicable complaint and any complaint proceeding.

(1) Each issuer must [shall] maintain a complaint and appeal log regarding each complaint.

(2) Each issuer must [shall] maintain documentation on each complaint received and the action taken on each complaint until the third anniversary of the date of receipt of the complaint. The Texas Department of Insurance may review documentation maintained under this subsection, including original documentation, during any investigation of the issuer.

(d) The commissioner may examine the complaint system for compliance with this subchapter and may require the issuer to make necessary corrections.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601815

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Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555

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CHAPTER 5. PROPERTY AND CASUALTY
INSURANCE

SUBCHAPTER Q. GENERAL PROPERTY AND
CASUALTY RULES

DIVISION 4. APPRAISAL REQUIREMENTS

28 TAC §§5.9800 - 5.9806

The Texas Department of Insurance (TDI) proposes new 28 TAC §§5.9800 - 5.9806, concerning requirements for appraisals, in new Division 4. Sections 5.9800 - 5.9806 implement Senate Bill 458, 89th Legislature, 2025.

EXPLANATION. New §§5.9800 - 5.9806 are necessary to implement SB 458, which added new Insurance Code Chapter 1813, concerning Appraisal of Disputed Losses. SB 458 requires certain insurers writing personal automobile or residential property insurance to include an appraisal provision that complies with Insurance Code Chapter 1813 in an insurance policy delivered, issued for delivery, or renewed in Texas. New Insurance Code §1813.002 directs the commissioner to adopt rules necessary to implement the chapter, including rules that mandate appraisal and establish the period in which appraisal must be completed. The statute also directs the commissioner to consider the qualifications and selection of appraisers and umpires in adopting rules.

Sections 5.9800 - 5.9806 are added to new Division 4, which addresses the appraisal process for both personal automobile and residential property insurance and the notice insurers must send to a policyholder informing them of their right to appraisal. The requirements and conditions in Division 4 do not prohibit appraisal provisions from including other requirements or conditions that do not limit and are not contrary to Insurance Code Chapter 1813 and Division 4. Any other requirements and conditions remain subject to other applicable Texas laws, such as the standards for forms subject to filing and approval under Insurance Code Chapter 2301, Subchapter A.

To provide enough time for insurers to comply with these changes, TDI proposes to make September 1, 2026, the deadline to implement the new requirements. This proposed compliance date will give insurers ample time to amend the appraisal provisions in automobile and homeowners insurance policies and to draft and incorporate the appraisal process notice into their claims-handling process. In addition, it gives insurers time to file the amended policy forms with TDI for review and approval before September 1, 2026.

TDI received comments on an informal draft posted on September 22, 2025. TDI considered those comments when drafting this proposal.

Descriptions of the proposed new sections follow.

New §5.9800. This section describes the purpose and scope of new Division 4, relating to Appraisal Requirements. Subsection (a) states that the purpose of Division 4 is to implement In-

Insurance Code Chapter 1813. Subsections (b) and (c) provide the applicability of Division 4, consistent with Insurance Code §1813.001, and state that Division 4 applies to personal automobile and residential property insurance delivered, issued for delivery, or renewed on or after September 1, 2026.

New §5.9801. This section provides definitions for use in new Division 4, including definitions of appraisal, appraisal provision, appraisal award, appraiser, party, personal automobile insurance, residential property insurance, and umpire.

The definition of "appraisal" refers to the process to resolve disputes about the amount of loss as described in Insurance Code Chapter 1813, and the definition of "appraisal provision" refers to the policy provision that provides for appraisal required under Chapter 1813.

The definition of "appraisal award" specifies that the determination of the amount of loss is signed by both appraisers or one appraiser and the umpire. Consistent with a typical appraisal provision, the umpire cannot unilaterally determine the amount of loss.

The definition of "party" means the insurer or the policyholder.

The definitions of "personal automobile insurance" and "residential property insurance" align with the description of those terms in Insurance Code §2301.051, helping to ensure clear and consistent application of these rules.

"Appraiser" and "umpire" are defined similarly to mean an individual who is qualified to act as an appraiser or umpire under Division 4 and who is hired or otherwise selected or appointed to participate in the appraisal process.

New §5.9802. This section outlines the general requirements for appraisal provisions required in certain insurance policies under Insurance Code Chapter 1813. These requirements do not prohibit appraisal provisions from including other requirements or conditions that do not limit and are not contrary to Insurance Code Chapter 1813 and new Division 4. Any other requirements and conditions remain subject to other applicable Texas laws, such as the standards for forms subject to filing and approval under Insurance Code Chapter 2301, Subchapter A.

This section also requires every policy subject to Insurance Code Chapter 1813 to include an appraisal provision that meets the standards outlined in paragraphs (1) - (6) of the section. Under paragraph (1), applicable policies must contain an appraisal provision that states either party has the right to unilaterally demand appraisal. Permitting either party to invoke appraisal is consistent with SB 458, which mandates that certain automobile and homeowners insurance policies include an appraisal provision. Requiring both parties to consent to appraisal before it is executed would frustrate the purpose of SB 458.

Under paragraph (2), the ability to demand appraisal must not be conditioned on the parties reaching an impasse. As described in Insurance Code §1813.003, the appraisal provision is intended to provide a dispute resolution process when the amount of loss is in dispute. A dispute indicates disagreement between the parties and does not require the parties to show that there is no chance of reaching an agreement. Paragraph (2) does not prevent an insurer from requiring proof of loss, consistent with Insurance Code Chapter 542, Subchapter B.

Paragraph (3) clarifies that appraisal is available for partial and total losses. Appraisal is not limited to total losses; it is also available for damaged property that only requires repair.

Paragraph (4) aligns with Insurance Code §1813.004 to clarify that an appraisal provision must require the appraisal award to be binding as to the amount of loss unless it was made without authority; was not made in substantial compliance with the appraisal provision; or there was fraud, or a material mistake relevant to the appraisal.

Paragraph (5) requires appraisal provisions to state the deadlines and process for appraisal. Deadlines must include the specific amounts of time listed in new §5.9805 and §5.9806 and be consistent with the other requirements in Division 4. The time limits and deadlines in new §5.9805 and §5.9806 provide a consistent and reliable basic timeframe for the appraisal process. For example, paragraph (5) ensures that every residential property policy subject to Insurance Code Chapter 1813 will give the policyholder one year to demand appraisal after the notice required under Insurance Code §542.056 is provided. It also gives the parties flexibility to agree to modify deadlines after a claim is made and the notice of acceptance or rejection under Insurance Code §542.056 has been provided. For example, after the notice is provided, the parties could agree to shorten the amount of time for the appraisers to reach an agreement on the amount of loss because the loss at issue is relatively simple. Paragraph (5) does not prohibit an appraisal provision from having additional deadlines.

Paragraph (6) clarifies that appraisal provisions must not conflict with new Division 4 or other Texas law, such as the policy form standards in Insurance Code Chapter 2301, Subchapter A.

New §5.9803. This section outlines the information that must be included in an appraisal process notice to policyholders. Subsection (a) requires an insurer to provide an appraisal process notice to the policyholder at the same time the insurer provides the notice of acceptance or rejection of the claim required under Insurance Code §542.056. The insurer may add the information required under subsection (b) to the notice sent under Insurance Code §542.056. Insurers may also choose to create a separate notice containing the information required under new §5.9803 and provide it to the policyholder at the same time as the notice required under Insurance Code §542.056.

Findings in TDI's 2024 Appraisal Experience Data Call Report (available at www.tdi.texas.gov/reports/pc/documents/2024-appraisal-experience-data-call-report.pdf) indicate that appraisal is demanded in only a small percentage of claims. Policyholders are unlikely to be familiar with how appraisal works and might not be aware of the availability of appraisal to resolve a dispute about the amount of loss. Policyholders should be made aware of appraisal and receive basic information about how it works when an insurer notifies the policyholder of the acceptance or rejection of a claim.

Subsection (b) requires the appraisal process notice to be written in plain language and appear in at least 10-point type, and explain:

- where the appraisal provision is located in the policy contract;
- how the policyholder may demand appraisal, including where to send the demand and what information the demand should include;
- the policyholder's responsibilities in the appraisal process;
- how the policyholder may request appointment of an umpire if the appraisers fail to jointly choose the umpire within the time provided, including how to request judicial appointment of an umpire;

- the applicable time limits in the appraisal process, including certain minimum information regarding deadlines; and
- the effect of the appraisal award.

New §5.9804. This section outlines the minimum qualifications that an appraiser or umpire must possess for appraisals subject to Insurance Code Chapter 1813 and new Division 4. Under subsection (a), all appraisers and umpires must meet the minimum qualifications, including (1) competency to evaluate the type of loss in the dispute, (2) independence from the parties, and (3) disinterest in the appraisal's outcome. A competency element is a long-standing, standard feature in personal automobile and residential property appraisal provisions, including in promulgated Texas personal automobile and homeowners policies. Likewise, independence from the parties is a common element in many appraisal provisions, including in promulgated Texas homeowners policies. Appraiser and umpire disinterest in the outcome is also preferred. It prevents appraisers from having a particular pecuniary interest in the outcome, ensuring an appraisal's fairness and trustworthiness as a dispute resolution tool.

Under subsection (b), appraisers and umpires in a residential property appraisal that involves loss to a dwelling must also be (1) an adjuster or public adjuster or public adjuster with experience or training in estimating residential property losses; (2) an engineer or architect with experience or training in residential construction or repair, investigating residential property damage, or estimating residential property losses; or (3) an individual who otherwise has occupational experience or training in constructing or repairing the type of damaged property at issue or estimating the type of property loss at issue. Specifying particular experience or training for appraisal of loss to a dwelling helps ensure that only properly qualified individuals participate and increases consistency in the market.

Because the section outlines only the minimum qualifications of an appraiser or umpire, appraisal provisions may establish additional or more specific qualifications as long as those provisions do not conflict with Division 4. This added flexibility reflects that loss disputes of this nature can vary significantly, such as the variation in the type and extent of property at issue; insurers can decide whether more nuanced qualifications may be appropriate.

New §5.9805. This section specifies requirements for the appraisal process under residential property insurance policies.

Subsection (a)(1) specifies that, except as provided in subsection (a)(2), an appraisal demand must be made in writing not later than one year after the insurer notifies the policyholder of acceptance or rejection of the claim as required under Insurance Code §542.056. Establishing the period to complete appraisal includes addressing the time that appraisal must begin. The one-year time limit to demand appraisal strikes a balance between giving time for a party to identify a disagreement about the amount of loss while ensuring appraisal is begun in a reasonable amount of time.

According to findings in the Appraisal Experience Data Call Report, while appraisal was used in only a small percentage of residential property claims, it was almost always initiated by the claimant, i.e., the policyholder. Most policyholders are likely unfamiliar with appraisal even though it is an important dispute resolution tool, so it is reasonable to favor a relatively long deadline to demand appraisal. According to the Appraisal Experience Data Call Report, approximately 90% of residential property ap-

praisals were demanded within 11 months after the claim was filed. For the vast majority of claims, a one-year time limit from the date an insurer provides the notice required under Insurance Code §542.056 should be sufficient time for parties to evaluate whether to use appraisal. Using the notice required under Insurance Code §542.056 as a timing trigger provides a clear, consistent, well-established marker in the claim settlement process.

Subsection (a)(2) provides that if a lawsuit is filed concerning the loss at issue, the respondent to the lawsuit must have 30 days to demand appraisal. Subsection (a)(2) preserves the ability of a responding party to initiate appraisal even if the deadline in subsection (a)(1) has passed. Appraisal can be a more affordable and efficient dispute resolution process than litigation when an amount of loss is in dispute, so preserving the ability to initiate appraisal is beneficial.

Subsection (b) outlines other procedures and deadlines for residential property appraisal, including the deadlines to hire an appraiser, choose an umpire, and attempt to agree on the amount of loss. An appraisal award ordinarily represents the completion of appraisal. Because an appraisal award requires either both appraisers or the umpire and one of the appraisers to agree on an amount of loss, setting deadlines fundamentally helps establish the time in which appraisal must be completed.

Under subsection (b)(1), each party must hire an appraiser and provide the other party with the appraiser's name and contact information in writing within 20 days after written demand for appraisal is made. This prevents undue delay and is consistent with many appraisal provisions, including those in promulgated Texas homeowners policies.

Subsection (b)(2) requires appraisers to jointly choose an umpire and requires the appraisal provision to use one of the two deadline options in subparagraphs (A) and (B) for when umpire selection must occur. The first option requires the appraisers to choose an umpire not later than 15 days after the requirements in subsection (b)(1) are completed. This is a common deadline used in many appraisal provisions, including those in promulgated Texas homeowners policies. The second option requires the appraisers to choose an umpire not later than 15 days after the appraisers cannot agree on the amount of loss in dispute within the time under subsection (b)(4). The second option is an alternative for insurers that might prefer to have an appraisal provision that allows appraisers to wait to see whether they can agree on the amount of loss before choosing an umpire. The two options give insurers flexibility to establish when the umpire selection should occur during the appraisal process.

For circumstances in which the appraisers fail to choose an umpire within the deadlines described in proposed subsection (b)(2)(A) and (B), subsection (b)(3) states the required and permitted methods of umpire selection. Under subsection (b)(3)(A), an appraisal provision must allow either party to request judicial appointment of an umpire through a county or district where the residential property is located. Judicial appointment is the method many residential property appraisal provisions use, including in promulgated Texas homeowners policies, if the appraisers cannot agree on an umpire. Appraisal is a binding dispute resolution process that can offer an alternative to litigation, so it is reasonable to require appraisal provisions to have a judicial appointment option if there is a disagreement over who should be the umpire.

Subsection (b)(3)(B) authorizes insurers to include, in addition to judicial appointment, other methods of umpire appointment

in an appraisal provision. Some residential property appraisal provisions currently provide for the umpire to be chosen by an independent vendor if the appraisers cannot agree. Subsection (b)(3)(B)(i) allows an insurer to provide an option for umpire appointment by an independent vendor that offers umpire selection services, but the insurer must include at least two vendors and let the policyholder select the vendor, or allow only the policyholder to invoke this option. Subsection (b)(3)(B)(ii) allows an insurer to provide umpire appointment through any alternative method that both parties mutually agree to in writing after appraisal has been demanded. By allowing these options in addition to judicial appointment, the proposed rule gives insurers added flexibility and efficiency in the appointment process while still ensuring a level of policyholder choice, regardless of the method.

Subsection (b)(3)(C) requires a party requesting umpire appointment through judicial appointment or by independent vendor to give written notice to the other party at least 10 days before making the request and, for judicial-appointment purposes, requires the written notice to include the location and identity of the court. Subsection (b)(3)(D) also requires the party requesting appointment to provide the other party with a copy of the request before or when the request is submitted. Subparagraphs (C) and (D) in subsection (b)(3) ensure that both parties are aware of an umpire appointment request.

Subsections (b)(4) and (5) outline the deadlines for attempting to agree on the amount of loss in dispute during appraisal. Under subsection (b)(4), appraisers must attempt to agree within 120 days after the appraisal demand was made. The 120-day deadline strikes a balance between providing time for the appraisers to attempt to agree on the amount of loss while ensuring that appraisal is completed in a reasonable amount of time. Findings in the Appraisal Experience Data Call Report indicate that about 75% of residential property appraisal awards that did not involve an umpire were made within 120 days after appraisal was demanded.

Under subsection (b)(5), where appraisers are unable to agree and an umpire is involved, the appraisers must submit their differences to the umpire and each other. An appraisal award must be issued not later than 240 days after the appraisal demand was made. Appraisal provisions, including those in promulgated Texas homeowners policies, commonly require appraisers to submit their differences to an umpire if the appraisers cannot agree on an amount of loss. According to the Appraisal Experience Data Call Report, 75% of residential property appraisal awards involving an umpire were made within 278 days after appraisal was demanded, and 50% were made within 193 days. The proposed 240-day deadline strikes a balance between completing appraisal in a timely manner and the need to give the umpire sufficient time to evaluate the loss, examine the differences, and attempt to agree on the amount of loss with at least one of the appraisers. Subject to subsection (c), if the appraisal award is not issued by the 240-day deadline, then the umpire's engagement is terminated on that date, and the appraisers must choose a new umpire within 15 days after the deadline passes.

Subsection (c) authorizes parties to modify any deadline in the appraisal process by written agreement after the appraisal process notice is provided under §5.9803. This gives the parties flexibility to adjust the timeframe after a loss occurs, allowing them to tailor it to the relative breadth and complexity of the loss at issue.

Section 5.9806. This section specifies requirements for the appraisal process under personal automobile insurance policies.

Subsection (a)(1) specifies that except as provided in subsection (a)(2), an appraisal demand must be made in writing not later than 120 days after the insurer notifies the policyholder of acceptance or rejection of a claim as required under Insurance Code §542.056. Establishing the period to complete appraisal reasonably includes addressing the time in which appraisal must begin. The 120-day deadline to demand appraisal strikes a balance between giving time for a party to identify a disagreement about the amount of loss while ensuring appraisal is begun in a reasonable amount of time.

According to findings in the Appraisal Experience Data Call Report, while appraisal was used in only a small percentage of personal automobile claims, it was almost always initiated by the claimant, i.e., the policyholder. Because most policyholders are likely unfamiliar with the appraisal process, even though it is an important dispute resolution tool, it is reasonable to favor a relatively long deadline to demand appraisal. According to the Appraisal Experience Data Call Report, over 90% of personal automobile appraisals were demanded within 120 days after the claim was filed. For the vast majority of claims, a 120-day deadline from the date an insurer provides the notice required under Insurance Code §542.056 should be sufficient time for parties to evaluate whether to use appraisal. Using the notice required under Insurance Code §542.056 as a timing trigger provides a clear, consistent, well-established marker in the claim settlement process.

Subsection (a)(2) provides that if a lawsuit is filed concerning the loss at issue, the respondent to the lawsuit must have 30 days to demand appraisal. Subsection (a)(2) preserves the ability of a responding party to initiate appraisal in case the deadline in subsection (a)(1) has passed. Appraisal can be a more affordable and efficient dispute resolution process than litigation when an amount of loss is in dispute, so preserving the ability to initiate appraisal is beneficial.

Subsection (b) outlines other procedures and deadlines for personal automobile appraisal, including the deadlines to hire an appraiser, choose an umpire, and attempt to agree on the amount of loss. An appraisal award ordinarily represents the completion of appraisal. Because an appraisal award requires either both appraisers or the umpire and one of the appraisers to agree on an amount of loss, setting deadlines fundamentally helps establish the time in which appraisal must be completed.

Under subsection (b)(1), each party must hire an appraiser and provide the other party with the appraiser's name and contact information in writing within 20 days after written demand for appraisal is made. While many appraisal provisions do not specify a deadline to select an appraiser, setting a 20-day deadline will help ensure that appraisers are identified and able to begin efforts to agree on the amount of loss in a timely manner.

Subsection (b)(2) requires appraisers to jointly choose an umpire and requires the appraisal provision to use one of the two deadline options in subparagraphs (A) and (B) for when umpire selection must occur. The first option in subsection (b)(2)(A) requires the appraisers to choose an umpire not later than 15 days after the requirements in subsection (b)(1) are completed. The second option in subsection (b)(2)(B) requires the appraisers to choose an umpire not later than 15 days after the appraisers cannot agree on the amount of loss in dispute within the time under subsection (b)(4). While many personal auto appraisal provi-

sions do not specify a deadline to choose an umpire, setting a 15-day deadline will help ensure that an umpire is identified and able to begin efforts to resolve the appraisal in a timely manner if the appraisers cannot agree on the amount of loss. The two options give insurers flexibility to establish when the umpire selection should occur during the appraisal process.

For circumstances in which the appraisers fail to choose an umpire within the deadlines described in proposed subsection (b)(2)(A) and (B), subsection (b)(3) states the required and permitted methods of umpire selection. Under subsection (b)(3)(A), an appraisal provision must allow either party to request judicial appointment of an umpire through a county or district court where the residential property is located. Appraisal is a binding dispute resolution process that can offer an alternative to litigation, so it is reasonable to require appraisal provisions to have a judicial appointment option if there is a disagreement over who should be the umpire.

Subsection (b)(3)(B) authorizes insurers to include, in addition to judicial appointment, other methods of umpire appointment in an appraisal provision. Subsection (b)(3)(B)(i) allows an insurer to provide an option for umpire appointment by an independent vendor that offers umpire selection services, but the insurer must include at least two vendors and let the policyholder select the vendor, or allow only the policyholder to invoke this option. Subsection (b)(3)(B)(ii) allows an insurer to provide umpire appointment through any alternative method that both parties mutually agree to in writing after appraisal has been demanded. By allowing these options in addition to judicial appointment, the proposed rule gives insurers the ability to increase flexibility and, potentially, efficiency of the appointment process and still ensures a level of policyholder choice regardless of the method.

Subsection (b)(3)(C) requires a party requesting umpire appointment through judicial appointment or by independent vendor to give written notice to the other party at least 10 days before making the request and, for purposes of judicial appointment, requires the written notice to include the location and identity of the court. Subsection (b)(3)(D) also requires the party requesting appointment to provide the other party with a copy of the request before or when the request is submitted. Subsections (b)(3)(C) and (D) ensure that both parties are aware of an umpire appointment request.

Subsections (b)(4) and (5) outline the deadlines for attempting to agree on the amount of loss in dispute during appraisal. Under subsection (b)(4), appraisers must attempt to agree within 40 days after the appraisal demand was made. The 40-day deadline strikes a balance between providing time for the appraisers to attempt to agree on the amount of loss while ensuring that appraisal is completed in a reasonable amount of time. Findings in the Appraisal Experience Data Call Report indicate that over 75% of personal automobile appraisal awards that did not involve an umpire were made within 40 days after appraisal was demanded.

Under subsection (b)(5), where appraisers are unable to agree and an umpire is involved, the appraisers must submit their differences to the umpire and each other. An appraisal award must be issued not later than 180 days after the appraisal demand was made. Appraisal provisions, including those in the promulgated Texas personal automobile policy, commonly require appraisers to submit their differences to an umpire if the appraisers cannot agree on an amount of loss. According to the Appraisal Experience Data Call Report, 75% of personal automobile appraisal awards that involved an umpire were made within 210 days after

appraisal was demanded, and 50% were made within 114 days. Setting a 180-day deadline strikes a balance between completing appraisal in a timely manner and the need to give the umpire sufficient time to evaluate the loss, examine the differences, and attempt to agree on the amount of loss with at least one of the appraisers. Subject to subsection (c), if the appraisal award is not issued by the 180-day deadline, then the umpire's engagement is terminated on that date, and the appraisers must choose a new umpire within 15 days after the deadline passes.

Subsection (c) authorizes parties to modify any deadline in the appraisal process by written agreement after the appraisal process notice is provided under §5.9803. This gives the parties flexibility to adjust the timeframe after a loss occurs, allowing them to tailor it to the relative breadth and complexity of the loss at issue.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. David Muckerheide, assistant director of the Property and Casualty Lines Office, has determined that during each year of the first five years the proposed new sections are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the new sections, other than that imposed by statute. Mr. Muckerheide made this determination because the proposed new sections do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new sections.

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

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new sections are in effect, Mr. Muckerheide expects that administering them will have the public benefit of ensuring that TDI's rules conform with Insurance Code Chapter 1813, as added by SB 458. In addition, the new sections will benefit personal automobile and residential property policyholders by creating consistent timeframes and minimum standards for appraisal provisions and processes, and by ensuring they are made aware of the right to demand appraisal. Policyholders and insurers will also benefit from having reasonable deadlines to help promote the timely completion of appraisals, and from having required appraisal provisions in policies because appraisal can be cheaper, more efficient, and a timelier dispute resolution option than litigation.

Mr. Muckerheide expects that the proposed new sections will impose an economic cost on persons required to comply with the new sections.

Costs. TDI anticipates that implementing the proposed new sections will result in costs to insurers when updating personal automobile and residential property insurance policy forms and notices to comply with the proposed requirements. The cost to comply will vary depending on the contents of an insurer's appraisal provision, the insurer's operations, and how the insurer chooses to implement the notice requirements under new §5.9805. While it is not feasible to determine the actual time required or the cost of employees needed to comply with the requirements, TDI estimates that updating appraisal provision language and drafting the appraisal process notice to policyholders will take a range of three to five hours to complete and might require an attorney. According to the May 2024 Bureau of Labor Statistics Occupational Employment and Wage Statistics

at www.bls.gov/oes/current/oes_nat.htm, the national mean hourly wage for the "Lawyers" classification is \$87.86.

Depending on how insurers choose to implement the appraisal process notice to policyholders under new §5.9803, TDI anticipates that incorporating updated language into insurers' existing policy and notice form templates, filing updated policy forms with TDI, and updating policy and claim administration systems will take a range of five to 15 hours to complete and will likely require both software programming and clerical staff. According to the May 2024 Bureau of Labor Statistics Occupational Employment and Wage Statistics at www.bls.gov/oes/current/oes_nat.htm, the national mean hourly wage for the "Software and Web Developers, Programmers, and Testers" classification is \$65.34, and the national mean hourly wage for the "Secretaries and Administrative Assistants, Except Legal, Medical, and Executive" classification is \$25.03.

TDI anticipates there may be printing, copying, mailing, and transmitting costs associated with providing updated forms to policyholders at renewal and updated notice forms to policyholders when a claim is accepted or rejected. It may require clerical staff to implement these printing, copying, mailing, and transmission efforts. It is not possible for TDI to estimate the total increased printing, copying, mailing, and transmitting costs related to compliance with this proposal because there are many factors involved that TDI cannot quantify. For example, an insurer might conduct business with its policyholders electronically and would not incur printing, copying, mailing, or transmitting costs. Insurers are more capable of accurately estimating any costs they will incur to comply.

Factors mitigating costs. Because insurers were required to have an appraisal provision in their personal automobile and residential property insurance policy forms delivered, issued for delivery, or renewed on or after January 1, 2026, TDI anticipates that the updates required to comply with the new sections should be less burdensome to implement. In addition, TDI proposes delaying the date that insurers must begin complying with the new rule requirements to September 1, 2026, so insurers have additional time to implement the new requirements.

New §5.9803 permits insurers to choose how to comply with the appraisal process notice to policyholders. Insurers may choose to incorporate the appraisal process notice information into the notice of acceptance or rejection required under Insurance Code §542.056 or provide a separate appraisal process notice to policyholders at the same time the notice under Insurance Code §542.056 is sent. If insurers choose to incorporate the information into the notice of acceptance or rejection, then insurers may incur lower printing, copying, mailing, and transmitting costs.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed new sections may have an adverse economic effect on small or micro businesses. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to small and micro businesses. TDI estimates that the proposed new sections may affect approximately 75 to 80 personal automobile insurers and 45 to 50 residential property insurers. The primary objective of this proposal is to establish the requirements for an appraisal provision in a personal auto or residential property insurance policy, consistent with Insurance Code Chapter 1813.

TDI has determined that the proposed new sections will not have an adverse economic effect or a disproportionate effect on rural

communities because the rules do not apply to rural communities.

TDI considered the following alternatives to minimize any adverse impact on small and micro businesses while accomplishing the proposal's objectives:

- (1) not proposing the new sections;
- (2) excluding small and micro businesses from complying with the new sections; and
- (3) extending the deadline for small and micro businesses to comply with the new sections.

Not proposing the new sections. As previously noted, the primary purpose of this rule is to implement Insurance Code Chapter 1813, which requires certain insurers that write personal automobile or residential property insurance to include an appraisal provision in an insurance policy beginning January 1, 2026. Insurance Code §1813.002 directs TDI to adopt rules necessary to implement the chapter, including rules that (1) establish the period in which an appraisal must be completed, considering the qualifications and selection of appraisers and umpires; and (2) mandate appraisal in certain circumstances. Not proposing the new sections would result in TDI failing to meet the clear directive in Insurance Code §1813.002. For this reason, TDI has rejected this option.

Excluding small and micro businesses from complying with the proposed new sections. Insurance Code §1813.001 identifies the insurers who are required to comply with Insurance Code Chapter 1813. Insurers who meet the definition of small and micro businesses under Government Code §2006.001 are not excluded under Insurance Code §1813.001(b). Excluding small and micro businesses from compliance would result in disparate treatment of policyholders who purchase a personal automobile or residential property insurance policy from a small or micro business. These policyholders would be deprived of the basic protections established by the rules, including the minimum appraisal provision requirements and the appraisal process notice requirements. For this reason, TDI has rejected this option.

Extending the deadline for small and micro businesses to comply with the proposed new sections. TDI decided to extend the deadline for compliance for all insurers because this option ensures consistent application of Insurance Code Chapter 1813, protects all policyholders who purchase a personal automobile or residential property policy, and lessens confusion by having only one compliance date for all applicable Texas insurers. In addition, the extended deadline for compliance will help alleviate some of the possible economic impacts of compliance, including economic impacts on small and micro businesses. Insurers will have the opportunity to incorporate the new requirements under Division 4 with other planned policy updates or changes during that period. For these reasons, TDI has decided to incorporate this option into the proposal.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does impose a possible cost on regulated persons. No additional rule amendments are required under Government Code §2001.0045 because the proposed rule is necessary to implement legislation. The proposed rule implements Insurance Code §1813.002, as added by SB 458.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new sections 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 create a new regulation;
- will not expand, limit, or repeal an existing regulation;
- will increase the number of individuals subject to the rule's applicability; and
- will positively affect the Texas economy by having appraisal provisions in policies because appraisal can be cheaper, more efficient, and a timelier dispute resolution option than litigation and by establishing reasonable and consistent minimum requirements that help ensure appraisals are fair and completed in a timely manner.

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 TDI no later than 5:00 p.m., central time, on June 8, 2026. 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 Chief-Clerk@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. 2862 at 10:00 a.m., central time, on June 2, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.035. Details of how to view and participate virtually in the public hearing will be made available on TDI's website at www.tdi.texas.gov/alert/event/index.html.

STATUTORY AUTHORITY. TDI proposes new §§5.9800 - 5.9806 under Insurance Code §1813.002 and §36.001.

Insurance Code §1813.002 requires the commissioner to adopt rules necessary to implement Insurance Code Chapter 1813, including rules establishing the period in which an appraisal under Insurance Code Chapter 1813 must be completed and rules mandating an appraisal for total loss and damage of the property that is the subject of the appraisal.

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 5.9800 - 5.9806 implement Insurance Code Chapter 1813.

§5.9800. Purpose and Scope.

(a) This division implements Insurance Code Chapter 1813, concerning Appraisal of Disputed Losses, which requires personal automobile and residential property insurance policies to include an appraisal provision that is intended to provide a type of dispute resolution process solely to determine the amount of loss when that amount is in dispute between the policyholder and the insurer.

(b) This division applies to personal automobile and residential property insurance policies delivered, issued for delivery, or renewed on or after September 1, 2026, in Texas by insurers described in Insurance Code §1813.001(a), concerning Applicability of Chapter.

(c) This division does not apply to:

- (1) Texas Windstorm Insurance Association policies; or
- (2) commercial insurance policies.

§5.9801. Definitions.

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

(1) Appraisal--The process to resolve a dispute between the insurer and a policyholder about the amount of loss as described in Insurance Code Chapter 1813, concerning Appraisal of Disputed Losses.

(2) Appraisal provision--The policy provision that provides for appraisal, as required under Insurance Code Chapter 1813.

(3) Appraisal award--The written determination of the amount of loss which is signed during the appraisal process by:

- (A) both appraisers; or
- (B) by either of the appraisers and the umpire.

(4) Appraiser--An individual who is qualified to be an appraiser under this division and is hired by either party to participate in the appraisal process.

(5) Party--The insurer or policyholder.

(6) Personal automobile insurance--Automobile insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous-type motor vehicle, including a motor home, trailer, or recreational vehicle, that is owned or leased by one or more individuals and not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(7) Residential property insurance--Insurance coverage against loss to tangible personal property or to residential real property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

(8) Umpire--An individual who is qualified to be an appraisal umpire under this division and is selected by the appraisers or otherwise appointed to participate in the appraisal process.

§5.9802. General Requirements for Appraisal Provisions.

Every insurance policy subject to this division must have an appraisal provision that:

- (1) states either party has the right to unilaterally demand appraisal;
- (2) does not require the parties to reach an impasse before a party can demand appraisal;
- (3) applies to disputes between the parties about the amount of loss, including partial or total loss;

(4) requires the appraisal award to be binding as to the amount of loss, unless:

(A) it was made without authority;

(B) it was not made in substantial compliance with the appraisal provision; or

(C) there was fraud, accident, or material mistake relevant to the appraisal;

(5) states the deadlines and process for appraisal, which must include the specific amounts of time listed in §5.9805 of this title (relating to Residential Property Appraisal Process) or §5.9806 of this title (relating to Personal Automobile Appraisal Process) as applicable and be consistent with the other requirements in this division; and

(6) does not conflict with this division or other Texas law.

§5.9803. Appraisal Process Notice to Policyholders.

(a) At the same time the insurer provides notice of acceptance or rejection of the claim as required under Insurance Code §542.056, concerning Notice of Acceptance or Rejection of Claim, the insurer must also provide notice of the appraisal process to the policyholder that is consistent with this section. Notice of the appraisal process may be a separate document or may be included in the notice under Insurance Code §542.056.

(b) The appraisal process notice must be written in plain language and at least 10-point type, and explain:

(1) where the appraisal provision is in the policy contract;

(2) how the policyholder may demand appraisal, including where to send the demand and what information the demand should include;

(3) the policyholder's responsibilities in the appraisal process, including the duty to hire an appraiser and any responsibility for appraisal expenses;

(4) how the policyholder may request appointment of an umpire if the appraisers fail to jointly choose the umpire within the time provided under §5.9805(b)(2) of this title (relating to Residential Property Appraisal Process) or §5.9806(b)(2) of this title (relating to Personal Automobile Appraisal Process), including how to request judicial appointment of an umpire;

(5) the applicable time limits in the appraisal process including, at a minimum, the deadlines for:

(A) demanding appraisal;

(B) appointing appraisers;

(C) selection of an umpire; and

(D) issuing the appraisal award; and

(6) the effect of the appraisal award.

§5.9804. Minimum Qualifications for Appraisers and Umpires.

(a) Appraisers and umpires must be:

(1) competent by training or experience to evaluate the type of loss in dispute;

(2) independent from the parties; and

(3) disinterested in the outcome of the appraisal.

(b) In addition to subsection (a) of this section, appraisers and umpires in a residential property appraisal that involves loss to a dwelling must also be one of the following:

(1) an adjuster or public adjuster with experience or training in estimating residential property losses;

(2) an engineer or architect with experience or training in residential building construction or repair, investigating residential property damage, or estimating residential property losses; or

(3) an individual who otherwise has occupational experience or training in constructing or repairing the type of damaged property at issue or estimating the type of property loss at issue.

§5.9805. Residential Property Appraisal Process.

(a) Appraisal demand.

(1) Except as provided in paragraph (2) of this subsection, a demand for appraisal under a residential property insurance policy must be made in writing not later than one year from the date the insurer notifies the policyholder of acceptance or rejection of the claim as required under Insurance Code §542.056, concerning Notice of Acceptance or Rejection of Claim.

(2) If a lawsuit is filed concerning the loss at issue, the respondent must have 30 days from when the lawsuit is filed to make an appraisal demand.

(b) Appraisal and umpire procedures. Subject to subsection (c) of this section, the following deadlines apply after a written demand for appraisal is made under subsection (a) of this section.

(1) Within 20 days, each party must hire its own appraiser and provide the appraiser's name and contact information to the other party in writing.

(2) The appraisers must jointly choose an umpire. The appraisal provision must require the appraisers to jointly choose an umpire not later than 15 days after either:

(A) the requirements in paragraph (1) of this subsection are completed; or

(B) the appraisers cannot agree on the amount of loss in dispute within the time provided in paragraph (4) of this subsection.

(3) If the appraisers fail to jointly choose an umpire within the time provided under paragraph (2) of this subsection, an umpire must be appointed subject to the following provisions.

(A) The appraisal provision must allow either party to request judicial appointment of an umpire. The judicial appointment must be through a county or district court where the residential property is located.

(B) An appraisal provision may also include:

(i) an option for umpire appointment by an independent vendor that offers umpire selection services. An option for umpire appointment by an independent vendor must include at least two vendors and allow the policyholder to select which vendor is used, or it must allow only the policyholder to invoke the option for umpire appointment by a vendor; and

(ii) an option for umpire appointment through any alternative method that the parties mutually agree to in writing after appraisal has been demanded.

(C) A party requesting umpire appointment through judicial appointment or by an independent vendor must give written notice to the other party at least 10 days before making the request. For a judicial appointment, the written notice must include the location and identity of the court.

(D) On or before submitting a request for umpire appointment under this subsection, the party requesting the appointment must give the other party a copy of the request.

(4) Within 120 days after the appraisal demand was made, the two appraisers must attempt to agree on the amount of loss in dispute.

(5) If the appraisers cannot agree on the amount of loss in dispute, they must submit their differences to each other and the umpire. When an umpire is involved, the appraisal award must be issued not later than 240 days after the appraisal demand was made. If an appraisal award is not issued by the deadline, the umpire's engagement is terminated on that date, and the appraisers must choose a new umpire within 15 days after the deadline passes.

(c) Modifying deadlines. The parties may modify any deadline in the appraisal process by written agreement after the insurer provides the appraisal process notice required under §5.9803 of this title (relating to Appraisal Process Notice to Policyholders).

§5.9806. Personal Automobile Appraisal Process.

(a) Appraisal demand.

(1) Except as provided in paragraph (2) of this subsection, a demand for appraisal under a personal automobile insurance policy must be made in writing not later than 120 days from the date the insurer notifies the policyholder of acceptance or rejection of the claim as required under Insurance Code §542.056, concerning Notice of Acceptance or Rejection of Claim.

(2) If a lawsuit is filed concerning the loss at issue, the respondent must have 30 days from when the lawsuit is filed to make an appraisal demand.

(b) Appraisal and umpire procedures. Subject to subsection (c) of this section, the following deadlines apply after a written demand for appraisal is made under subsection (a) of this section.

(1) Within 20 days, each party must hire its own appraiser and provide the appraiser's name and contact information to the other party in writing.

(2) The appraisers must jointly choose an umpire. The appraisal provision must require the appraisers to jointly choose an umpire not later than 15 days after either:

(A) the requirements in paragraph (1) of this subsection are completed; or

(B) the appraisers cannot agree on the amount of loss in dispute within the time provided in paragraph (4) of this subsection.

(3) If the appraisers fail to jointly choose an umpire within the time provided under paragraph (2) of this subsection, an umpire must be appointed subject to the following provisions.

(A) The appraisal provision must allow either party to request judicial appointment of an umpire. The judicial appointment must be through a county or district court where the vehicle is principally garaged.

(B) An appraisal provision may also include:

(i) an option for umpire appointment by an independent vendor that offers umpire selection services. An option for umpire appointment by an independent vendor must include at least two vendors and allow the policyholder to select which vendor is used, or it must allow only the policyholder to invoke the option for umpire appointment by a vendor; and

(ii) an option for umpire appointment through any alternative method that the parties mutually agree to in writing after appraisal has been demanded.

(C) A party requesting umpire appointment through judicial appointment or by an independent vendor must give written notice to the other party at least 10 days before making the request. For judicial appointment, the written notice must include the location and identity of the court.

(D) On or before submitting a request for umpire appointment under this subsection, the party requesting the appointment must give the other party a copy of the request.

(4) Within 40 days after the appraisal demand was made, the two appraisers must attempt to agree on the amount of loss in dispute.

(5) If the appraisers cannot agree on the amount of loss in dispute, they must submit their differences to each other and the umpire. When an umpire is involved, the appraisal award must be issued not later than 180 days after the appraisal demand was made. If an appraisal award is not issued by the deadline, the umpire's engagement is terminated on that date, and the appraisers must choose a new umpire within 15 days after the deadline passes.

(c) Modifying deadlines. The parties may modify any deadline in the appraisal process by written agreement after the insurer provides the appraisal process notice required under §5.9803 of this title (relating to Appraisal Process Notice to Policyholders).

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

Filed with the Office of the Secretary of State on April 23, 2026.

TRD-202601783

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Texas Department of Insurance (TDI) proposes to repeal 28 TAC §11.505 and amend §§11.202, 11.301, 11.302, 11.501 - 11.504, 11.506, 11.701, 11.901, 11.902, 11.1402, 11.1604, and 11.2503, concerning health maintenance organizations (HMOs). The repeal and amendments update HMO filing rules to align with filing requirements in 28 TAC Chapter 3, Subchapter A, and implement House Bills 388, 2221, and 3211, 89th Legislature, 2025; and Senate Bills 493, 896, 926, and 1236, 89th Legislature, 2025.

EXPLANATION. Amendments to §§11.504, 11.506, 11.901, 11.902, 11.1402, and 11.2503 are necessary to implement the following legislation:

- HB 388 requires health plans to use a uniform coordination of benefits questionnaire that is adopted by TDI.

- HB 2221 repeals certain provisions in Insurance Code Chapter 541, concerning unlawful rebates and inducements, and replaces them with similar provisions in new Chapter 1702.

- HB 3211 establishes new contracting requirements for vision care plans.
- SB 493 prohibits certain pharmacy benefit manager contract provisions.
- SB 896 extends the period during which a newborn child is automatically covered and the deadline to enroll a newborn child into coverage.
- SB 926 expands provisions related to health plans that use steering or tiering to encourage enrollees to use certain network physicians and providers.
- SB 1236 expands requirements for pharmacy benefit network contracts.

In separate proposals also published in this issue of the *Texas Register*, TDI proposes to amend 28 TAC Chapters 3 and 26 to make changes to implement the previously referenced legislation. In a separate proposal published October 24, 2025 (50 TexReg 6976), TDI proposed a uniform coordination of benefits questionnaire in 28 TAC Chapter 3, Subchapter V, to implement HB 388. At a later date, TDI also plans to propose amendments to 28 TAC Chapter 21 to implement provisions in HB 2221 and SB 1236.

Additional amendments to §§11.202, 11.301, 11.302, 11.501 - 11.504, 11.701, and 11.1604, and the repeal of §11.505 are necessary to update HMO filing rules to align with filing requirements for life, health, and HMO products in 28 TAC Chapter 3, Subchapter A. Historically, HMO filing requirements were addressed exclusively in Chapter 11. However, in 2025, TDI modernized the rules in 28 TAC Chapter 3, Subchapter A, and expanded the scope to include all HMO filings that are filed with TDI's Life and Health Division through the NAIC's System for Electronic Rates and Forms Filing (SERFF) after an HMO receives a certificate of authority. The proposed amendments and repeal remove provisions that duplicate or conflict with the provisions in 28 TAC Chapter 3, Subchapter A. Because of the proposed reorganization of §11.301, cross-references in other sections of Chapter 11 are amended to conform to the reorganized subsections and paragraphs.

Descriptions of the sections as proposed follow, organized by subchapter.

Subchapter C.

Section 11.202.

An amendment is proposed to §11.202 to delete subsection (i), which requires each item in the application to be identified by a unique form number. This requirement is no longer necessary. Form numbers are needed only for filings made in SERFF, and applicable requirements are contained in 28 TAC Chapter 3, Subchapter A. The deletion of subsection (i) conforms to the proposed amendments to §11.301.

Subchapter D.

Section 11.301.

The proposed amendments to §11.301 modify the filing requirements to conform to changes adopted in 28 TAC Chapter 3, Subchapter A, which broadly address filing requirements for life, health, and HMO products and remove the need for most HMO-specific filing requirements. As part of these amendments, provisions throughout the section are reorganized into subsections, renumbered paragraphs, and redesignated subparagraphs.

To improve readability, amendments to newly designated subsection (a) add statutory citations that are currently included in paragraph (1) and remove language addressing filings for preapproval or for information only because those filing types are addressed in subsequent subsections. Cross-references to paragraphs (4) and (5) are revised to instead reference newly designated subsections (c) and (d) to reflect the section's proposed reorganization. A sentence related to paper and electronic filings is deleted since other references in the section delineating such filing methods are also removed.

Paragraph (1) and subparagraph (A) are redesignated as subsection (b) and the catchline is modified to remove the words "and format," consistent with other changes to the subsection. To improve readability, the references to statutory citations that require filings for approval are moved to subsection (a). References to statutes and rules specifying the information that must be contained for a filing to be considered complete are reorganized into new paragraphs (1) - (3). New paragraph (4) adds a reference to filing rules in 28 TAC Chapter 3, Subchapter A, regarding submission requirements for life, health, and HMO products. Subparagraphs (B) - (E), related to filing format and methods, are deleted. Because almost all filings are made electronically, the provisions for paper filings are not necessary. The references to filing methods are unnecessary because they are addressed in newly designated subsections (c) and (d).

Paragraphs (2) and (3), related to form numbers, certification and transmittal forms, supporting documentation, and filing fees, are deleted because similar provisions are contained in 28 TAC Chapter 3, Subchapter A. Since form numbers are not required for filings outside the scope of 28 TAC Chapter 3, Subchapter A, and as previously discussed, the proposal makes a conforming amendment to §11.202 to remove a reference to paragraph (2).

Paragraph (4) is redesignated as subsection (c). References to submissions through SERFF are replaced with a reference to 28 TAC Chapter 3, Subchapter A, which requires electronic submission through SERFF.

Paragraph (5) is redesignated as subsection (d). The catchline is expanded to include filings for review because some filings, such as the schedule of charges, are classified as rate filings subject to review under 28 TAC Chapter 3, Subchapter A. To avoid duplication with filing requirements in 28 TAC Chapter 3, Subchapter A, the requirement for accompanying documents is removed. References to SERFF submissions are replaced with a reference to 28 TAC Chapter 3, Subchapter A, which requires electronic submission through SERFF.

Paragraph (6) is redesignated as subsection (e).

Paragraph (7) is redesignated as subsection (f) and updated to align with 28 TAC Chapter 3, Subchapter A. The catchline is revised to reference "requests for corrections" instead of "pending." Internal cross-references are updated to conform with organizational changes throughout the section. Subparagraph (C), which addresses holding a filing in a pending status, is deleted, since a corresponding requirement is not found in Insurance Code Chapter 1271 or in the filing rules in 28 TAC Chapter 3, Subchapter A. Redesignated paragraph (3) is revised to add a reference to 28 TAC §3.23 and to indicate that if an HMO has not addressed TDI's request for corrections or additional information within 10 business days, TDI may consider the filing withdrawn from review. This aligns with 28 TAC §3.23(c)(3) and replaces the current provision, stating that after 15 calendar days, the

HMO may withdraw the filing before the end of the review period.

Section 11.302.

An amendment is proposed to §11.302(b)(4) to revise a reference to §11.301 to conform to proposed amendments to that section.

Subchapter F.

Section 11.501.

The proposed amendments to §11.501 remove outdated filing fee provisions in subsection (b) and replace them with references to the filing requirements in 28 TAC Chapter 3, Subchapter A. Subsection (c), regarding matrix filing fees, is deleted.

Section 11.502.

The proposed amendments to §11.502 modify subsection (a) to revise the reference to §11.301 to conform to the proposed amendments reorganizing that section and add a reference to filing requirements in 28 TAC Chapter 3, Subchapter A.

Section 11.503.

The proposed amendments to §11.503 revise subsection (a) to add a reference to filing requirements contained in 28 TAC Chapter 3, Subchapter A. Subsection (c) is amended to remove a reference to §11.505, which is proposed for repeal. To avoid duplication with provisions in §3.23 and 28 TAC §11.301, subsections (d) - (f) are deleted.

Section 11.504.

The proposed amendments to §11.504 revise subsection (a)(1) to add a reference to filing requirements in 28 TAC Chapter 3, Subchapter A, and revise subsection (a)(3) to implement HB 2221 by adding a reference to new Insurance Code Chapter 1702.

Repeal of Section 11.505.

The proposed repeal of §11.505 avoids duplication with filing requirements in 28 TAC Chapter 3, Subchapter A.

Section 11.506.

The proposed amendments to §11.506(b)(8)(D)(iii) and (v) implement SB 896 by expanding required coverage for newborn children from 31 days to 60 days following birth and by extending the deadline to notify the HMO.

Subchapter H.

Section 11.701.

The proposed amendments to §11.701 add a reference in subsection (a) to the filing requirements in 28 TAC Chapter 3, Subchapter A. New subsection (c) is added to reference requirements for major medical rate filings in 28 TAC Chapter 3, Subchapter F, which implements Insurance Code Chapter 1698.

Subchapter J.

Section 11.901.

The proposed amendments to §11.901 implement legislation related to health plan contracting. An amendment to subsection (b)(12) implements HB 388 by adding a citation to new Insurance Code §1203.153, in connection to a requirement for a contracted physician or provider to retain records on a patient's other health plan coverage, including the coordination of benefits questionnaire. New subsection (h) is added to implement SB 1236 by re-

quiring that a contract between an HMO and a pharmacy or pharmacist comply with pharmacy benefits contracting standards in Insurance Code Chapter 1369.

Section 11.902.

Subsection (a)(7) is redesignated as (a)(8), and new subsection (a)(7) is added to implement HB 3211 by prohibiting HMO conduct that violates §1451.1545 or §1451.157. New subsection (a)(9) is added to implement SB 493 by prohibiting conduct that violates Insurance Code §4151.155.

Subsection (b) is amended to implement SB 926 by adding a reference to Insurance Code §843.322. To avoid duplicating the statute, subparagraphs (A) - (D) of paragraph (3) are deleted.

Subchapter O.

Section 11.1402.

An amendment is proposed to §11.1402 to implement HB 3211 by adding new subsection (e) to require vision care plans specifically to comply with Insurance Code §1451.1545.

Subchapter Q.

Section 11.1604.

A proposed amendment to §11.1604 revises a reference in paragraph (2) to §11.301 to conform to proposed amendments to that section.

Subchapter Z.

Section 11.2503.

An amendment is proposed to §11.2503(d) to implement HB 2221 by adding a citation to Insurance Code Chapter 1702.

The sections as proposed also include nonsubstantive editorial and formatting changes to conform them to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include correcting the style of statutory citations; adding headings to cited statutes and rules; updating cross-references to other rules; updating terminology; and making other grammatical, punctuational, and formatting changes to reflect TDI's current drafting style and plain language preferences.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of the Regulatory Initiatives Office in the Life and Health Division, has determined that during each year of the first five years the sections as proposed are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering them other than that imposed by statute. Ms. Bowden made this determination because the sections as proposed do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with them.

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 sections as proposed are in effect, Ms. Bowden expects that administering them will have the public benefit of ensuring that TDI's rules conform to House Bills 388, 2221, and 3211, and Senate Bills 493, 896, 926, and 1236. The sections as proposed will also have the public benefit of simplifying HMO filing rules in Chapter 11 by conforming them

to unified life, health, and HMO filing rules in 28 TAC Chapter 3, Subchapter A.

Ms. Bowden expects that the sections as proposed will not increase the cost of compliance. The 28 TAC Chapter 3 filing requirements were adopted in April 2025 and are already being applied to HMOs. The sections as proposed conform the HMO rules in Chapter 11 with the 28 TAC Chapter 3 rules and will not increase compliance costs. Any cost for those required to comply with the sections as proposed are attributable to House Bills 388, 2221, and 3211, and Senate Bills 493, 896, 926, and 1236.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS.

TDI has determined that the sections as proposed 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. As explained in the Public Benefits and Cost Note, TDI has determined that this proposal does not impose a cost on regulated persons. Therefore, no additional rule amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT.

TDI has determined that for each year of the first five years that the sections as proposed 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 not increase or decrease 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 TDI no later than 5:00 p.m., central time, on June 8, 2026. 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. 2864. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.034. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

28 TAC §11.202

STATUTORY AUTHORITY.

TDI proposes amendments to §11.202 under Insurance Code §§843.080, 843.151 and 36.001.

Insurance Code §843.080 authorizes the commissioner to adopt reasonable rules that the commissioner considers necessary for the proper administration of Insurance Code Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments for the commissioner's approval or information.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code and to ensure adequate access to health care services.

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 amendments to §11.202 implement Insurance Code Chapter 843, Subchapter C.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) A proposed HMO may submit an application for a certificate of authority in electronic format, by electronic file transmission or in a data storage format acceptable to the department, or by paper.

(b) If an HMO submits an application in paper format, the applicant must submit three separate copies of the application in separate three-ring binders^[§] so that pages may be easily replaced when necessary. Paper applications must include dividers with identifying subject tabs preceding each separate exhibit.

(c) Applications submitted in an electronic format must include separate file folders with names identifying each exhibit.

(d) Each application must contain a table of contents.

(e) All pages must be clearly legible and numbered.

(f) An HMO should not use identical items in more than one section of the application. Instead of using the same information in more than one place, an application must refer to the file or page on which the required form or list may be found.

(g) An original application becomes the charter file once the applicant submits all required revisions and the commissioner approves the application.

(h) The application is subject to Government Code Chapter 552, ^[§]concerning Public Information^[§].

{(i) Each item in the application must be identified by a unique number as more fully described in §11.301(2) of this title (relating to Filing Requirements).}

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601803

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO AFTER ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §11.301, §11.302

STATUTORY AUTHORITY.

TDI proposes amendments to §11.301 and §11.302 under Insurance Code §§843.080, 843.151 and 36.001.

Insurance Code §843.080 provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Insurance Code Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments for the commissioner's approval or information.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code and to ensure adequate access to health care services.

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 amendments to §11.301 and §11.302 implement Insurance Code Chapters 843 and 1271.

§11.301. Filing Requirements.

(a) Filings required. Consistent with Insurance Code §843.080, concerning Modification or Amendment of Application Information, and Insurance Code Chapter 1271, Subchapter C, concerning Commissioner Approval, after [After] the commissioner issues an HMO's certificate of authority, the HMO is required to file with the commissioner[, either for approval before effect or for information only,] any items specified in §11.204 of this title (relating to Contents) that the HMO has deleted, amended, or revised as outlined in subsections (c) and (d) [paragraphs (4) and (5)] of this section and any items specified in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes made necessary by federal or state law or regulations. [All requirements in this section apply to both electronic and paper filings unless stated otherwise.]

(b) [(1)] Completeness [and format] of filings. [(A)] The department will not accept a filing for review until the filing is complete.

An application to modify an approved application for a certificate of authority [that requires the commissioner's approval under Insurance Code §843.080 (concerning Modification or Amendment of Application Information) or Insurance Code Chapter 1271, Subchapter C, (concerning Commissioner Approval)] is considered complete when all information [required by this section; §11.302; and Chapter 11, Subchapter T, of this title (relating to Quality of Care)] that is applicable and reasonably necessary for the department to make a final determination has been filed, including information required by: [-]

(1) this section;

(2) §11.302 of this title;

(3) Subchapter T of this chapter (relating to Quality of Care); and

(4) Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

[(B) Unless otherwise required by this chapter or the Insurance Code, an HMO may submit a filing electronically through the NAIC's System for Electronic Rate and Form Filing or through any other method acceptable to the department.]

[(C) Unless otherwise required by this chapter or the Insurance Code, paper filings must:]

[(i) be submitted on 8-1/2- by 11-inch paper;]

[(ii) not be submitted in bound booklets;]

[(iii) be legible;]

[(iv) be in typewritten, computer generated, or printer's proof format; and]

[(v) except for maps, not contain any color highlighting unless accompanied by a clean copy without highlighting.]

[(D) As provided in this section, an HMO may submit some filings as provided in §7.201 of this title (relating to Forms Filings).]

[(E) As provided in this section, an HMO may submit some filings as provided in §11.203(a) of this title (relating to Revisions During Review Process).]

[(2) Identifying form numbers required. Each item required to be filed by paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. The identifying form numbers must be composed of a total of no more than 40 letters, numbers, symbols, or spaces.]

[(A) The identifying form number must appear in the lower left-hand corner of the page. In the case of a multiple-page document, the identifying form number must only appear on the lower left-hand corner of the first page, and page numbers should appear on subsequent pages.]

[(B) If an item is to be replaced or revised after issuance of a certificate of authority, a new identifying form number must be assigned.]

[(i) A change in address or phone number on a form will not require a new identifying form number.]

[(ii) A new edition date added to the original identifying form number is an acceptable way of revising the number so that it is identifiable from any previously approved item; for example, if "G-100" was the originally approved number, then the revision may be numbered "G-100 12/79."]

~~{(iii) Changing the case of the suffix is not considered to be a change in the number; for example, "ED" and "ed," or "REV" and "rev" are the same for form numbering purposes.}~~

~~{(3) Attachments for filings. Filings required by paragraphs (4)(A) and (B) and (5)(A) and (B) of this section must be accompanied by the following:}~~

~~{(A) an HMO certification and transmittal form for each new, revised, or replaced item;}~~

~~{(B) the supporting documentation considered necessary by the commissioner to review the filing and, for filings submitted on paper, a cover letter which includes the following:}~~

~~{(i) company name;}~~

~~{(ii) form numbers that are being submitted; and}~~

~~{(iii) a paragraph that describes the type of filing being submitted, along with any additional information that would aid in processing the filing, including the reasons for submitting the filing; and}~~

~~{(C) the applicable filing fee as determined by §7.1301 of this title (relating to Regulatory Fees), unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees should not be attached to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System).}~~

~~{(c) [(4)] Filings requiring approval. After issuance of a certificate of authority, each HMO must file with the commissioner, using the method specified below, a written request to implement or modify the following operations or documents and receive the commissioner's approval before putting the modifications into effect:~~

~~(1) as provided in Chapter 3, Subchapter A, of this title:~~

~~{(A) electronically through the NAIC's System for Electronic Rate and Form Filing;}~~

~~(A) [(+)] evidence of coverage filings, as described in §11.501 of this title (relating to Contents of the Evidence of Coverage);~~

~~(B) [(+)] a description and a map of the service area, with key and scale, which must identify the county or counties or portions of counties to be served;~~

~~(C) [(+)] the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the member handbook for all plans other than Children's Health Insurance Program (CHIP) plans in compliance with the requirements of Insurance Code §843.201, [(concerning Disclosure of Information About Health Care Plan Terms,)] and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and~~

~~(D) [(+)] any material change in the HMO's emergency care procedures;~~

~~{(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department;}~~

~~(E) [(+)] any material change in network configuration; and~~

~~(F) [(+)] if a material change in the network configuration results in the HMO's inability to comply with the network adequacy standards described in §11.1607 of this title (relating to Acces-~~

sibility and Availability Requirements), an access plan that complies with that section;

~~(2) [(C)] as provided in §7.201 of this title (relating to Forms Filings):~~

~~(A) [(+)] the form of all contracts described in §11.204(14)(A), (C), (D), and (E) of this title, including any amendments to those contracts and prior notification of the cancellation of any management contracts in §11.204(14)(E) of this title;~~

~~(B) [(+)] the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B) of this title, including any amendments to those contracts;~~

~~(C) [(+)] any new or revised loan agreements or amendments documenting loans made by the HMO to any affiliated person or to any medical or other health care physician or provider, whether providing services currently, previously, or potentially in the future, and any guarantees of any affiliated person's, physician's, or provider's obligations to any third party;~~

~~(D) [(+)] any agreement by which an affiliate agrees to handle an HMO's investments under §11.806 of this title (relating to Investment Management by Affiliate Corporation);~~

~~(E) [(+)] any change in the physical address of the books and records described in §11.205 of this title (relating to Additional Documents to be Available for Review);~~

~~(F) [(+)] any change to any of the requirements for guarantees under §11.810 of this title (relating to Guarantee from a Sponsoring Organization);~~

~~(G) [(+)] any insurance contracts or amendments, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, between the HMO and affiliates, as described in §11.204(16) of this title; and~~

~~(H) [(+)] modifications to any type of affiliate compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to, enrollees, including any financial incentives for physicians and providers;~~

~~(3) [(D)] as provided in §11.203(a) of this title, a copy of any proposed amendment to basic organizational documents, bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant and, if the approved amendment must be filed with the secretary of state, a certified copy of the amendment with the file mark of the secretary of state; and~~

~~(4) [(E)] as provided in Chapter 11, Subchapter B, of this title (relating to Name Application Procedure), any name or assumed name on a form, as specified in §11.105 of this title (relating to Use of the Term "HMO," Service Marks, Trademarks, Assumed Name).~~

~~(d) [(5)] Filings for review or information. Material filed under this subsection [paragraph] is not to be considered approved but may be subject to review for compliance with Texas law and consistency with other HMO documents. [Each item filed under this paragraph must be accompanied by a completed HMO certification and transmittal form in addition to those attachments required under paragraph (3) of this section.] Within 30 days of the effective date, an HMO must file with the commissioner, for review or information, deletions~~

and modifications to the following previously approved or filed operations and documents:

(1) as provided in Chapter 3, Subchapter A, of this title:

(A) electronically through the NAIC's System for Electronic Rate and Form Filing;

(A) [(+)] the formula or method for calculating the schedule of charges as specified in Chapter 11, Subchapter H, of this title (relating to Schedule of Charges);

(B) [(+)] any modification of drug coverage under Insurance Code §1369.0541, [(concerning Modification of Drug Coverage Under Plan)]; and

(C) [(+)] the member handbook for CHIP plans, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook;

(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department;

(D) [(+)] a copy of the form of any new contract or sub-contract or any substantive change to previously filed copies of forms of all contracts between the HMO and any physician or provider described in §11.204(14)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether used with all contracts or on an individual basis. All copies of amended contracts must be marked to indicate revisions. In addition, the HMO must answer all questions listed on the HMO certification and transmittal form;

(E) [(+)] a copy of the executed agreement between the HMO and any delegated entities and delegated networks as defined in §11.2602 of this title (relating to Definitions); and

(F) [(+)] any change in the quality assurance program, including the peer review program, as required by Insurance Code §843.082(1), [(concerning Requirements for Approval of Application,)] or §843.102, [(concerning Health Maintenance Organization Quality Assurance)], with descriptions of arrangements for sharing pertinent medical records between physicians and providers contracting or subcontracting under §11.204(14)(B) of this title with the HMO and ensuring the records' confidentiality;

(2) [(C)] as provided in §7.201 of this title, a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds, for officers and employees, including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (14)(D) of this title;

(3) [(D)] as provided in §11.203(a) of this title:

(A) [(+)] a list of officers and directors and a biographical data sheet for each person listed on the officers and directors page under Insurance Code §843.078(b), [(concerning Contents of Application,)] and biographical data forms in §11.204(5)(A), (B), and (C) of this title; and

(B) [(+)] any change of the certificate of authority for a domestic or foreign HMO; and, if a foreign HMO, a certified copy of the certificate of authority and power of attorney.

(c) [(6)] Approval period. Any modification for which the commissioner's approval is required may be considered approved, unless it is disapproved within 30 days from the date the filing is determined by the department to be complete. The commissioner may postpone

the action for a period not to exceed 30 days, as necessary for proper consideration. The department will notify the HMO in writing if it postpones a decision on a modification.

(f) [(7)] Approval, disapproval, and requests for corrections [pending].

(1) [(A)] Filings requiring approval under subsection (c)(1)(A) - (C) [paragraph (4)(A)-(i)- (iii)] of this section will be approved or disapproved in writing within the period set forth in subsection (e) [paragraph (6)] of this section unless, before the department's issuance of notice of proposed negative action under §1.704(a) of this title (relating to Summary Procedure; Notice), the HMO has been contacted by the department regarding corrections or additional information necessary for commissioner's approval, and files a written consent to waive the approval period with the department.

(2) [(B)] The department may waive the approval period on its receipt of the HMO's written consent.

(C) The department may hold the filing in a pending status for a reasonable period, but not more than 15 calendar days after the date of the department's request;

(3) [(D)] Consistent with §3.23 of this title (relating to Acceptance, Rejection, and Disposition of Filings), if [(H)] the HMO has not addressed the department's request for corrections or additional information within 10 business days, then the department may consider the filing withdrawn from review [15 calendar days, then the HMO may withdraw the filing before the end of the applicable review period, which is either the 30th day after filing or the 60th day after filing for an extended review period].

§11.302. Service Area Expansion or Reduction Applications.

(a) An HMO must file an application with the department for approval before the HMO may expand or reduce an existing service area; [reduce an existing service area,] or add a new service area.

(b) For the purposes of an application to expand or reduce an existing service area; [reduce an existing service area,] or add a new service area, an HMO must file the following items:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area, as required by §11.204(13) of this title (relating to Contents);

(2) network configuration information, as required by §11.204(19) of this title;

(3) combined financial projections, as described in §11.204(10)(B) of this title, including a breakdown of the income statement for existing business, and the effect of the proposed service area expansion or reduction; and

(4) if any of the items specified in §11.301 of this title (relating to Filing Requirements) are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be filed as specified in §11.301 [for approval or filed for information, as outlined in §11.301(4) and (5)] of this title.

(c) The department will not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval under Insurance Code §843.080, [(concerning Modification or Amendment of Application Information,)] or Chapter 1271, Subchapter C, [(concerning Commissioner Approval,)] is considered complete when all information required by §11.301 of this title; this section; and Chapter 11, Subchapter T, of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department has been filed with the department.

(d) Before consideration of a service area expansion or reduction application, an HMO must comply with the requirements of Chapter 11, Subchapter T, of this title, in the existing service areas and in the proposed service areas.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601804

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER F. EVIDENCE OF COVERAGE

28 TAC §§11.501 - 11.504, 11.506

STATUTORY AUTHORITY.

TDI proposes amendments to §§11.501 - 11.504 and 11.506 under Insurance Code §§843.151, 1271.004, 1501.010, 1702.006, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §1271.004 authorizes the commissioner to adopt rules necessary to implement the section and meet the minimum requirements of federal law, including regulations.

Insurance Code §1501.010 directs the commissioner to adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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 amendments to §§11.501 - 11.504 and 11.506 implement Insurance Code Chapters 843 and 1271. The amendments to §11.504 implement Insurance Code Chapter 1702. The amendments to §11.506 implement Insurance Code §§1271.103, 1501.157 and 1501.607.

§11.501. Contents of the Evidence of Coverage.

(a) An evidence of coverage or an amendment to an evidence of coverage may not be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

- (1) group agreement;

- (2) certificate issued to each subscriber who is enrolled through a group (the same form may be used as both the group agreement and the group certificate);

- (3) conversion and individual agreements;

- (4) group, conversion, and individual applications for coverage;

- (5) group subscriber enrollment form;

- (6) riders, endorsements, amendments, and letters of agreement;

- (7) matrix filings;

- (8) schedule of benefits; and

- (9) any other form attached to or made a part of the evidence of coverage.

(b) Each of the forms described in subsection (a) of this section must be identified with a unique form number and individually approved by the commissioner before being issued, delivered, or used in Texas, consistent with the filing requirements under Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). [Each form described in subsection (a) of this section will be considered a separate evidence of coverage filing and, except as provided in subsection (e) of this section, is subject to the filing fee prescribed in §7.1301(g)(4) of this title (relating to Regulatory Fees) for initial submissions.]

[(e) The filing fee for matrix filings is \$100 per individual evidence of coverage provision, with a maximum fee of \$500, whether the filing is an initial submission or a resubmission.]

§11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority.

(a) The filing and formatting requirements of §11.301[(1)(B) and (2)(A)] of this title (relating to Filing Requirements) and Chapter 3, Subchapter A, (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) apply to an evidence of coverage[,] when filed as part of the application for a certificate of authority.

(b) During the review period, an applicant must submit each new page or form reflecting any revisions.

(c) No later than the 10th calendar day after approval or issuance of a certificate of authority, an HMO must file a clean, final version of the evidence of coverage with revisions and a copy of the original version of the evidence of coverage showing the new or revised text as redlined. The submission must include:

- (1) an explanation that the evidence of coverage was submitted as part of the application for a certificate of authority and is being submitted in compliance with subsection (c) of this section;

- (2) a certification that the forms are without deviation and are the exact final evidence of coverage versions that resulted in approval of the certificate of authority application; and

- (3) the final version of an approved service area description and map as attached to the evidence of coverage, with key and scale, which must identify the county or counties or portions of counties to be served.

(d) Any discrepancy in content between the final document to be issued and the approved version is grounds for revocation of a certificate of authority.

§11.503. Filing Requirements for Evidence of Coverage after Receipt of Certificate of Authority.

(a) After receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the commissioner's approval [of the commissioner]. The evidence of coverage must be filed as provided in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §11.301 of this title (relating to Filing Requirements).

(b) The department will notify the HMO of the department's action in compliance with §1.704 of this title (relating to Summary Procedure; Notice).

(c) The department will base its approval or disapproval on the content of drafts submitted to the department. [Filings must comply with the specifications described in §11.505 of this title (relating to Specifications for the Evidence of Coverage and Matrix Filings).] Any discrepancy in content between the final document to be issued and the approved draft is grounds for revocation of the certificate of authority.

[(d) The review period for an evidence of coverage filing begins on the date an acceptable, typed draft of the form is received.]

[(e) The review period may be extended on 30-days written notice of extension to the HMO before the expiration of the initial review period.]

[(f) At the end of the review period, the evidence of coverage filing is considered approved unless it has already been withdrawn, affirmatively approved, or disapproved by the commissioner.]

§11.504. *Disapproval of Evidence of Coverage.*

(a) If the department disapproves any portion of an evidence of coverage, the department will specify the reason for the disapproval. The department may disapprove any form or withdraw any previous approval if a form:

(1) fails to meet the requirements of Insurance Code Chapter 1271, [(concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges;)] this chapter; Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings); [;] or other applicable statutes and regulations;

(2) does not properly describe the services and benefits;

(3) contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate Insurance Code Chapters 541, [(concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices;)] 542, [(concerning Processing and Settlement of Claims;)] 543, [(concerning Prohibited Practices Related to Policy or Certificate of Membership;)] 544, [(concerning Prohibited Discrimination;)] or 547, [(concerning False Advertising by Unauthorized Insurers;)] or Insurance Code Chapter 1702, concerning Regulation Of Certain Trade Practices, or any other applicable laws [law] or regulations;

(4) provides services or benefits that are too restrictive to achieve the form's purpose [for which the form was designed];

(5) fails to attain a reasonable degree of readability, simplicity, and conciseness;

(6) provides services or benefits or contains other provisions that would endanger the solvency of the issuing HMO; or

(7) is contrary to the laws or policies [law or policy] of this state.

(b) If the department disapproves a form, the HMO may file a written request for a hearing on the matter under Insurance Code §1271.102, [(concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval)].

§11.506. *Mandatory Contractual Provisions; Group, Individual, and Conversion Agreement and Group Certificate.*

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions:

(1) Face page. Where applicable, the HMO's name, address, website address, and phone number [of the HMO] must appear. The toll-free number referred to in Insurance Code §521.102, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form, the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Insurance Code Chapter 521, Subchapter C, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, in compliance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(2) Benefits. A schedule of all health care services that are available to enrollees under the basic, limited, or single service plan must be included, together with any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The schedule must clearly indicate the benefit it applies to [which it applies].

(A) Copayments. An HMO may require copayments to supplement payment for health care services.

(i) Each basic health care service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50% of the total cost of services provided.

(ii) A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year[;] when the copayments made by the enrollee in that calendar year total 200% of the total annual premium cost that [which] is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

(iii) The HMO must state the copayment[;] the limit on enrollee copayments[;] and the enrollee reporting responsibility in the group, individual, or conversion agreement and group certificate.

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. Except for a consumer choice benefit plan authorized by Insurance Code Chapter 1507, concerning Consumer Choice of Benefits Plans, an HMO may not charge a deductible for services received in the HMO's delivery network. Except in cases involving emergency care and services that are not available in the HMO's delivery network, as described in §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), an HMO may charge an out-of-network deductible for services performed out of the HMO's

service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Facility-based physicians or other health care practitioners. In compliance with Insurance Code §1456.003, concerning Required Disclosure: Health Benefit Plan, a statement must be included that is consistent with §21.4903 of this title (relating to Out-of-Network Notice and Disclosure Requirements) and that provides notice that:

(i) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network;

(ii) unless the enrollee elects to receive out-of-network care and signs a waiver of balance billing protections, a non-network facility-based physician or other health care practitioner may not balance bill the enrollee for amounts not paid by the health benefit plan for covered services or supplies provided in a network facility; and

(iii) if the enrollee receives a balance bill, the enrollee should contact the HMO.

(D) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B, concerning Childhood Immunizations, for a child from birth through the date the child is 6 years of age, except that a small employer health benefit plan as defined by Insurance Code §1501.002, concerning Definitions, that covers the immunizations may charge a copayment, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

(3) Cancellation and nonrenewal. A statement must be included that specifies the following grounds for cancellation and nonrenewal of coverage and the minimum notice period that will apply.

(A) Unless otherwise prohibited by law, an HMO may cancel coverage of a subscriber in a group and the subscriber's enrolled dependents under circumstances described in this subparagraph, as [so] long as the circumstances do not include health status-related factors:

(i) for nonpayment of amounts due under the contract, after not less than 30-days' written notice, except no additional written notice will be required for failure to pay premium;

(ii) after not less than 15-days' written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (13) of this subsection;

(iii) after not less than 15-days' written notice, in the case of fraud in the use of services or facilities;

(iv) immediately, subject to continuation of coverage and conversion privilege provisions, if applicable, for failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area; and

(v) after not less than 30-days' written notice, where the subscriber does not reside, live, or work in the HMO's service area [of the HMO] or area [for which] the HMO is authorized to do business in, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premium, at the end of the grace period as described in paragraph (12) of this subsection;

(ii) in the case of fraud on the part of the group, after 15-days' written notice;

(iii) for employer groups, for violation of participation or contribution rules, under §26.8 of this title (relating to Guaranteed Issue; Contribution and Participation Requirements) and §26.303 of this title (relating to Coverage Requirements);

(iv) for employer groups, under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) on discontinuance of:

(I) each of its small or large employer coverages;

(II) a particular type of small or large employer coverage;

(v) where no enrollee resides, lives, or works in the HMO's service area [of the HMO] or area [for which] the HMO is authorized to do business in, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees after 30-days' written notice; and

(vi) if an employer's membership [of an employer] in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, after 30-days' written notice.

(C) A group or individual contract holder may cancel a contract in the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees under this chapter or other law after not less than 30-days' written notice to the HMO.

(D) Unless otherwise prohibited by law, an [An] HMO may cancel an individual contract [under circumstances described below; unless otherwise prohibited by law]:

(i) for nonpayment of premiums under the terms of the contract, including any timeliness provisions, without written notice, subject to paragraph (12) of this subsection;

(ii) in the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this subsection, after not less than 15-days' written notice;

(iii) in the case of fraud in the use of services or facilities, after not less than 15-days' written notice;

(iv) after not less than 30-days' written notice where the subscriber does not reside, live, or work in the HMO's service area [of the HMO] or area [in which] the HMO is authorized to do business in, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area;

(v) in case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 90-days' written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area; and

(vi) in case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area,

but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 180-days' written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance of the last coverage not renewed.

(4) Claim payment procedure. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment of Claims; Insurance Code §1271.005, concerning Applicability of Other Law; and rules adopted under these Insurance Code provisions.

(5) Complaint and appeal procedures. A description of the HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy).

(6) Definitions. A provision defining any words in the evidence of coverage that have other than the usual meaning. Definitions must be in alphabetical order.

(7) Effective date. A statement of the effective date requirements of various kinds of enrollees.

(8) Eligibility. A statement of the eligibility requirements for membership.

(A) The statement must provide that the subscriber must reside, live, or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;

(iii) in the service area with the subscriber's spouse;

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) The statement must provide the conditions under which dependent enrollees may be added to those originally covered.

(C) The statement must describe any limiting age for subscriber and dependents.

(D) The statement must provide a clear statement regarding the coverage of newborn children.

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury [for which] coverage is provided for.

(iii) The HMO may require that the subscriber notify the HMO not later than the 60th day [during the initial 31 days] after the

birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) The HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency or born in a non-network facility to a mother who does not have HMO coverage, but it may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 60 [31] days following birth. The HMO must allow an enrollee 60 [31] days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren that complies with Insurance Code §1201.062, concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program, and §1271.006, concerning Benefits to Dependent Child and Grandchild.

(9) Emergency services. A description of how to obtain services in emergency situations, including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition;

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or in a comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that:

(i) the HMO must approve or deny coverage of post-stabilization care as requested by a treating physician or provider; and

(ii) the HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request; and

(F) for purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including[; but not limited to,] Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002, concerning Definitions;

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by Texas Health and Safety Code §534.001, concerning Establishment;

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

(10) Entire contract, amendments. A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

(11) Exclusions and limitations. A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(12) Grace period. A provision for a grace period of at least 30 days for the payment of any premium due after the first premium payment during which the coverage remains in effect. An HMO may add a charge to the premium for late payments received within the grace period.

(A) If payment is not received within the 30 days, coverage may be canceled after the 30th day and the terminated members may be held liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(B) Despite subparagraph (A) of this paragraph, provisions regarding the liability of group contract holder for an enrollee's premiums must comply with Insurance Code §843.210, concerning Terms of Enrollee Eligibility, and §21.4003 of this title (relating to Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations).

(13) Incontestability:

(A) All statements made by the subscriber on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, terminate, or nonrenew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract or group certificate may ~~only~~ be contested only because of fraud or intentional misrepresentation of material fact made on the enrollment application. For small employer coverage, the misrepresentation must be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31-days' prior written notice of any premium rate change.

(14) Out-of-network services. Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO must offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO may not require the enrollee to change primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(15) Schedule of charges. A statement that discloses the HMO's right to change the rate charged with 60-days' written notice under Insurance Code §843.2071, concerning Notice of Increase in Charge for Coverage, and Insurance Code Chapter 1254, concerning Notice of Rate Increase for Group Health and Accident Coverage.

(16) Service area. A description and a map of the service area, with key and scale, that identifies the county, or counties, or portions of counties to be served, and indicates primary care physicians, hospitals, and emergency care sites. A ZIP code map and a physician and provider list may be used to meet the requirement.

(17) Termination due to attaining limiting age. A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage while that child is incapable of self-sustaining employment due to intellectual disability or physical disability, and chiefly dependent on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of the limiting age.

(18) Termination due to student dependent's change in status. A provision regarding coverage of student dependents that complies with Insurance Code Chapter 1503, concerning Coverage of Certain Students, if applicable.

(19) Conformity with state law. A provision that if the agreement or certificate contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271, concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges, or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement, the long-term care rules, and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician. A provision that allows enrollees with chronic, disabling, or life-threatening [life threatening] illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201, concerning Designation of Specialist as Primary Care Physician.

(22) Selected obstetrician or gynecologist. Group, individual, and conversion agreements, and group certificates, except small employer health benefit plans as defined by Insurance Code §1501.002, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Chapter 1451, Subchapter F, concerning Access to Obstetrical or Gynecological Care. An HMO may not prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO must permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) Access to the health care services of an obstetrician or gynecologist includes:

- (i) one well-woman examination per year;
- (ii) care related to pregnancy;
- (iii) care for all active gynecological conditions; and
- (iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO may not impose any penalty, financial or otherwise, on the obstetrician or gynecologist for failure to provide this information if the obstetrician or

gynecologist has made a reasonable and good-faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. The limitation must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist[,] but may instead receive obstetrical or gynecological services from the enrollee's primary care physician or primary care provider. The enrollee must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee who elects to receive obstetrical or gynecological services from a primary care physician (a family physician, internal medicine physician, or other qualified physician) must adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

(23) Diagnosis of Alzheimer's disease. An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354, concerning Eligibility for Benefits for Alzheimer's Disease, by a physician licensed in this state satisfies any requirement for demonstrable proof of organic disease.

(24) Drug coverage. An agreement that covers prescription drugs must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, and Chapter 21, Subchapter V, of this title (relating to Pharmacy Benefits), as applicable.

(25) Inpatient care by nonprimary care physician. If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility, for example, hospital or skilled nursing facility, a provision that on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601805

Jessica Barta

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Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



28 TAC §11.505

STATUTORY AUTHORITY.

TDI proposes the repeal of §11.505 under Insurance Code §§843.151 and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance

Code related to HMOs and ensure adequate access to health care services.

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 repeal of §11.505 implements Insurance Code Chapter 1271.

§11.505. Specifications for Evidence of Coverage Including Insert Pages and Matrix Filings.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601818

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Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER H. SCHEDULE OF CHARGES

28 TAC §11.701

STATUTORY AUTHORITY.

TDI proposes amendments to §11.701 under Insurance Code §§843.151, 1271.253, 1698.051, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code as applicable to HMOs, including Insurance Code Chapter 1271.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1698.051 requires that the commissioner by rule establish a process under which the commissioner will review individual and small group health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal laws, including 42 USC §§300gg, 300gg-94, and 18032(c) and those sections' implementing regulations, including rules establishing geographic rating areas.

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 amendments to §11.701 implement Insurance Code Chapter 1271 and Chapter 1698.

§11.701. Schedule of Charges Must be Filed Before Use.

(a) No schedule of charges, formula, or method for calculating the schedule of charges may be used until a copy of the formula or

method for calculating the schedule of charges with supporting documentation has been filed with the commissioner, as required by §11.703 of this title (relating to Filings and Supporting Documentation) and consistent with Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filing).

(b) The schedule of charges must include all charges made for group, conversion, or individual coverage.

(c) Any applicable schedule of charges must comply with the requirements under Chapter 3, Subchapter F, of this title (relating to Rate Review for Health Benefit Plans).

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601806

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Earliest possible date of adoption: June 7, 2026

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SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

28 TAC §11.901, §11.902

STATUTORY AUTHORITY.

TDI proposes amendments to §11.901 and §11.902 under Insurance Code §§843.151, 4151.006, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §4151.006 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 4151, including rules establishing required contract provisions.

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 amendment to §11.901(b)(12) implements Insurance Code §1203.153 The amendment to §11.901(h) implements Insurance Code Chapter 1369 and SB 1236. Section 11.901(i) implements Chapter 1451, Subchapter D. Section 11.902(a)(7) implements §1451.1545 and §1451.157. The amendment to §11.902(a)(8) implements Insurance Code §4151.155. The amendment to §11.902(b) implements Insurance Code §832.322.

§11.901. Required and Prohibited Provisions.

(a) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding a hold-harmless clause as described in Insurance Code §843.361, concerning Enrollees Held Harmless.

(1) A hold-harmless clause is a provision in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(2) In compliance with Insurance Code §843.002, concerning Definitions, relating to an "uncovered expense," if a physician or health care provider agreement contains a hold-harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405, concerning Deposit with Comptroller.

(3) The following is an example of an approvable hold-harmless clause: "(Physician or Provider) agrees that in no event, including, but not limited to, nonpayment by the HMO, HMO insolvency, or breach of this agreement, may (Physician or Provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between the HMO and subscriber or enrollee. (Physician or Provider) further agrees that:

(A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and

(B) this provision supersedes any oral or written contrary agreement now existing or later entered into between (Physician or Provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes."

(b) Physician and provider contracts, subcontracts, and arrangements must include provisions:

(1) regarding retaliation as described in Insurance Code §843.281, concerning Retaliatory Action Prohibited;

(2) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309, concerning Contracts with Physicians or Providers: Notice to Certain Enrollees of Termination of Physician or Provider Participation in Plan, and §843.362, concerning Continuity of Care; Obligation of Health Maintenance Organization;

(3) regarding written notification to enrollees receiving care from a physician or provider of the termination of that physician or provider in compliance with Insurance Code §843.308, concerning Notification of Patients of Deselected Physician or Provider, and §843.309;

(4) regarding posting of complaint notices in physician or provider offices as described in Insurance Code §843.283, concerning Posting of Information on Complaint Process Required, provided that a representative notice that complies with this requirement may be obtained from the Managed Care Quality Assurance Office, MC: LH-MCQA, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030, or the department's website at www.tdi.texas.gov;

(5) regarding indemnification of the HMO as described in Insurance Code §843.310, concerning Contracts with Physicians or Providers: Certain Indemnity Clauses Prohibited;

(6) regarding prompt payment of claims as described in Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment

of Claims; §1271.005, concerning Applicability of Other Law; and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J, concerning Payment of Claims to Physicians and Providers; and Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims) with respect to payment to the physician or provider for covered services rendered to enrollees;

(7) regarding capitation, if applicable, as described in Insurance Code §843.315, concerning Payment of Capitation; Assignment of Primary Care Physician or Provider, and §843.316, concerning Alternative Capitation System;

(8) regarding selection of a primary care physician or provider, if applicable, as described in Insurance Code §843.203, concerning Selection of Primary Care Physician or Provider;

(9) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish X-rays and non-prefabricated orthotics covered by the evidence of coverage as described in Insurance Code §843.311, concerning Contracts with Podiatrists;

(10) regarding the requirements of §21.3701 of this title (relating to Electronic Claims Filing Requirements) if the contract requires electronic submission of any information described by that section;

(11) requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005, concerning Refund of Overpayment; and

(12) requiring a contracting physician or provider to retain in the contracting physician's or provider's records updated information concerning a patient's other health benefit plan coverage, consistent with Insurance Code §1203.153, concerning Uniform Coordination of Benefits Questionnaire Required.

(c) Physician and provider contracts and arrangements must include provisions entitling the physician or provider, on request, to all information necessary to determine that the physician or provider is being compensated in compliance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information provided must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including email, computer disks, or other electronic storage and transfer technology, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided under this paragraph must comply with paragraph (4) of this subsection. The HMO must provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(1) The information provided must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider, including at a minimum, the:

(A) fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM, ICD-10-CM, ICD-11-CM, and successor codes, and modifiers:

(i) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

(ii) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis, along with a toll-free number or electronic address through which the contracting physician or provider may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee, and any other information required by this subsection that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;

(B) all applicable coding methodologies;

(C) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;

(D) all applicable downcoding policies;

(E) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;

(F) any addenda, schedules, exhibits, or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided under this subsection; and

(G) the published product name and version of any software the HMO uses to determine bundling and unbundling of claims.

(2) In the case of a reference to source information outside the control of the HMO as the basis for fee computation, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides must clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(3) Nothing in this subsection may be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, instead of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services that are rendered to enrollees as required by paragraph (1) of this subsection.

(4) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days' written notice to the contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

(5) The HMO must provide the information required by paragraphs (1) - (4) of this subsection to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(6) A physician or provider receiving information under this subsection may not:

(A) use or disclose the information for any purpose other than:

(i) the physician's or provider's practice management;

(ii) billing activities;

(iii) other business operations; or

(iv) communications with a governmental agency involved in the regulation of health care or insurance;

(B) use the information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; or

(C) rely on information provided under this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(7) A physician or provider that receives information under this subsection may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider must provide for reasonable advance notice to enrollees being treated by the physician or provider before the termination consistent with Insurance Code §843.309.

(8) The provisions of this subsection may not be waived, voided, or nullified by contract.

(d) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding written notification of termination to a physician or provider in compliance with Insurance Code §843.306, concerning Termination of Participation; Advisory Review Panel, and §843.307, concerning Expedited Review Process on Termination or Deselection, including provisions providing that:

(1) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days before the effective date of the termination;

(2) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel except in a case involving:

(A) imminent harm to patient health;

(B) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance; and

(3) within 60 days after receipt of the physician's or provider's request for review, the advisory review panel must make its formal recommendation, and the HMO must communicate its decision to the physician or provider.

(e) On request by a participating physician or provider, an HMO must include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" means "a group of electronic claims submitted for processing at the

same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N 837 Transaction Set and identified by a batch control number." This subsection applies to a contract entered into or renewed on or after August 1, 2017. For a contract entered into or renewed before August 1, 2017, the law and regulations in effect at the time the contract was entered or renewed, whichever is later, governs.

(f) A contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115, concerning Contracts with Dentists.

(g) A contract between an HMO and a provider, as that term is defined in Insurance Code §1458.001, concerning General Definitions, must comply with Insurance Code §1458.101, concerning Contract Requirements, to the extent applicable.

(h) A contract between an HMO and a pharmacy or pharmacist must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services.

§11.902. Prohibited Actions.

(a) An HMO may not:

(1) require a physician to use a hospitalist for a hospitalized patient by contract under Insurance Code §843.320, concerning Use of Hospitalist;

(2) refuse to contract with a nurse first assistant to be part of a provider network or refuse to reimburse a nurse first assistant under Insurance Code §843.3045, concerning Nurse First Assistant;

(3) require a physician to use the services of a nurse first assistant as defined by Occupations Code §301.354, concerning Nurse First Assistants; Assisting at Surgery by Other Nurses;

(4) refuse to contract with a podiatrist licensed by the Texas Department of Licensing and Regulation who joins the professional practice of a contracted physician or provider under Insurance Code §843.319, concerning Certain Required Contracts;

(5) refuse a request to identify a physician assistant or advanced practice registered nurse as a provider in the HMO's network under Insurance Code §843.312, concerning Physician Assistants and Advanced Practice Nurses;

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156, ~~[(concerning Prohibited Conduct)];~~ or

(7) engage in conduct that violates Insurance Code §1451.1545, concerning Participation in Vision Care Plan; Effect on Other Plans, or §1451.157, concerning Vision Plan Conduct;

(8) ~~[(7)]~~ contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115, concerning Contracts with Dentists; ~~or[-]~~

(9) engage in conduct that violates Insurance Code §4151.155, concerning Certain Disclosures and Communications by Pharmacist or Pharmacy Protected.

(b) An HMO that uses steering or a tiered network to encourage an enrollee to obtain a health care service from a particular provider, as defined under Insurance Code Chapter 1458, concerning Provider Network Contract Arrangements, must do so in a manner that complies with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §843.322, concerning

Incentives to Use Certain Physicians and Providers, and Insurance Code §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the enrollee or contract holder. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific physicians or providers;

(2) "tiered network" refers to a network of contracted physicians and providers in which an HMO assigns contracted physicians and providers to tiers within the network that are associated with different levels of cost sharing; and

(3) violations of the fiduciary duty ~~[under Insurance Code §1458.101(i)]~~ will be determined by TDI based on an assessment of the HMO's conduct. ~~[Examples of conduct that would violate the HMO's fiduciary duty include, but are not limited to:]~~

~~[(A) using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services; to encourage receipt of lower quality medically necessary services or receipt of services; or in violation of state or federal law;]~~

~~[(B) failing to implement reasonable processes to ensure that the contracted physicians and providers that enrollees are encouraged to use within any steering approach or tiered network are not of a materially lower quality as compared with contracted physicians and providers that enrollees are not encouraged to use;]~~

~~[(C) failing to implement reasonable processes to ensure that the HMO does not make materially false statements or representations about a physician's or provider's quality of care or costs; or]~~

~~[(D) failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection.]~~

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601808

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Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

28 TAC §11.1402

STATUTORY AUTHORITY.

TDI proposes amendments to §11.1402 under Insurance Code §843.151 and §36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

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 amendments to §11.1402 implement Insurance Code §§843.305 and §1451.1545 as added by HB 3211.

§11.1402. Notification to Physicians and Providers.

(a) An HMO that provides coverage for health care services or medical care through one or more physicians or providers is required by Insurance Code §843.305, [(concerning Annual Application Period for Physician and Providers to Contract,)] to provide a 20-calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in each of the HMO's networks providing health care services or medical care under the terms and conditions established by the HMO for the provision of the services and the designation of the physicians and providers. Section 843.305 may not be construed to:

(1) require that an HMO use a particular type of provider or physician in its operation;

(2) require that an HMO accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the HMO; or

(3) require that an HMO contract directly with the physicians or providers.

(b) An HMO subject to Insurance Code §843.305 must publish a notice of an application period to physicians and providers both in the public notice section of at least one major newspaper with general circulation in each of its service areas and on the HMO's website. The notice must be published for at least five consecutive days during the period of January 2 through January 23 of each calendar year and must include the caption "Notice to Physicians and Providers" in bold type, the name and address of the HMO, what networks the HMO provides, and the specific dates of the 20-day period during which physicians and providers may make application to be a participating physician or provider in each network.

(c) An HMO must notify a physician or provider of acceptance or nonacceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider in a network.

(d) An HMO must file a copy of the published notice with the department in compliance with §11.301 of this title (relating to Filing Requirements), for information, within 30 days of publication. The filing must include the following:

(1) the name of the newspaper and the beginning and ending date of the publication; and

(2) a copy of the website screen shots and the beginning and ending date of the publication.

(e) Notwithstanding other provisions in this section, with respect to vision care plans, an HMO must comply with Insurance Code §1451.1545, concerning Participation in Vision Care Plan; Effect on Other Plans.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601810

Jessica Barta

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Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §11.1604

STATUTORY AUTHORITY.

TDI proposes amendments to §11.1604 under Insurance Code §§843.151, 844.004, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §844.004 authorizes the commissioner to adopt rules to implement Insurance Chapter 844.

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 amendments to §11.1604 implement Insurance Code Chapter 843.

§11.1604. Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services other than medical care or services ancillary to the practice of medicine, or with a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network must:

(1) submit a monitoring plan to the department setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all department regulatory requirements;

(2) file with the department a copy of the form of the written contract with an ANHC or provider HMO, in accordance with §11.301 [~~§11.301(5)~~] of this title (relating to Filing Requirements), that:

(A) requires that the ANHC or provider HMO cannot terminate the contract without 90-days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members, except for authorized copayments and deductibles, charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC, or provider HMO;

(C) contains a provision stating that nothing in the contract will be construed to in any way limit the HMO's authority or responsibility to comply with all of the department's regulatory requirements;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate, and maintain a health care delivery system, quality assurance system, physician and provider credentialing system, and other systems and programs meeting department standards and is directly accountable for compliance with the standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, using [utilizing] standards approved by the primary HMO, and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to ensure that all HMO systems and functions that are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all department regulatory requirements;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers to ensure compliance with contractual requirements set out in subparagraphs (B) and (C) of this paragraph;

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by an independent certified public accountant, using generally accepted accounting and auditing principles; and

(G) requires the ANHC or provider HMO to provide the primary HMO, on at least a monthly basis and in a usable form necessary for audit purposes, the data necessary for the HMO to comply with department reporting requirements with respect to any services provided under the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) number of primary HMO enrollees served or assigned to the ANHC or primary HMO to receive services, including the number added and terminated since the last reporting period;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO, for example, capitation, fee-for-services, or other risk-sharing arrangements;

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) the time that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits, and subrogation;

(x) physician and provider and enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of the inquiry or investigation; and

(xiii) any other data necessary to ensure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO at least annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all of the department's regulatory requirements, and provide written documentation of each audit to the department on request; and

(4) take prompt action to correct any failure by the ANHC or provider HMO to comply with the department's regulatory requirements relating to any matters delegated by the primary HMO to the ANHC or provider HMO and necessary to ensure the primary HMO's compliance with the regulatory requirements.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601813

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Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

28 TAC §11.2503

STATUTORY AUTHORITY.

TDI proposes to amend §11.2503 under Insurance Code§1702.006 and §36.001.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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 amendments to §11.2503 implement Insurance Code Chapter 1702, as added by HB 2221.

§11.2503. *Coverage Relating to Point-of-Service Rider Plans.*

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the point-of-service rider.

(b) An HMO may not require an enrollee to use either the point-of-service rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) may not limit the access, under the point-of-service rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, to either participating physicians and providers or nonparticipating physicians and providers;

(2) may not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the point-of-service rider, accesses a participating physician or provider outside the limited provider network, that differ from the cost-sharing arrangements for in-plan covered services obtained by the enrollee from a physician or provider in the limited provider network; and

(3) may provide for cost-sharing arrangements for benefits obtained from nonparticipating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50% [~~50 percent~~] of the total amount to be covered.

(d) An HMO that issues or offers to issue a point-of-service rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of Insurance Code Chapters 541, [(concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices);]; 542, [(concerning Processing and Settlement of Claims);]; 543, [(concerning Prohibited Practices Related to Policy or Certificate of Membership);]; 544, [(concerning Prohibited Discrimination);]; 547, [(concerning False Advertising by Unauthorized Insurers);]; 843, [(concerning Health Maintenance Organizations);]; and 1273, [(concerning Point-Of-Service Plans; and 1702, concerning Regulation of Certain Trade Practices)].

(e) A point-of-service rider plan offered under this subchapter must contain:

(1) a point-of-service rider that:

(A) includes coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) may not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F), and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage as so long as the allowances and limits comply with applicable federal and state laws;

(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50% [~~50 percent~~] of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) may not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the point-of-service rider;

(I) if applicable, must disclose:

(i) how the point-of-service rider cost-sharing arrangements differ from those in the evidence of coverage;

(ii) any reduction of benefits as set forth in subparagraph (G) of this paragraph;

(iii) any deductible that must be met by the enrollee under the point-of-service rider; and

(iv) whether copayments made for in-plan covered services apply toward the point-of-service rider deductible;

(J) must provide coverage for services obtained without the HMO's authorization from a participating physician or provider, but the enrollee must comply with any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the point-of-service rider;

(K) must include a description of how an enrollee may access out-of-plan covered benefits under the point-of-service rider, including coverage contained in other riders attached to the evidence of coverage;

(L) must disclose all precertification requirements for coverage under the point-of-service rider including any penalties for failure to comply with any precertification or cost containment provisions, provided that the penalties will not reduce benefits more than 50% [~~50 percent~~] in the aggregate;

(M) if it is issued to a group, must contain provisions that comply with Insurance Code Chapter 1251, Subchapter C, [(concerning Partnership for Long-Term Care Program)]; and

(N) if it is issued to an individual, must contain provisions that comply with Insurance Code §§1201.211 - 1201.217, [(concerning Policy Provision: Notice of Claim, Policy Provision: Claim Forms, Policy Provision: Proof of Loss, Policy Provision: Time of Payment of Claims, Policy Provision: Payment of Claims, Policy Provision: Physical Examinations and Autopsy, Policy Provision: Legal Actions)];

(2) an evidence of coverage that includes a description and reference to the point-of-service rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as nonparticipating physicians and providers for out-of-plan covered benefits, and that accessing these benefits through the point-of-service rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the point-of-service rider and services, benefits, and supplies available in the evidence of coverage that together constitute the point-of-service rider plan.

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

Filed with the Office of the Secretary of State on April 27, 2026.
TRD-202601816



CHAPTER 21. TRADE PRACTICES SUBCHAPTER X. EVALUATION OF NETWORK PHYSICIANS AND PROVIDERS

The Texas Department of Insurance (TDI) proposes to repeal 28 TAC §21.3202, concerning physician ranking requirements, and replace it with new §21.3202, concerning designated organizations for physician ranking, which designates organizations whose standards may be used by health benefit plan issuers for physician rankings. The proposed repeal and new section are necessary to implement Senate Bill 926, 89th Legislature, 2025.

EXPLANATION. The proposed repeal and replacement of §21.3202 implement Insurance Code §1460.003 and §1460.005. Chapter 1460 was added by House Bill 1888, 81st Legislature, 2009, to address the requirements for health benefit plan issuers when making certain comparisons of physicians. Under HB 1888, issuers could make only certain comparisons of physicians, using nationally recognized standards and guidelines adopted by the commissioner. SB 926 made substantive changes to Insurance Code Chapter 1460 by removing the list of nationally recognized organizations that establish guidelines and performance measures, and instead providing criteria that an organization and its standards must meet to be eligible to be designated by TDI rules.

Under SB 926, a health benefit plan issuer may rank physicians or classify physicians into tiers based on performance only if the standards used in the ranking are developed or prescribed by an organization designated by the commissioner. Insurance Code §1460.005 provides amended eligibility criteria that organizations must meet to be designated.

SB 926 also extends the commissioner's enforcement authority. Insurance Code §1460.007(c) states that the commissioner shall prohibit a health benefit plan issuer from using a ranking or classification system for not less than 12 consecutive months if the commissioner determines that the health benefit plan issuer has engaged in a pattern of discrepancies, falsehoods, or violations described by §1460.003(a-1).

Additionally, SB 926 amended the due process protections that health benefit plan issuers are required to provide to affected physicians.

Since the passage of SB 926, TDI has been receiving nominations of organizations that the commissioner should designate to implement Insurance Code Chapter 1460. On November 20, 2025, TDI also issued a public request for such nominations. TDI has received nominations of the following entities:

- Any national medical specialty society, as defined in Insurance Code Chapter 1460;
- Blue Health Intelligence (BHI);
- CareMetro;
- Core Quality Measures Collaborative (CQMC);
- Denniston Data Inc. (DDI);

- Global Appropriateness Measures (GAM);
- IntegerHealth;
- Joint Commission;
- Motive Medical Intelligence;
- National Committee for Quality Assurance (NCQA);
- National Quality Forum (NQF);
- Partnership for Quality Measures (PQM);
- Patient Centered Episode System (PACES);
- Purchaser Business Group on Health (PBGH);
- United States Department of Health and Human Services (HHS), including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), and National Institutes of Health (NIH);
- U.S. Preventive Services Task Force (USPSTF);
- Commission on Accreditation of Rehabilitation Facilities (CARF® International); and
- Utilization Review Accreditation Commission (URAC).

Proposed new §21.3202 includes the nominated organizations for commissioner designation under Insurance Code Chapter 1460. Two nominated organizations, CARF and URAC, are excluded from the list of proposed organizations because they indicated that they did not wish to be designated.

TDI sent a survey to each nominated organization (other than medical specialty societies, and federal agencies and task forces) to assess whether the organization and its standards meet the statutory criteria. TDI's determination regarding each entity will be based on survey responses, publicly available information, and comments received. For some of the listed organizations, eligibility has not been clearly established, and detailed comments are encouraged in support of, or opposition to, all of them. For example, comments are welcome on whether an organization is "unbiased" under Insurance Code §1460.005(c)(1)(B), whether an organization's standards were developed by "physicians currently in clinical practice," consistent with Insurance Code §1460.006, whether an organization's standards are "nationally recognized" under Insurance Code §1460.005(c)(2)(A)(i), and whether an organization qualifies even if its standards do not themselves reference physicians' ability to "report data, evidentiary, factual, or mathematical discrepancies, errors, omissions, or faulty assumptions" under Insurance Code §1460.005(c)(2)(B).

Note that if new entities are suggested for designation in comments on this proposal, it is likely that they will not be considered in this rulemaking due to the absence of an opportunity for the public to comment on them. However, they may be considered in future rulemaking.

In separate proposals TDI will propose to amend 28 TAC Chapters 3 and 11 to make changes to implement portions of SB 926 that amend Insurance Code Chapters 1301 and 843.

A description of the new section follows.

Repeal of §21.3202. TDI proposes to repeal §21.3202.

New §21.3202. Designated Organizations for Physician Ranking.

Proposed new §21.3202 specifically lists the designated organizations whose standards health benefit plan issuers may use when ranking or classifying physicians.

New §21.3202(a) lists the organizations designated by the commissioner under Insurance Code Chapter 1460. New §21.3202(b) provides that the commissioner may enter an order designating a qualified entity on an interim basis, which would be followed by a designation by rule within three years in order to continue. New §21.3202(c) specifies that a health benefit plan issuer retains responsibility for compliance with the requirements of Insurance Code Chapter 1460.

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 repeal and new section 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 increase or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Bowden does not anticipate a 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 repeal and new section are in effect, Ms. Bowden expects that administering the proposed rule will have the public benefit of designating the organizations to develop or prescribe the standards required for health benefit plan issuers to rank or classify physicians. These amendments ensure that TDI's rules conform to Insurance Code Chapter 1460 and promote a transparent system of physician ranking that is based on standards developed or prescribed by designated organizations meeting the statutory criteria.

Ms. Bowden expects that while some designated organizations make standards for ranking or classifying physicians freely available, others may charge fees to access the standards. Multiple organizations are designated in the proposed rule, so any fees may vary. Nonetheless, the requirement to use designated organizations is statutory, so all associated costs are also attributable to statute and do not result from enforcement or administration of the proposed rule. Thus, the proposed repeal and new section will not increase the cost of compliance beyond what is already required by Insurance Code Chapter 1460. Issuers may choose to avoid cost by using standards that are available for free or choosing not to rank or classify physicians.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed repeal and new section will not have an adverse economic effect on small or micro businesses, or on rural communities. The rule does not apply to rural communities. Small or micro businesses are not required by statute or by this proposed rule to perform physician ranking. While costs may arise for businesses that choose to perform physician ranking and to use standards that require a fee, all businesses, including small and microbusinesses, can choose to use standards from organizations that provide them at no cost. 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 may impose

costs on regulated persons that choose to perform physician ranking and to use standards that require a fee. However, regulated persons may choose to instead use standards that are available at no cost. In addition, no additional rule amendments are required under Government Code §2001.0045 because the proposed amendments to §21.3202 are necessary to implement legislation. The proposed rule implements Insurance Code Chapter 1460, as amended by SB 926.

GOVERNMENT GROWTH IMPACT STATEMENT.

TDI has determined that for each year of the first five years that the proposed repeal and new section 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 create a new regulation;
- will expand, limit, or repeal an existing regulation;
- will not increase or decrease the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

The proposed rule will expand, limit, or repeal an existing regulation by removing and replacing the outdated rule applying Insurance Code Chapter 1460 requirements for health benefit plan issuers to rank or classify physicians.

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 TDI no later than 5:00 p.m., central time, on June 8, 2026. 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 Chief-Clerk@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. 2863. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing both remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.034. Details of how to view and participate virtually in the public hearing will be made available on TDI's website at www.tdi.texas.gov/alert/event/index.html.

28 TAC §21.3202

STATUTORY AUTHORITY. TDI proposes the repeal of §21.3202 under Insurance Code §1460.005(a) and (b) and §36.001.

Insurance Code §1460.005(a) requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1460.

Insurance Code §1460.005(b) requires the commissioner to adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described in Insurance Code §1460.005(c).

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 repeal of §21.3202 implements Insurance Code Chapter 1460.

§21.3202. Physician Ranking Requirements.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601799

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555



28 TAC §21.3202

STATUTORY AUTHORITY. TDI proposes new §21.3202 under Insurance Code §§1460.003(a), 1460.005(a) and (b) and 36.001.

Insurance Code §1460.003(a) prohibits health benefit plan issuers from ranking or classifying physicians into tiers based on performance unless, among other things, the standards used to rank or classify are developed or prescribed by an organization designated by the commissioner by rule.

Insurance Code §1460.005(a) requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1460.

Insurance Code §1460.005(b) requires the commissioner to adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described in Insurance Code §1460.005(c).

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. New §21.3202 implements Insurance Code Chapter 1460.

§21.3202. Designated Organizations for Physician Ranking.

(a) For the purposes of Insurance Code Chapter 1460, concerning Standards Required Regarding Certain Physician Rankings by Health Benefit Plans, the commissioner designates the following organizations:

(1) any national medical specialty society, as defined in Insurance Code Chapter 1460;

(2) Blue Health Intelligence (BHI);

(3) CareMetro;

(4) Core Quality Measures Collaborative (CQMC);

(5) Denniston Data Inc. (DDI);

(6) Global Appropriateness Measures (GAM);

(7) IntegerHealth;

(8) Joint Commission;

(9) Motive Medical Intelligence;

(10) National Committee for Quality Assurance (NCQA);

(11) National Quality Forum (NQF);

(12) Patient Centered Episode System (PACES);

(13) Partnership for Quality Measures Evaluation and Maintenance (PQM);

(14) Purchaser Business Group on Health (PBGH);

(15) United States Department of Health and Human Services (HHS), including:

(A) the Agency for Healthcare Research and Quality (AHRQ);

(B) Centers for Disease Control and Prevention (CDC);

(C) Centers for Medicare and Medicaid Services

(CMS);

(D) Food and Drug Administration (FDA), and;

(E) National Institutes of Health; and;

(16) United States Preventive Services Task Force (USPSTF).

(b) If an entity meets the requirements for designation under Insurance Code Chapter 1460, the commissioner may enter an order designating the entity on an interim basis as one whose standards may be used by health benefit plan issuers for the ranking or tiering of physicians consistent with Insurance Code §1460.003, concerning Physician Ranking Requirements. Interim designations will not be for a period longer than three years and will not be renewed or extended.

(c) A health benefit plan issuer retains ultimate responsibility for compliance with the requirements of Insurance Code Chapter 1460, including ensuring that any standard used to rank physicians or classify physicians into tiers based on performance meets the requirements of Insurance Code §§1460.003 - 1460.006.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601800



CHAPTER 26. EMPLOYER-RELATED HEALTH BENEFIT PLAN REGULATIONS

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §26.9 and §26.305, concerning small employer and large employer health benefit plans. The amendments implement Senate Bill 896, 89th Legislature, 2025.

EXPLANATION. Proposed amendments to §26.9 and §26.305 are necessary to implement SB 896, which expands the coverage period for newborn children under small and large employer health plans subject to Insurance Code Chapter 1501. SB 896 extends the end date of the mandatory coverage period from the 32nd day to the 61st day after a child's birth, and extends the deadline for an enrollee to notify the health plan and pay any additional premium from the 31st day to the 60th day after the date of birth.

In separate proposals also published in this issue of the *Texas Register*, TDI proposes amendments to 28 TAC Chapters 3 and 11 to implement multiple bills, including SB 896.

Descriptions of the sections' proposed amendments follow.

Section 26.9. The proposed amendments to §26.9 implement SB 896. Subsection (a)(4) is amended by replacing the reference to newborn coverage termination on the 32nd day after birth with the 61st day after birth. And the subsection is also amended by replacing the references to a 31-day premium payment deadline with a 60-day payment deadline.

Section 26.305. The proposed amendments to §26.305 implement SB 896. Subsection (f) is amended by replacing the reference to newborn coverage termination on the 32nd day after birth with the 61st day after birth. Subsection (f)(2) is amended by replacing the references to a 31-day premium payment deadline with a 60-day payment deadline. An amendment to subsection (h)(1) deletes "an" to correct a grammatical error.

The proposed amendments also include nonsubstantive editorial and formatting changes to conform the sections to TDI's current drafting style and plain language preferences and to improve the rule's clarity. These changes appear throughout the amended sections and include nonsubstantive text edits, including replacing the word "must" with "may," replacing the word "nonpayment" with "no payment," and corrections to punctuation.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of the Regulatory Initiatives Office in the Life and Health Division, 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 the 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.

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 §1501.157 and §1501.607, as amended by SB 896.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance with Insurance Code §1501.157 and §1501.607 because it does not impose requirements beyond those in statute. As a result, the cost associated with extending the coverage period for newborn children 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. Even if it did, no additional rule amendments are required under Government Code §2001.0045 because the proposed amendments are necessary to implement legislation. The proposed rule implements Insurance Code §1501.157 and §1501.607, as amended by SB 896.

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 not increase or decrease 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 TDI no later than 5:00 p.m., central time, on June 8, 2026. 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 Chief-

Clerk@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. 2864. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing both remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.034. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

SUBCHAPTER A. DEFINITIONS, SEVERABILITY, AND SMALL EMPLOYER HEALTH REGULATIONS

28 TAC §26.9

STATUTORY AUTHORITY. TDI proposes amendments to §26.9 under Insurance Code §1501.010(1) and §36.001.

Insurance Code §1501.010(1) directs the commissioner to adopt rules necessary to implement Insurance Code Chapter 1501.

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 26.9 implements Insurance Code §1501.157, as amended by SB 896.

§26.9. Exclusions, Limitations, Waiting Periods, Affiliation Periods, Preexisting Conditions, and Restrictive Riders.

(a) All health benefit plans that provide coverage for small employers and their employees must comply with the following requirements.

(1) A small employer carrier may not exclude any eligible employee or dependent (including a late enrollee who would otherwise be covered under a small employer health benefit plan), except to the extent permitted under Insurance Code §1501.156, [(concerning Employee Enrollment; Waiting Period)].

(2) A small employer carrier may not limit or exclude (by use of rider, amendment, or other provision of the plan, applicable to a specific individual) coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases or an affiliation period, as permitted under Insurance Code Chapter 1501, [(concerning Health Insurance Portability and Availability Act)].

(3) A preexisting condition provision in a small employer health benefit plan may not apply to expenses incurred on or after the expiration of the 12 months following the effective date of coverage of the enrollee or late enrollee, except as authorized by paragraph (9)(B) of this subsection.

(4) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 61st ~~[32nd]~~ day after the date of the birth of the child unless notification of the birth and any required additional premium are received by the small employer carrier not later than the 60th ~~[34th]~~ day after the date of birth. A small employer carrier may ~~[must]~~ not terminate coverage of a newborn child if the carrier's billing cycle does not coincide with this 60-day ~~[34-day]~~ premium payment requirement, until the next billing cycle has occurred and there has been no payment

~~[nonpayment]~~ of the additional required premium~~[,]~~ within 30 days of the due date of the premium.

(5) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. An adopted child of an insured may be enrolled, at the option of the insured, within either:

(A) 31 days after the insured is a party in a suit for adoption; or

(B) 31 days of the date the adoption is final.

(6) Coverage of an adopted child of an insured under paragraph (5) of this subsection terminates unless notification of the adoption and any required additional premium are received by the small employer carrier not later than either:

(A) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(B) the 31st day after the date of the adoption. A small employer carrier may not terminate coverage of an adopted child if the carrier's billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of the premium.

(7) For purposes of paragraphs (4) and (6) of this subsection, "received by the small employer within a specified period" means that the item(s) must be either received or postmarked by the specified period.

(8) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the periods specified in paragraph (4) or (5) of this subsection, and subsequently enrolls in another health benefit plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion or affiliation period with regard to the child. If a newborn or adopted child is not enrolled within the periods specified in paragraph (4) or (5) of this subsection, then in accordance with paragraph (9) of this subsection, the newborn or adopted child may be considered a late enrollee or excluded from coverage until the next open enrollment period.

(9) A small employer carrier must choose one of the methods set forth in subparagraph (A) or (B) of this paragraph for handling requests for enrollment as a late enrollee in any health benefit plan subject to this subchapter. The small employer carrier must use the same method for all small employer health benefit plans.

(A) The eligible employee or dependent may be excluded from coverage and any application for coverage rejected until the next annual open enrollment period and, once enrolled, may be subject to a 12-month preexisting condition provision or, in the case of an HMO, may be subject to a 60-day affiliation provision, as described by Insurance Code §§1501.102 - 1501.104, [(concerning Preexisting Condition Provision; Treatment of Certain Conditions as Preexisting Prohibited; and Affiliation Period)].

(B) The eligible employee or dependent's application may be accepted immediately and the employee or dependent enrolled as a late enrollee during the plan year. If so enrolled, the preexisting condition provision imposed for a late enrollee may not exceed 18 months or, in the case of an HMO, the affiliation period may not exceed 90 days from the date of the late enrollee's application for coverage.

(C) The provisions of subparagraphs (A) and (B) of this paragraph do not apply to eligible employees or dependents under the special circumstances listed as exceptions under the definition of late enrollee in §26.4 of this title (relating to Definitions).

(D) Examples for applying subparagraphs (A) and (B) of this paragraph, in the case of both insurers and HMOs: Individual A requests coverage on October 1, 2014, after the enrollment period of July 1, 2014, through July 31, 2014, has ended. The next annual open enrollment period is July 1, 2015, through July 31, 2015. The effective date of coverage for persons enrolling during an open enrollment period is the beginning of the plan year, which is September 1 of each year.

(i) If the carrier is an insurer and has elected to exclude all applicants requesting late enrollment until the next open enrollment period, Individual A must reapply for coverage in July 2015 and the carrier may apply up to a 12-month preexisting condition period from the effective date of coverage, and as with any other enrollee, the preexisting condition period would begin on September 1, 2015, and expire on September 1, 2016.

(ii) If the carrier is an insurer and has elected to accept applications for late enrollment immediately and enroll the applicant during the plan year, the carrier may apply up to an 18-month preexisting condition period from the date of application. If Individual A applied for coverage on October 1, 2014, the preexisting condition period would begin on that date and expire on April 1, 2016.

(iii) If the carrier is an HMO and has elected to exclude all applicants requesting late enrollment until the next open enrollment period, Individual A must reapply for coverage in July 2015, and the carrier may apply up to a 60-day affiliation period, as with any other enrollee.

(iv) If the carrier is an HMO and has elected to accept applications for late enrollment immediately and enroll the applicant during the plan year, the carrier may apply up to a 90-day affiliation period from the day Individual A applied for coverage.

(10) A preexisting condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received from an individual licensed to provide the services under state law and operating within the scope of practice authorized by state law during the six months before the effective date of coverage.

(11) A small employer carrier may not treat genetic information as a preexisting condition described by Insurance Code §1501.002, [concerning Definitions,] in the absence of a diagnosis of the condition related to the information.

(12) A small employer carrier may not treat a pregnancy as a preexisting condition described in Insurance Code §1501.002.

(13) A preexisting condition provision in a small employer health benefit plan does not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the small employer health benefit plan, excluding any waiting period under the previous coverage. For example, Individual A has coverage under an individual policy for six months beginning on May 1, 2014, through October 31, 2014, followed by a gap in coverage of 61 days until December 31, 2014. Individual A is covered under an individual health plan beginning on January 1, 2015, for six months through June 30, 2015, followed by a gap in coverage of 62 days until August 31, 2015. Individual A's effective date of coverage under a small employer health benefit plan is September 1, 2015. Individual A has 12 months of creditable coverage and would not be subject to a preexisting condition exclusion under the small employer health benefit plan.

(14) In determining whether a preexisting condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier must credit the time the individual was covered under creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. Any waiting period that applied before that coverage became effective also must be credited against the preexisting condition provision period. For instance, Individual B is covered under an individual health insurance policy for 18 months beginning May 1, 2014, through November 30, 2015, followed by a four-month gap in coverage from December 1, 2015, to March 31, 2016. On April 1, 2016, Individual B is covered under a group health plan for three months through June 30, 2016, followed by a two-month gap in coverage until August 31, 2016. Individual B's coverage became effective on September 1, 2016. Under this example, since there was a significant break in coverage, to determine the length of creditable coverage, the small employer carrier counts the creditable coverage the individual had for the 12-month period preceding the effective date of the individual's coverage under the small employer health benefit plan. Individual B has creditable coverage of six months and the issuer of the small employer health benefit plan may impose a preexisting condition limitation for six months on Individual B.

(15) A small employer may establish a waiting period in accordance with Insurance Code §1501.156. On completion of the waiting period and enrollment within the time frame allowed by §26.7(h) of this title (relating to Requirement to Insure Entire Groups), coverage must be effective no later than the next premium due date. Coverage may be effective at an earlier date as agreed between the small employer and the small employer carrier.

(16) An HMO may impose an affiliation period in accordance with Insurance Code §1501.104, if the period is applied uniformly without regard to any health-status-related factor. The affiliation period may not exceed two months for an enrollee, other than a late enrollee, and may not exceed 90 days for a late enrollee. An affiliation period under a plan must run concurrently with any applicable waiting period under the plan. An HMO may not impose any preexisting condition limitation, except for an affiliation period.

(17) The imposition of an affiliation period by an HMO does not preclude application of any applicable waiting period as determined by the employer for all new entrants under a health benefit plan.

(18) An affiliation period provision in a small employer health benefit plan does not apply to an individual who would not be subject to a preexisting condition limitation in accordance with paragraphs (12) and (13) of this subsection.

(b) To determine if preexisting conditions exist, a small employer carrier must ascertain the source of previous or existing coverage of each eligible employee or dependent at the time the employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has the responsibility to contact the source of the previous or existing coverage to resolve any questions about the benefits or limitations related to that coverage in the absence of a creditable coverage certification form.

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

Filed with the Office of the Secretary of State on April 27, 2026.
TRD-202601811

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**SUBCHAPTER C. LARGE EMPLOYER
HEALTH INSURANCE REGULATIONS**

28 TAC §26.305

STATUTORY AUTHORITY. TDI proposes amendments to §26.305 under Insurance Code §1501.010(1) and §36.001.

Insurance Code §1501.010(1) directs the commissioner to adopt rules necessary to implement Insurance Code Chapter 1501.

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 26.305 implements Insurance Code §1501.607, as amended by SB 896.

§26.305. Enrollment.

(a) Periods provided for enrollment in and application for any health benefit plan provided to a large employer group must comply with the following.[:]

(1) The [the] initial enrollment period for the employees meeting the large employer's participation criteria must extend at least 31 consecutive days after the employee's initial date of employment, or, if the waiting period exceeds 31 days, at least 31 consecutive days after the date the new entrant completes the waiting period for coverage.[:]

(2) The [the] new entrant who meets the large employer's participation criteria must be notified of his or her opportunity to enroll at least 31 days in advance of the last date enrollment is permitted.[:]

(3) A [a] new entrant's application for coverage is timely if he or she submits the application within 31 consecutive days following the initial date of employment, or following the date the new entrant is eligible for coverage:

(A) in person;

(B) by mail, postmarked by the end of the specified period; or

(C) in an alternative method normally accepted by the large employer carrier, including facsimile transmission (fax), email, or web-based application.[: and]

(4) The [the] large employer carrier must provide an annual open enrollment period of at least 31 consecutive days.

(b) If dependent coverage is offered to enrollees under a large employer health benefit plan, the initial enrollment period for the dependents must be at least 31 consecutive days, with a 31-consecutive-day annual open enrollment period.

(c) A new employee who meets the participation criteria of a covered large employer may not be denied coverage if the application for coverage is received by the large employer carrier not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under Insurance Code §1501.606₂ [(c)concerning Employee Enrollment; Waiting Period₂] expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan, a dependent of a new employee who meets the participation criteria established by the large employer may not be denied coverage if the application for coverage is received by the large employer carrier not later than the 31st day after the later of:

(1) the date on which the employment begins;

(2) the date on which the waiting period established under Insurance Code §1501.606 expires; or

(3) the date on which the dependent becomes eligible for enrollment.

(e) A large employer carrier may not exclude any eligible employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

(f) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an insured under this subsection terminates on the 61st [~~32nd~~] day after the date of the birth of the child unless:

(1) dependent children are eligible for coverage under the large employer health benefit plan; and

(2) notification of the birth and any required additional premium are received by the large employer not later than the 60th [~~31st~~] day after the date of birth. A large employer carrier may not terminate coverage of a newborn child if the carrier's billing cycle does not coincide with this 60-day [~~31-day~~] premium payment requirement, until the next billing cycle has occurred and there has been no payment [~~nonpayment~~] of the additional required premium[:] within 30 days of the due date of the premium.

(g) If dependent children are eligible for coverage under the large employer health benefit plan, a large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured.

(h) If dependent children are eligible for coverage under the large employer health benefit plan, an adopted child of an insured may be enrolled, at the option of the insured, within either:

(1) 31 days after the [an] insured is a party in a suit for adoption; or

(2) 31 days of the date the adoption is final.

(i) Coverage of an adopted child of an employee terminates unless notification of the adoption and any required additional premiums are received by the large employer not later than either:

(1) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(2) the 31st day after the date of the adoption. A large employer carrier may not terminate coverage of an adopted child if the carrier's billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium within 30 days of the date of the premium.

(j) For purposes of this section, "received by the large employer" within a specified period means that the item(s) must be post-marked by the specified period.

(k) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the periods specified in this section, and subsequently enrolls in another health benefit plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child. If a newborn or adopted child is not enrolled within the periods specified in this section, then in accordance with §26.306(h) of this title (relating to Exclusions, Limitations, Waiting Periods, Affiliation Periods, Preexisting Conditions, and Restrictive Riders), the newborn or adopted child may be considered a late enrollee or excluded from coverage until the next open enrollment period.

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

Filed with the Office of the Secretary of State on April 27, 2026.

TRD-202601814

Jessica Barta

General Counsel

Texas Department of Insurance

Earliest possible date of adoption: June 7, 2026

For further information, please call: (512) 676-6555

