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 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 60. PROCEDURAL RULES OF THE COMMISSION AND THE DEPARTMENT

The Texas Department of Licensing and Regulation (Department) proposes amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 60, Subchapter C, §60.32; Subchapter F, §60.82; and Subchapter I, §60.301 and §60.302, regarding the Procedural Rules of the Commission and the Department. These proposed changes are referred to as the "proposed rules."

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 60 implement Texas Occupations Code, Chapter 51, the enabling statute of the Texas Commission of Licensing and Regulation (Commission) and the Department, and other laws applicable to the Commission and the Department.

The Chapter 60 rules are the procedural rules of the Commission and the Department. These rules apply to all of the agency's programs and to all license applicants and licensees, except where there is a conflict with the statutes and rules of a specific program.

The proposed rules are necessary to implement Senate Bill (SB) 2443, 89th Legislature, Regular Session (2025), which amends certain provisions under Texas Occupations Code, Chapter 51, including §51.207, Use of Technology.

Background

Prior to the passage of SB 2443, provisions of the Administrative Procedure Act (Texas Government Code, Chapter 2001) and several of the Department's program statutes required the Department to use certified mail or personal delivery to provide pleadings, notices, or orders to contested case respondents. While previous legislation and agency rules authorized the Department to require an applicant or license holder to provide an e-mail address for purposes of receiving licensing-related correspondence, the Department remained unable to use electronic means to provide documents to contested case respondents. SB 2443 addressed this conflict by specifically authorizing the Department to use electronic methods of notice for all purposes, regardless of conflicting provisions in program statutes or the Administrative Procedure Act.

The Department is currently working with a vendor to develop a modern licensing system that will allow customers to interact with the agency via an online portal similar to those provided by a bank or medical office. SB 2443 and the proposed rules will thus allow the Department to develop its system in a manner that will provide increased access and convenience to customers, as well as cost savings for the agency.

Explanation of Proposed Rules

The proposed rules will modernize the delivery of contested case pleadings, notices, and orders by allowing applicants and license holders to opt in to receiving those notices electronically, and to opt out of electronic service if desired. Pursuant to previous legislation and agency rules, the Department may send other types of correspondence (such as communications related to a license application or renewal) to applicants and license holders without their explicit consent.

Additionally, consistent with SB 2443, the proposed rules clarify that the Department's authority to require e-mail addresses extends only to applicants and license holders. The proposed rules also amend the rules concerning dishonored payment fees, notices of alleged violation and continued license restrictions, and notices of proposed denial, to allow electronic service of these notices. Lastly, the proposed rules provide that the presumption of receipt, which currently applies to certain documents sent through certified mail, also applies to electronically served documents and that it is the recipient's responsibility to view electronically served documents, including those that may have been directed to a "spam" or "junk" folder.

SECTION-BY-SECTION SUMMARY

The proposed rules amend §60.32 by changing the title from "E-mail Communications and Requirements" to "Electronic Communications and Requirements." Existing subsection (a) has been modified to clarify who may be required to provide the Department with an e-mail address for purposes of receiving general correspondence. New subsection (c) is added to provide that an applicant or license holder may consent to receive contested case pleadings, notices, and orders through electronic means including e-mail, an online portal, or another electronic method authorized by the Department. Subsection (c) also provides that a person may opt out of electronic service of these documents. New subsection (d) provides that once the applicant or license holder consents to electronic delivery, the Department may serve contested case-related documents to the person electronically.

The proposed rules amend §60.82, Dishonored Payment Fee. Existing subsection (c) has been modified to include electronic service as a way for the Department to notify an applicant, license holder, or other person if a payment has been dishonored.

The proposed rules amend §60.301, Contested Cases. Existing subsection (c) has been amended to include electronic service as an option when the Department sends notices under this rule.

Existing subsection (d) has been modified by adding language to clarify proper service of notices under existing subsection (c). New subsection (e) has been added to clarify how the presumption of receipt applies to electronically served documents. The remaining subsections have been re-lettered.

The proposed rules amend §60.302, Notice of Proposed Denial. Existing subsection (b) has been modified to include electronic service as an option when the Department sends notices of proposed denials under this rule. Existing subsection (c) has been modified by adding language to clarify proper service of notices under existing subsection (b). New subsection (d) has been added to clarify how the presumption of receipt applies to electronically served documents. The remaining subsections are re-lettered.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Tony Couvillon, Senior Policy Research and Fiscal 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 also 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 benefit will be reduction in postage costs by decreasing certified mail costs and thereby reducing costs for the State. Additionally, the electronic delivery of correspondence would allow the recipients of that correspondence to receive agency notices and documents in a more convenient, modern manner.

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. The proposed rules expand an existing regulation by authorizing applicants and license holders to consent to electronic delivery of contested case-related notices and notices of dishonored payment.

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/Ch60_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 C. LICENSE APPLICATIONS AND RENEWALS

16 TAC §60.32

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code §51.201 and §51.203, which authorize the Texas Commission of Licensing and Regulation (Commission), the Department's governing body, to adopt rules as necessary to implement its own procedures, Chapter 51, and any other law establishing a program regulated by the Department; and §51.207, which authorizes the Commission by rule to require an applicant or license holder to provide an e-mail address to the Department and to provide that any correspondence sent or received by the Department be delivered electronically. In addition, the proposed rules are proposed under Texas Government Code §2001.004, which requires a state agency to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 2001; and the program statutes for all of the Department programs: Agriculture Code, Chapter 301 (Weather Modification and Control); Education Code, Chapter 1001 (Driver and Traffic Safety Education); Government Code, Chapters 171 (Court-Ordered Programs); and 469 (Elimination of Architectural Barriers); Health and Safety Code, Chapters 401, Subchapter M (Laser Hair Removal); 466 (State Lottery); 754 (Elevators, Escalators, and Related Equipment); and 755 (Boilers); Labor Code, Chapter 91 (Professional Employer Organizations); Occupations Code, Chapters 202 (Podiatrists); 203 (Midwives); 401 (Speech-Language Pathologists and Audiologists); 402 (Hearing Instrument Fitters and Dispensers); 403 (Dyslexia Practitioners and Therapists); 451 (Athletic Trainers); 455 (Massage Therapy); 506 (Behavioral Analysts); 605 (Orthotists and Prosthetists); 701 (Dietitians); 802 (Dog or Cat Breeders); 1151 (Property Tax Professionals); 1152 (Property Tax Consultants); 1202 (Industrialized Housing and Buildings); 1302 (Air Conditioning and Refrigeration Contractors); 1304 (Service Contract Providers and Administrators); 1305 (Electricians); 1603 (Barbers and Cosmetologists); 1802 (Auctioneers); 1806 (Residential Solar Retailers); 1901 (Water Well Drillers); 1902 (Water Well Pump Installers): 1952 (Code Enforcement Officers); 1953 (Sanitarians); 1958 (Mold Assessors and Remediators); 2001 (Charitable Bingo); 2052 (Combative Sports); 2303 (Vehicle Storage Facilities); 2308 (Vehicle Towing and Booting); 2309 (Used Automotive Parts Recyclers); 2310 (Motor Fuel Metering and Quality); 2311 (Electric Vehicle Charging Stations); and 2402 (Transportation Network Companies); and Transportation Code, Chapters 551A (Off-Highway Vehicle Training and Safety); and 662 (Motorcycle Operator Training and Safety). 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 2443, 89th Legislature, Regular Session (2025).

§60.32. Electronic [~~E-mail~~] Communications and Requirements.

(a) The department may require an applicant or license holder, [~~licensee, or other person who regularly receives communications from the department,~~] to provide an e-mail address for purposes of receiving correspondence. The department may send any correspondence to the e-mail address furnished by the person unless another form of notice is required by law.

(b) (No change.)

(c) An applicant or license holder may consent to receive service of contested case-related notices, pleadings, or orders via e-mail, an online portal maintained by the department, or other electronic means authorized by the department. Consent remains effective unless revoked in a manner prescribed by the department.

(d) Upon receiving an applicant or license holder's consent to electronic service, the department may serve documents on the person in a manner consistent with subsection (c).

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 May 18, 2026.

TRD-202602088
Deanne Rienstra
General Counsel
Texas Department of Licensing and Regulation
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 463-3306

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SUBCHAPTER F. FEES

16 TAC §60.82

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code §51.201 and §51.203, which authorize the Texas Commission of Licensing and Regulation (Commission), the Department's governing body, to adopt rules as necessary to implement its own procedures, Chapter 51, and any other law establishing a program regulated by the Department; and §51.207, which authorizes the Commission by rule to require an applicant or license holder to provide an e-mail address to the Department and to provide that any correspondence sent or received by the Department be delivered electronically. In addition, the proposed rules are proposed under Texas Government Code §2001.004, which requires a state agency to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 2001; and the program statutes for all of the Department programs: Agriculture Code, Chapter 301 (Weather Modification and Control); Education Code, Chapter 1001 (Driver and Traffic Safety Education); Government Code, Chapters 171 (Court-Ordered Programs); and 469 (Elimination of Architectural Barriers); Health and Safety Code, Chapters 401, Subchapter M (Laser Hair Removal); 466 (State Lottery); 754 (Elevators, Escalators, and Related Equipment); and 755 (Boilers); Labor Code, Chapter 91 (Professional Employer Organizations); Occupations Code, Chapters 202 (Podiatrists); 203 (Midwives); 401 (Speech-Language Pathologists and Audiologists); 402 (Hearing Instrument Fitters and Dispensers); 403 (Dyslexia Practitioners and Therapists); 451 (Athletic Trainers); 455 (Massage Therapy); 506 (Behavioral Analysts); 605 (Orthotists and Prosthetists); 701 (Dietitians); 802 (Dog or Cat Breeders); 1151 (Property Tax Professionals); 1152 (Property Tax Consultants); 1202 (Industrialized Housing and Buildings); 1302 (Air Conditioning and Refrigeration Contractors); 1304 (Service Contract Providers and Administrators); 1305 (Electricians); 1603 (Barbers and Cosmetologists); 1802 (Auctioneers);

1806 (Residential Solar Retailers); 1901 (Water Well Drillers); 1902 (Water Well Pump Installers): 1952 (Code Enforcement Officers); 1953 (Sanitarians); 1958 (Mold Assessors and Remediators); 2001 (Charitable Bingo); 2052 (Combative Sports); 2303 (Vehicle Storage Facilities); 2308 (Vehicle Towing and Booting); 2309 (Used Automotive Parts Recyclers); 2310 (Motor Fuel Metering and Quality); 2311 (Electric Vehicle Charging Stations); and 2402 (Transportation Network Companies); and Transportation Code, Chapters 551A (Off-Highway Vehicle Training and Safety); and 662 (Motorcycle Operator Training and Safety). 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 2443, 89th Legislature, Regular Session (2025).

§60.82. Dishonored Payment Fee.

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

(c) The department will notify the applicant, license holder, or other person by certified mail, or by electronic service in accordance with §60.32, that the payment has been dishonored. The applicant, license holder, or other person must pay the required processing fee and the amount of the original payment submitted to the department within 15 days after receipt of notice of the dishonored payment.

(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 May 18, 2026.

TRD-202602089
Deanne Rienstra
General Counsel
Texas Department of Licensing and Regulation
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 463-3306

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SUBCHAPTER I. CONTESTED CASES

16 TAC §60.301, §60.302

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code §51.201 and §51.203, which authorize the Texas Commission of Licensing and Regulation (Commission), the Department's governing body, to adopt rules as necessary to implement its own procedures, Chapter 51, and any other law establishing a program regulated by the Department; and §51.207, which authorizes the Commission by rule to require an applicant or license holder to provide an e-mail address to the Department and to provide that any correspondence sent or received by the Department be delivered electronically. In addition, the proposed rules are proposed under Texas Government Code §2001.004, which requires a state agency to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 2001; and the program statutes for all of the Department programs: Agriculture Code, Chapter 301 (Weather Modification and Control); Education Code, Chapter 1001 (Driver and Traffic Safety Education); Government Code, Chapters 171 (Court-Ordered Programs); and 469 (Elimination of Architectural Barriers); Health and Safety Code, Chapters 401, Subchapter M (Laser Hair Removal); 466 (State Lottery); 754 (Elevators, Escalators, and Related Equipment); and 755 (Boilers); Labor Code, Chapter 91 (Professional Employer Organizations); Occupations Code, Chapters 202 (Podiatrists); 203 (Midwives); 401 (Speech-Language Pathologists and Audiologists); 402 (Hearing Instrument Fitters and Dispensers); 403 (Dyslexia Practitioners and Therapists); 451 (Athletic Trainers); 455 (Massage Therapy); 506 (Behavioral Analysts); 605 (Orthotists and Prosthetists); 701 (Dietitians); 802 (Dog or Cat Breeders); 1151 (Property Tax Professionals); 1152 (Property Tax Consultants); 1202 (Industrialized Housing and Buildings); 1302 (Air Conditioning and Refrigeration Contractors); 1304 (Service Contract Providers and Administrators); 1305 (Electricians); 1603 (Barbers and Cosmetologists); 1802 (Auctioneers); 1806 (Residential Solar Retailers); 1901 (Water Well Drillers); 1902 (Water Well Pump Installers): 1952 (Code Enforcement Officers); 1953 (Sanitarians); 1958 (Mold Assessors and Remediators); 2001 (Charitable Bingo); 2052 (Combative Sports); 2303 (Vehicle Storage Facilities); 2308 (Vehicle Towing and Booting); 2309 (Used Automotive Parts Recyclers); 2310 (Motor Fuel Metering and Quality); 2311 (Electric Vehicle Charging Stations); and 2402 (Transportation Network Companies); and Transportation Code, Chapters 551A (Off-Highway Vehicle Training and Safety); and 662 (Motorcycle Operator Training and Safety). 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 2443, 89th Legislature, Regular Session (2025).

§60.301. Notice of Alleged Violation; Notice of Continued License Restrictions.

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

(c) The department shall send the notices under subsections (a) and (b) by certified mail with electronic return receipt, or by electronic service in accordance with §60.32.

(d) A notice under subsection (c) is served properly if it is:

(1) mailed to the person's last known address as shown by the department's records; or

(2) provided to the person electronically in accordance with §60.32.

~~[(d) Any notice or document served upon a person is prima facie evidence of receipt if it is directed to the person's last known complete, correct address as shown by the department's records. This presumption is rebuttable. Failure to claim properly addressed certified or registered mail will not support a finding of non-delivery.]~~

(e) Proper service is rebuttably presumed if the notice is sent in accordance with subsection (d). A person's failure to claim properly addressed mail, or to monitor their e-mail account - including "junk" or "spam" folders - will not justify a finding of non-delivery.

(f) [~~(e)~~] Within twenty days after receiving a notice of alleged violation or notice of continued license restrictions, the person may either: accept the department's determination and recommended administrative penalty, sanction, or both; or make a written request for a hearing on the department's determination. There is a rebuttable presumption that notice is received three days after the notice was mailed.

(g) [~~(f)~~] If the person accepts the department's determination, the department and the person shall enter into an agreement as prescribed under §60.304. If a timely written request for a hearing is made, the department shall refer the department's determination to SOAH for a hearing.

(h) [~~(g)~~] If the person fails to accept the department's determination or fails to request a hearing, the department may propose entry of a default order against the person, unless otherwise provided by applicable law.

(1) - (3) (No change.)

§60.302. Notice of Proposed Denial.

(a) (No change.)

(b) The department shall send the notice of proposed denial under subsection (a) by certified mail with electronic return receipt, or by electronic service in accordance with §60.32.

(c) A notice under subsection (b) is served properly if it is:

(1) mailed to the person's last known address as shown by the department's records; or

(2) provided to the person electronically in accordance with §60.32.

[~~(c) Any notice or document served upon a person is prima facie evidence of receipt if it is directed to the person's last known complete, correct address as shown by the department's records. This presumption is rebuttable. Failure to claim properly addressed certified or registered mail will not support a finding of non-delivery.~~]

(d) Proper service is rebuttably presumed if the notice is sent in accordance with subsection (c). A person's failure to claim properly addressed mail, or to monitor their e-mail account - including "junk" or "spam" folders - will not justify a finding of non-delivery.

(e) [~~(d)~~] After receiving a notice of proposed denial, the person must request a hearing in writing within twenty days of receipt of the notice or forfeit the right to a hearing, unless otherwise provided by applicable law. There is a rebuttable presumption that notice is received three days after the notice was mailed.

(f) [~~(e)~~] If a timely written request is made, the department shall refer the proposed denial to SOAH for a hearing. If a timely written request is not made, the proposed denial is final.

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 May 18, 2026.

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Deanne Rienstra
General Counsel
Texas Department of Licensing and Regulation
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For further information, please call: (512) 463-3306

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TITLE 22. EXAMINING BOARDS

PART 22. TEXAS STATE BOARD OF PUBLIC ACCOUNTANCY

CHAPTER 501. RULES OF PROFESSIONAL CONDUCT

SUBCHAPTER D. RESPONSIBILITIES TO THE PUBLIC

22 TAC §501.81

The Texas State Board of Public Accountancy (Board) proposes an amendment to §501.81 concerning Firm Licensing.

Background, Justification and Summary

CPAs providing accounting services in a non-licensed firm may use their CPA designation so long as they provide the disclaimer that the firm they are practicing in is not a CPA firm. The proposed revision reduces the location of the disclaimer and the font size of the disclaimer.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit

The adoption of the proposed rule amendment will continue to provide adequate information regarding a CPAs licensing status while providing services in a non-licensed firm without being as onerous.

Probable Economic Cost and Local Employment Impact

Mr. Treacy, Executive Director, has determined that there will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business, Rural Community and Micro-Business Impact Analysis

William Treacy, Executive Director, has determined that the proposed amendment will not have an adverse economic effect on small businesses, rural communities or micro-businesses because the amendment does not impose any duties or obligations upon small businesses, rural communities or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis are not required.

Government Growth Impact Statement

William Treacy, Executive Director, has determined that for the first five-year period the amendment is in effect, the proposed rule: does not create or eliminate a government program; does not create or eliminate employee positions; does not increase or decrease future legislative appropriations to the Board; does not increase or decrease fees paid to the Board; does not create a new regulation; limits the existing regulation; does not increase or decrease the number of individuals subject to the proposed rule's applicability; and does not positively or adversely affect the state's economy.

Takings Impact Assessment

No takings impact assessment is necessary because there is no proposed use of private real property as a result of the proposed rule revision.

The requirement related to a rule increasing costs to regulated persons does not apply to the Texas State Board of Public Accountancy because the rule is being proposed by a self-directed semi-independent agency. (§2001.0045(c)(8))

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 505 E. Huntland Dr., Suite 380, Austin, Texas 78752 or faxed to his attention at (512) 305-7854, no later than noon on June 29, 2026.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses. If the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; and finally, describe how the health, safety, environmental, and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code §901.151, which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

§501.81. Firm Licensing.

(a) A firm, may not provide or offer to provide attest services or use the title "CPA," "CPAs," "CPA Firm," "Certified Public Accountants," "Certified Public Accounting Firm," or "Auditing Firm" or any variation of those titles unless the firm holds a firm license issued by the board or qualifies under a practice privilege. A firm license is not valid for any date or for any period prior to the date it is issued by the board and it automatically expires and is no longer valid after the end of the period for which it is issued. A firm license does not expire when the application for license renewal is received by the board prior to its expiration date. An expiration date for a firm license may be extended by the board, in its sole discretion, upon a demonstration of extenuating circumstances that prevented the firm from timely applying for or renewing a firm license.

(b) A firm is required to hold a license issued by the board if the firm establishes or maintains an office in this state.

(c) An individual licensee may use the designation "certified public accountant" or the abbreviation "CPA" in referring to himself or herself, regardless of his or her employer. However, a licensee employed by an unlicensed entity that references the individual CPA's designation in advertisements or written promotional statements relating to the client practice of public accountancy must disclose that the firm is not a CPA firm and its services are not regulated by the Texas State Board of Public Accountancy. [~~Each advertisement or written promotional statement that refers to a CPA's designation and his or her association with an unlicensed entity in the client practice of public accountancy must include the disclaimer: "This firm is not a CPA firm and these services are not regulated by the Texas State Board of Public Accountancy." The disclaimer must be included in conspicuous proximity to the name of the unlicensed entity and be printed in a size at least equal to, and a type not less bold than that contained in the body of the advertisement or written statement. If the advertisement is in audio format only, the disclaimer shall be clearly declared at the conclusion of each such presentation.~~]

(d) The requirement [~~requirements~~] of subsection (c) of this section does [~~do~~] not apply to a licensee [~~with regard to a person~~] performing services:

(1) as a licensed attorney at law of this state while in the practice of law or as an employee of a licensed attorney when acting within the scope of the attorney's practice of law;

(2) as an employee, officer, or director of a federally-insured depository institution, when lawfully acting within the scope of the legally permitted activities of the institution's trust department; or

(3) pursuant to a practice privilege.

(e) On the determination by the board that a person has practiced without a license or through an unlicensed firm in violation of subsection (c) of this section, the person's certificate shall be subject to revocation and may not be reinstated for at least 12 months from the date of the revocation.

(f) Interpretive Comment: A person who is employed by an unlicensed firm that offers services that fall within the definitions of the client practice of public accountancy as defined in §501.52(8) and (22) of this chapter (relating to Definitions) and §901.003 of the Act (relating to Practice of Public Accountancy) must comply with the disclaimer requirement found in subsection (c) of this section.

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 May 14, 2026.

TRD-202602046
J. Randal (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 305-7848

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CHAPTER 515. LICENSES

22 TAC §515.8

The Texas State Board of Public Accountancy (Board) proposes an amendment to §515.8 concerning Retired or Disability Status.

Background, Justification and Summary

The proposed revised language clarifies that a faculty member of an educational institution providing accounting services to the public is associated with accounting services and therefore does not qualify for the CPA retired status.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit

The adoption of the proposed rule amendment clarifies that a faculty member of an educational institution who uses the CPA designation must be licensed as an individual and a firm when providing accounting services to the public.

Probable Economic Cost and Local Employment Impact

Mr. Treacy, Executive Director, has determined that there will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business, Rural Community and Micro-Business Impact Analysis

William Treacy, Executive Director, has determined that the proposed amendment will not have an adverse economic effect on small businesses, rural communities or micro-businesses because the amendment does not impose any duties or obligations upon small businesses, rural communities or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis are not required.

Government Growth Impact Statement

William Treacy, Executive Director, has determined that for the first five-year period the amendment is in effect, the proposed rule: does not create or eliminate a government program; does not create or eliminate employee positions; does not increase or decrease future legislative appropriations to the Board; does not increase or decrease fees paid to the Board; does not create a new regulation; limits the existing regulation; does not increase or decrease the number of individuals subject to the proposed rule's applicability; and does not positively or adversely affect the state's economy.

Takings Impact Assessment

No takings impact assessment is necessary because there is no proposed use of private real property as a result of the proposed rule revision.

The requirement related to a rule increasing costs to regulated persons does not apply to the Texas State Board of Public Accountancy because the rule is being proposed by a self-directed semi-independent agency. (§2001.0045(c)(8))

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 505 E. Huntland Dr., Suite 380, Austin, Texas 78752 or faxed to his attention at (512) 305-7854, no later than noon on June 29, 2026.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses. If the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; and finally, describe how the health, safety, environmental, and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code §901.151, which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

§515.8. Retired or Disability Status.

(a) Retired status. A licensee who is at least 60 years old and has affirmed that the licensee has no association with accounting may be granted retired status at the time of license renewal. A licensee in retired status is exempt from the fingerprinting required in §515.1(d) of this chapter (relating to License). A licensee who has been granted retired status and who reenters the workforce in a position that has an association with accounting automatically loses the retired status [~~except as provided for in subsection (a)(1) of this section,~~] and must provide the fingerprinting required in §515.1(d) of this chapter unless previously submitted to the board.

(1) A licensee who serves without compensation on a Board of Directors, or Board of Trustees, or provides volunteer tax preparation services, participates in a government sponsored business mentoring program such as the Internal Revenue Service's Volunteer Income Tax Assistance (VITA) program or the Small Business Administration's SCORE program or participates in an advisory role for a similar charitable, civic or other non-profit organization continues to be eligible for retired status.

(2) Licensees providing [~~such~~] uncompensated volunteer services have the responsibility to maintain professional competence relative to the volunteer services they provide even though exempted from CPE requirements.

(3) The board shall require licensees to affirm in writing their understanding of the limited types of activities in which they may engage while in retired status and their understanding that they have a professional duty to ensure that they hold the professional competencies necessary to offer these limited volunteer services.

(4) Licensees may only convert to retired status if they hold a license in good standing and not be subject to any sanction or disciplinary action.

(5) Compensated services do not include routine reimbursement for travel costs and meals associated with the volunteer services or de minimis per diem amounts paid to cover such expenses.

(6) A retired licensee shall place the word "retired" adjacent to the retired licensee's CPA or Public Accountant title on any business card, letterhead or any other document. A licensee may be held responsible for a third party incorrectly repeating the CPA's title and shall make reasonable efforts to assure that the word "retired" is used in conjunction with CPA. Any of these terms must not be applied in such a manner that could likely confuse the public as to the current status of the licensee. The licensee will not be required to have a certificate issued with the word "retired" on the certificate.

(7) A licensee in "retired" status is not required:

(A) to maintain CPE; and

(B) provide fingerprinting in accordance with §515.1(d) of this chapter unless the retired status is removed.

(8) A retired licensee shall not offer or render professional services that require the retired licensee's signature and use of the CPA title either with or without "retired" attached, except a retired licensee may sign the work experience form of an applicant for CPA certification if the supervision occurred prior to retirement.

(9) Upon reentry into the workforce, the licensee must notify the board and request a new license renewal notice and:

(A) pay the license fee established by the board for the period since the licensee became employed;

(B) complete a new license renewal notice; and

(C) meet the CPE requirements for the period since the licensee was granted the retired status as required by §523.113(3) of this title (relating to Exemptions from CPE).

(b) Disability status. Disability status may be granted to an individual who submits to the board a statement and an affidavit from the licensee's physician which identifies the disability and states that the individual is unable to work because of a severe ongoing physical or mental impairment or medical condition that is not likely to improve within the next 12 consecutive months. This status may be granted only at the time of license renewal.

(1) Disability status is immediately revoked upon:

(A) the CPA reentering the workforce in a position that has an association with accounting work for which the CPA receives compensation; or

(B) the CPA serving on a Board of Directors, Board of Trustees, or in a similar governance position unless the service is for a charity, civic, or similar non-profit organization.

(2) Upon reentry into the workforce under such conditions, the individual must notify the board and request a new license renewal notice and:

(A) pay the license fee established by the board for the period since the individual became employed;

(B) complete a new license renewal notice;

(C) meet the CPE requirements for the period pursuant to §523.113(3) of this title; and

(D) provide the fingerprinting required in §515.1(d) of this chapter unless previously submitted.

(c) For purposes of this section the term "association with accounting" shall include any of the following:

(1) working or providing oversight of accounting or supervising work performed in the areas of financial accounting and reporting; tax compliance, planning or advice; management advisory services; accounting information systems; treasury, finance, or audit; [~~or~~]

(2) representing to the public, including an employer, that the individual is a CPA or public accountant in connection with the sale of any services or products involving accounting services or work, as provided for in §501.52(22) of this title (relating to Definitions) including such designation on a business card, letterhead, proxy statement, promotional brochure, advertisement, or office; [~~or~~]

(3) offering testimony in a court of law purporting to have expertise in accounting and reporting, auditing, tax, or management services; [~~or~~]

(4) A faculty member of an educational institution offering accounting services to the public; [~~providing instruction in accounting courses; or~~]

(5) for purposes of making a determination as to whether the individual fits one of the categories listed in this section the questions shall be resolved in favor of including the work as an "association with accounting."

(d) Nothing herein shall be construed to limit the board's disciplinary authority with regard to a license in retired or disabled status. All board rules and all provisions of the Act apply to an individual in retired or disability status.

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 May 14, 2026.

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J. Randal (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 305-7848

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CHAPTER 518. UNAUTHORIZED PRACTICE OF PUBLIC ACCOUNTANCY

22 TAC §518.5

The Texas State Board of Public Accountancy (Board) proposes an amendment to §518.5 concerning Unlicensed Entities.

Background, Justification and Summary

Eliminates the font size and locations of the disclaimer advising the public that the licensed CPA is providing accounting services in a non-licensed firm.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit

The adoption of the proposed rule amendment will continue to protect the public without being unnecessarily burdensome.

Probable Economic Cost and Local Employment Impact

Mr. Treacy, Executive Director, has determined that there will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business, Rural Community and Micro-Business Impact Analysis

William Treacy, Executive Director, has determined that the proposed amendment will not have an adverse economic effect on small businesses, rural communities or micro-businesses because the amendment does not impose any duties or obligations upon small businesses, rural communities or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis are not required.

Government Growth Impact Statement

William Treacy, Executive Director, has determined that for the first five-year period the amendment is in effect, the proposed rule: does not create or eliminate a government program; does

not create or eliminate employee positions; does not increase or decrease future legislative appropriations to the Board; does not increase or decrease fees paid to the Board; does not create a new regulation; limits the existing regulation; does not increase or decrease the number of individuals subject to the proposed rule's applicability; and does not positively or adversely affect the state's economy.

Takings Impact Assessment

No takings impact assessment is necessary because there is no proposed use of private real property as a result of the proposed rule revision.

The requirement related to a rule increasing costs to regulated persons does not apply to the Texas State Board of Public Accountancy because the rule is being proposed by a self-directed semi-independent agency. (§2001.0045(c)(8))

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 505 E. Huntland Dr., Suite 380, Austin, Texas 78752 or faxed to his attention at (512) 305-7854, no later than noon on June 29, 2026.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses. If the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; and finally, describe how the health, safety, environmental, and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code §901.151, which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

§518.5. Unlicensed Entities.

(a) An unlicensed entity is permitted to state that it has an ownership interest and a business affiliation with a registered CPA firm provided each such statement complies with subsection (b) of this section.

(b) In any letterhead, or in any advertising or promotional statements by an unlicensed entity that refers to accounting, auditing or attest services or any derivative terms associated with those services, there must be a statement that such services are only performed by the affiliated registered CPA firm. [~~This statement must be included in conspicuous proximity to the name of the unlicensed entity and be printed in type not less bold than that contained in the body of the letterhead, advertisement or promotional statement. If the advertisement is in audio format, the statement must be clearly declared in each such presentation.~~]

(c) An unlicensed entity [~~using restricted terms and/or~~] performing attest services is in the unauthorized practice of public accountancy and in violation of the Act and the board's rules except a firm authorized to practice in this state pursuant to §901.461 of the Act (relating to Practice by Certain Out-of-State Firms).

(d) Interpretative Comment: This section clarifies that the mere mention of a business and ownership affiliation with a registered CPA firm on the letterhead, or in advertising or promotional statements, of an unlicensed entity does not violate the Act when done in compliance with the provisions of this section. This section also clarifies that the letterhead, advertising or promotional statements of the unlicensed entity may refer to accounting, auditing or attest services, or any derivative terms associated with those services, without violating §901.453 of the Act (relating to Use of Other Titles or Abbreviations). It also clarifies that all attest services must still be performed exclusively by registered CPA firms in accordance with the Act and all board rules. The definition of "attest services" is set forth in §501.52 of this title (relating to Definitions).

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 May 14, 2026.

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J. Randal (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
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CHAPTER 523. CONTINUING PROFESSIONAL EDUCATION
SUBCHAPTER B. CONTINUING PROFESSIONAL EDUCATION RULES FOR INDIVIDUALS

22 TAC §523.113

The Texas State Board of Public Accountancy (Board) proposes an amendment to §523.113 concerning Exemptions from CPE.

Background, Justification and Summary

Section 901.003(c)(2) of the Public accountancy Act provides that faculty members of an educational institution, are not in the practice of public accountancy when they are performing duties as a faculty member. They may refer to themselves as a CPA if they are in fact a CPA of another state without the need for an individual license or firm license and are not required to obtain Continuing Professional Education.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit

The adoption of the proposed rule amendment will help the public to understand the requirements of a CPA faculty member of an educational institution.

Probable Economic Cost and Local Employment Impact

Mr. Treacy, Executive Director, has determined that there will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business, Rural Community and Micro-Business Impact Analysis

William Treacy, Executive Director, has determined that the proposed amendment will not have an adverse economic effect on small businesses, rural communities or micro-businesses because the amendment does not impose any duties or obligations upon small businesses, rural communities or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis are not required.

Government Growth Impact Statement

William Treacy, Executive Director, has determined that for the first five-year period the amendment is in effect, the proposed rule: does not create or eliminate a government program; does not create or eliminate employee positions; does not increase or decrease future legislative appropriations to the Board; does not increase or decrease fees paid to the Board; does not create a new regulation; limits the existing regulation; does not increase or decrease the number of individuals subject to the proposed rule's applicability; and does not positively or adversely affect the state's economy.

Takings Impact Assessment

No takings impact assessment is necessary because there is no proposed use of private real property as a result of the proposed rule revision.

The requirement related to a rule increasing costs to regulated persons does not apply to the Texas State Board of Public Accountancy because the rule is being proposed by a self-directed semi-independent agency. (§2001.0045(c)(8))

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 505 E. Huntland Dr., Suite 380, Austin, Texas 78752 or faxed to his attention at (512) 305-7854, no later than noon on June 29, 2026.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses. If the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; and finally, describe how the health, safety, environmental, and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code §901.151, which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

§523.113. Exemptions from CPE.

The board shall not issue or renew a license to an individual who has not earned the required CPE credits unless an exemption has been granted by the board.

(1) The board may consider granting an exemption from the CPE requirement during the period for which the exemption is requested on a case-by-case basis if:

(A) a licensee completes and forwards to the board an affidavit indicating that the licensee is not employed; or

(B) a licensee completes and forwards to the board an affidavit indicating no association with accounting. The affidavit shall include, as a minimum, a brief description of the duties performed, job title, and verification by the licensee's immediate supervisor. For purposes of this section, the term "association with accounting" shall include the following:

(i) working, providing oversight of accounting, or supervising work performed in the areas of financial accounting and reporting; tax compliance, planning or advice; management advisory services; accounting information systems; treasury, finance, or audit; or

(ii) representing to the public, including an employer, that the licensee is a CPA or public accountant in connection with the sale of any services or products involving professional accounting services as defined in the Rules of Professional Conduct, §501.52(22) of this title (relating to Definitions), including such designation on a business card, letterhead, proxy statement, promotional brochure, advertisement, or office; or

(iii) offering testimony in a court of law purporting to have expertise in accounting and reporting, auditing, tax, or management services; or

(iv) for purposes of making a determination as to whether the licensee fits one of the categories listed in this clause and clauses (i) - (iii) of this subparagraph, the questions shall be resolved in favor of including the work as having an association with accounting.

(C) a licensee not residing in Texas, who submits an affidavit to the board that the licensee does not serve Texas clients from out of state;

(D) a licensee shows reasons of health, certified by a medical doctor, that prevent compliance with the CPE requirement. A licensee must petition the board for the exemption and provide documentation that clearly establishes the period of disability and the resulting physical limitations;

(E) a licensee who is a military service member during the period for which the exemption is requested, and files a copy of orders to active military duty with the board; or

(F) a licensee shows reason which prevents compliance that is acceptable to the board.

(2) A licensee who has been granted the retired or disability status under §515.8 of this title (relating to Retired or Disability Status) is not required to report any CPE credits.

(3) A licensee who no longer meets the eligibility requirements for an exemption under this section or no longer qualifies for retired or disability status under §515.8 of this title shall be required to report sufficient CPE credits to be in compliance with §523.112 of this chapter (relating to Required CPE Participation). CPE credits shall be

earned in the technical area as described in §523.102 of this chapter (relating to CPE Purpose and Definitions) and §523.130 of this chapter (relating to Ethics Course Requirements).

(4) A faculty member may be exempt from CPE requirements as long as they do not provide accounting services to the public. [A ~~faculty member of an educational institution may be exempt from CPE only when offering accounting services as a faculty member.~~]

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 May 14, 2026.

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J. Randal (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 305-7848

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 229. FOOD AND DRUG SUBCHAPTER W. LICENSING OF WHOLESALE DISTRIBUTORS OF PRESCRIPTION DRUGS--INCLUDING GOOD MANUFACTURING PRACTICES

25 TAC §229.420

The executive commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Texas Department of State Health Services (DSHS), proposes an amendment to §229.420, concerning Medical Gases.

BACKGROUND AND PURPOSE

The proposed amendment to Title 25 of the Texas Administrative Code (TAC) Chapter 229, Subchapter W, relating to Licensing of Wholesale Distributors of Prescription Drugs--Including Good Manufacturing Practices (GMP) is required to continue adherence with applicable federal laws pertaining to medical gases. Specifically, the proposed amendment aligns the minimum standards in the current rule with new Medical Gases GMP requirements under 21 Code of Federal Regulations (CFR) Part 213 and 21 CFR Part 230, which are already in effect. The proposed amendment will adopt the new 21 CFR Part 213 and 21 CFR Part 230 in 25 TAC §229.420(a).

SECTION-BY-SECTION SUMMARY

The proposed amendment to §229.420 updates federal reference citations and updates numbering for consistency throughout this section.

FISCAL NOTE

Christy Havel Burton, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

DSHS has determined that during the first five years that the rule will be in effect:

(1) the proposed rule will not create or eliminate a government program;

(2) implementation of the proposed rule will not affect the number of DSHS employee positions;

(3) implementation of the proposed rule will result in no assumed change in future legislative appropriations;

(4) the proposed rule will not affect fees paid to DSHS;

(5) the proposed rule will not create a new regulation;

(6) the proposed rule will not expand, limit, or repeal existing regulations;

(7) the proposed rule will not change the number of individuals subject to the rule; and

(8) the proposed rule will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Christy Havel Burton has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities because the rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule is necessary to protect the health, safety, and welfare of the residents of Texas, does not impose a cost on regulated persons, and is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT AND COSTS

Timothy Stevenson, Deputy Commissioner, Consumer Protection Division, has determined that for each year of the first five years the rule is in effect, the public benefit will include improved rule clarity and greater compliance with updated Good Manufacturing Practices, which help ensure that medical gases produced in the state are safe and effective for their intended use.

Christy Havel Burton has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the amendment is adopting federal regulations that will not have additional costs.

TAKINGS IMPACT ASSESSMENT

DSHS has determined that the proposal does not restrict or limit an owner's right to the owner's 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

Written comments on the proposal, including information related to the cost, benefit, or effect of the proposed rule, as

well as any applicable data, research, or analysis, may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhs.texas.gov*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 26R054" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151 and Texas Health and Safety Code (HSC) §1001.075, which authorize the executive commissioner of HHSC to adopt rules for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001, and by Texas Health and Safety Code §431.241 and §431.244 which provide the executive commissioner of HHSC with authority to adopt rules enforcing the Texas Food, Drug, and Cosmetic Act, and adopt specific rules under the Code of Federal Regulations, Title 21, as a rule under chapter 431.

The amendment affects Texas Government Code §524.0151 and HSC Chapters 1001 and 431.

§229.420. Applicable Laws and Regulations.

(a) The department adopts by reference the following laws and regulations:

(1) Federal Food, Drug, and Cosmetic Act, 21 United States Code (USC) §301 et seq., as amended;

(2) 9 Code of Federal Regulations (CFR) Part 113, Standard Requirements, as amended;

(3) 21 CFR Part 70, Color Additives, as amended;

(4) 21 CFR Part 71, Color Additive Petitions, as amended;

(5) 21 CFR Part 73, Listing of Color Additives Exempt From Certification, as amended;

(6) 21 CFR Part 74, Listing of Color Additives Subject to Certification, as amended;

(7) 21 CFR Part 80, Color Additive Certification, as amended;

(8) 21 CFR Part 81, General Specifications and General Restrictions for Provisional Color Additives for Use in Foods, Drugs, and Cosmetics, as amended;

(9) 21 CFR Part 82, Listing of Certified Provisionally Listed Colors and Specifications, as amended;

(10) 21 CFR Part 200, General, as amended;

(11) 21 CFR Part 201, Labeling, as amended;

(12) 21 CFR Part 202, Prescription Drug Advertising, as amended;

(13) 21 CFR Part 203, Prescription Drug Marketing, as amended;

(14) 21 CFR Part 205, Guidelines for State Licensing of Wholesale Prescription Drug Distributors, as amended;

(15) 21 CFR Part 206, Imprinting of Solid Oral Dosage Form Drug Products for Human Use, as amended;

(16) 21 CFR Part 207, Requirements for Foreign and Domestic Establishment Registration and Listing for Human Drugs, Including Drugs That Are Regulated Under a Biologics License Application, and Animal Drugs, and the National Drug Code, as amended;

(17) 21 CFR Part 210, Current Good Manufacturing Practice in Manufacturing, Processing, Packing, or Holding of Drugs; General, as amended;

(18) 21 CFR Part 211, Current Good Manufacturing Practice for Finished Pharmaceuticals, as amended;

(19) 21 CFR Part 212, Current Good Manufacturing Practice for Positron Emission Tomography Drugs, as amended;

(20) 21 CFR Part 213, Current Good Manufacturing Practice for Medical Gases, as amended;

(21) [~~(20)~~] 21 CFR Part 216, Human Drug Compounding, as amended;

(22) [~~(21)~~] 21 CFR Part 225, Current Good Manufacturing Practice for Medicated Feeds, as amended;

(23) [~~(22)~~] 21 CFR Part 226, Current Good Manufacturing Practice for Type A Medicated Articles, as amended;

(24) 21 CFR Part 230, Certification and Postmarketing Reporting for Designated Medical Gases, as amended;

(25) [~~(23)~~] 21 CFR Part 250, Special Requirements For Specific Human Drugs, as amended;

(26) [~~(24)~~] 21 CFR Part 251, §804, Importation Program, as amended;

(27) [~~(25)~~] 21 CFR Part 290, Controlled Drugs, as amended;

(28) [~~(26)~~] 21 CFR Part 299, Drugs; Official Names and Established Names, as amended;

(29) [~~(27)~~] 21 CFR Part 300, General, as amended;

(30) [~~(28)~~] 21 CFR Part 310, New Drugs, as amended;

(31) [~~(29)~~] 21 CFR Part 312, Investigational New Drug Application, as amended;

(32) [~~(30)~~] 21 CFR Part 314, Applications for FDA Approval to Market a New Drug, as amended;

(33) [~~(31)~~] 21 CFR Part 315, Diagnostic Radiopharmaceuticals, as amended;

(34) [~~(32)~~] 21 CFR Part 316, Orphan Drugs, as amended;

(35) [~~(33)~~] 21 CFR Part 320, Bioavailability and Bioequivalence Requirements, as amended;

(36) [~~(34)~~] 21 CFR Part 361, Prescription Drugs for Human Use Generally Recognized as Safe and Effective and Not Misbranded: Drugs Used in Research, as amended;

(37) [~~(35)~~] 21 CFR Part 500, General, as amended;

(38) [~~(36)~~] 21 CFR Part 510, New Animal Drugs, as amended;

(39) [~~(37)~~] 21 CFR Part 511, New Animal Drugs for Investigational Use, as amended;

(40) [~~(38)~~] 21 CFR Part 514, New Animal Drug Applications, as amended;

(41) [~~39~~] 21 CFR Part 515, Medicated Feed Mill License, as amended;

(42) [~~(40)~~] 21 CFR Part 516, New Animal Drugs for Minor Use and Minor Species, as amended;

(43) [~~(41)~~] 21 CFR Part 520, Oral Dosage Form New Animal Drugs, as amended;

(44) [~~(42)~~] 21 CFR Part 522, Implantation or Injectable Dosage Form New Animal Drugs, as amended;

(45) [~~(43)~~] 21 CFR Part 524, Ophthalmic and Topical Dosage Form New Animal Drugs, as amended;

(46) [~~(44)~~] 21 CFR Part 526, Intramammary Dosage Form New Animal Drugs, as amended;

(47) [~~(45)~~] 21 CFR Part 528, Intentional Genomic Alterations in Animals [~~New Animal Drugs in Genetically Engineered Animals~~], as amended;

(48) [~~(46)~~] 21 CFR Part 529, Certain Other Dosage Form New Animal Drugs, as amended;

(49) [~~(47)~~] 21 CFR Part 530, Extralabel Drug Use in Animals, as amended;

(50) [~~(48)~~] 21 CFR Part 556, Tolerances for Residues of New Animal Drugs in Food, as amended;

(51) [~~(49)~~] 21 CFR Part 558, New Animal Drugs for Use in Animal Feeds, as amended;

(52) [~~(50)~~] 21 CFR Part 589, Substances Prohibited From Use in Animal Food or Feed, as amended;

(53) [~~(51)~~] 21 CFR Part 600, Biological Products: General, as amended;

(54) [~~(52)~~] 21 CFR Part 601, Licensing, as amended;

(55) [~~(53)~~] 21 CFR Part 610, General Biological Products Standards, as amended;

(56) [~~(54)~~] 21 CFR Part 660, Additional Standards for Diagnostic Substances for Laboratory Tests, as amended;

(57) [~~(55)~~] 21 CFR Part 680, Additional Standards for Miscellaneous Products, as amended;

(58) [~~(56)~~] 21 CFR Part 700, General, as amended;

(59) [~~(57)~~] 21 CFR Part 701, Cosmetic Labeling, as amended;

(60) [~~(58)~~] 21 CFR Part 740, Cosmetic Product Warning Statements, as amended;

(61) [~~(59)~~] 21 CFR Part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products, as amended;

(62) [~~(60)~~] 21 CFR Part 1300, Definitions, as amended;

(63) [~~(61)~~] 21 CFR Part 1301, Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances, as amended;

(64) [~~(62)~~] 21 CFR Part 1302, Labeling and Packaging Requirements For Controlled Substances, as amended;

(65) [~~(63)~~] 21 CFR Part 1304, Records and Reports of Registrants, as amended;

(66) [~~(64)~~] 21 CFR Part 1305, Orders for Schedule I and [~~Schedule~~] II Controlled Substances, as amended;

(67) [~~(65)~~] 21 CFR Part 1306, Prescriptions, as amended;

(68) [~~(66)~~] 21 CFR Part 1307, Miscellaneous; and

(69) [~~(67)~~] 21 CFR Part 1317, Disposal, as amended.

(b) Copies of these laws and regulations are indexed and filed at the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756, and are available for inspection during normal working hours. Electronic copies of these laws and regulations are available online at www.dshs.texas.gov.

(c) Nothing in this subchapter relieves any person of the responsibility for complying with other applicable Texas and federal laws and regulations.

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 May 15, 2026.

TRD-202602056
Cynthia Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 834-6755

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

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

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 1. GENERAL REQUIREMENTS

28 TAC §3.3704, §3.3707

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §3.3704 and §3.3707, concerning network adequacy requirements and other requirements for preferred and exclusive provider benefit plans. The amendments implement House Bill 3359, 88th Legislature, 2023, and Senate Bill 926, 89th Legislature, 2025, and address issues raised in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-26-000178 (TAHP Lawsuit).

EXPLANATION.

In April 2024, TDI adopted rules (2024 Rules) that implemented HB 3359 by amending multiple sections in Subchapter X of 28 TAC Chapter 3, including §3.3704 and §3.3707. HB 3359 provided extensive new network adequacy standards and expanded the requirements for waivers for a deviation from those standards. The 2024 Rules amended §3.3704 to align with HB 3359 and clarify that preferred provider plans must comply

with the new standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Amendments also deleted the previous network adequacy standards, consistent with the changes to statute in HB 3359.

The 2024 Rules also amended §3.3707 to (1) update the requirements for granting a waiver from network adequacy standards, subject to statutory limits; (2) require that a waiver request include certain information, including information demonstrating a good faith effort to contract and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract; and (3) clarify the commissioner's consideration of an access plan for waiver requests.

On January 9, 2026, the Texas Association of Health Plans (TAHP) filed the TAHP Lawsuit, which alleges that TDI engaged in ad hoc rulemaking in its implementation of HB 3359's waiver and sufficient access requirements and that certain 2024 Rules are contrary to the bill. In its petition to the court, TAHP stated that its members require additional guidance from TDI to comply with applicable regulations. Based on TAHP's claims and TDI's experience with network filings and waiver requests submitted since the adoption of the 2024 Rules, TDI has determined that additional rule amendments are necessary to implement HB 3359 in order to provide further guidance to health plans and adjust certain network requirements.

Accordingly, TDI proposes to amend §3.3704 to adjust and clarify minimum access standards. Amendments to §3.3704 are also necessary to implement SB 926, which expands provisions related to health plans that use steering or tiering to encourage enrollees to use certain network physicians and providers. TDI also proposes to amend §3.3707 to add guidance on how plans may demonstrate "good faith efforts" and "good cause" in waiver requests. TDI declines to define "good faith efforts" because the term is already defined in Insurance Code §1301.00565(a). In addition, form updates are needed to align the forms for network filings with the proposed rule amendments.

Descriptions of the sections' proposed amendments follow.

Section 3.3704.

A proposed amendment to subsection (b) of §3.3704 adds a catchline, to make the structure of the subsection consistent with the other subsections in the section. Proposed amendments to subsection (e) implement SB 926 and broaden the subsection to conform with both Insurance Code §1301.0047 and §1458.101(i). These include amendments to add a reference to new Insurance Code §1301.0047 and to apply the provisions in subsection (e) to an insurer that encourages an insured to obtain care from a particular "physician or health care provider," consistent with the terminology in §1301.0047, rather than "provider, as defined under Insurance Code Chapter 1458." To avoid duplicating language in Insurance Code §1301.0047(d), paragraphs (1) - (3) of subsection (e) are deleted.

Proposed amendments in subsection (f) implement HB 3359 by updating network adequacy standards. An obsolete date reference in subsection (f)(1)(E) relating to maximum appointment wait time standards is deleted. Although the TAHP Lawsuit raised concerns about the applicability of such standards to all provider types, TDI does not assess appointment wait time standards for services other than routine and preventive services. As described in subsequent paragraphs, recent updates to the forms for waiver applications prevent insurers from continuing to input appointment wait time data for nonroutine or nonpreventive services. In subsections (f)(2) and (f)(4), the minimum standards for sufficient choice and access to preferred providers are changed to require that all insureds have access to at least one preferred provider of each type within time and distance standards and at least 90% of insureds have access to at least two preferred providers.

TDI's review of network filings in 2024 and 2025 indicate that the current minimum standards requiring all insureds to have access to at least two preferred providers may be overly burdensome, especially in counties with provider shortages. The proposed standards would still allow consumers "sufficient choice" as required under Insurance Code §1301.0055(b) because at least 90% of insureds would have a choice between multiple preferred providers within the time and distance standards while the remaining 10% of insureds may need to travel farther to reach an alternative provider. TDI has also amended §3.3707(m) to make clear that insureds in this circumstance will be able to gain access to a choice of providers at the preferred provider benefit level through the insurer's access plan. TDI declines to apply less restrictive federal standards as argued by TAHP in the TAHP Lawsuit; unlike HB 3359, federal standards do not include "sufficient choice" requirements. The proposed amendments also confirm that the minimum standards require preferred providers within the network's service area, consistent with the express requirements of HB 3359.

Similarly, TDI proposes to amend subsection (f)(3) to require at least one preferred provider, instead of two preferred physicians, of each specialty and diagnostic type listed in Insurance Code §1301.0055(b)(4) at a preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility. Consistent with the proposed changes in subsection (f)(2), a network provides sufficient choice of preferred facilities if all insureds can access at least one preferred facility within the time and distance standards and at least 90% of insureds can access two or more preferred facilities. Clarifying that networks may include at least "one preferred provider" better aligns with Insurance Code §1301.0055(b)(4), which uses the term "preferred providers" and with longstanding TDI review standards. This change also reflects that in some cases licensure standards permit covered benefits to be delivered by a variety of provider types.

In addition to revised minimum standards for sufficient choice, subsection (f)(4) provides a 75-mile minimum distance standard for specialty care and specialty hospitals for which time and distance standards are not specified in statute. In the reporting forms under the current rule, TDI measures compliance with optometry and therapeutic optometry services, prescription drugs, durable medical equipment, and home health services. TDI will not assess network compliance with respect to optometrists and therapeutic optometrists for a plan that does not cover non-medical vision services. If a plan has a sufficient number of in-network ophthalmologists within network adequacy standards who can provide covered basic vision services, TDI will not consider the plan to be deficient based on an insufficient number of optometrists or therapeutic optometrists. Subsection (f)(4) implements Insurance Code §1301.0055(b)(3) to require that the network ensure sufficient access to covered services. The minimum distance standard is necessary for specialty care and specialty hospital services that consumers may need to access within a reasonable distance. As described in subsequent paragraphs, TDI proposes to remove home health from the list of specialty services assessed in the forms submitted as part of the network configuration filing.

Section 3.3707.

Proposed amendments to subsection (a) of §3.3707 add new paragraphs (1) - (5) listing nonexclusive factors that TDI will consider when determining whether there is good cause to grant a waiver. TDI will consider whether the waiver is needed due to an insufficient number of uncontracted physicians or provider or because the insurer has failed to contract with available providers. If providers are available, TDI will consider whether the insurer made good faith efforts to contract, and whether physicians and providers declined to contract. TDI will also consider whether granting a waiver will serve the public interest by maintaining health plan availability and competition or whether the waiver may harm the public interest by allowing a plan to be sold that does not provide reasonable access to covered services.

Proposed amendments reorganize and expand subsection (b) to address how TDI will evaluate whether an insurer has made a good faith effort to contract with available physicians or providers. Subsection (b)(1) expands the information that must be included in the attempt to contract form to describe the insurer's efforts to contract with available providers. Subsection (b)(1)(B) clarifies that the form should include all attempts to contract that the insurer made during the reporting period. Current subsection (b)(1)(C) is redesignated as (b)(1)(B)(iii) to align with the organization of the data within the attempt to contract form, and amended to remove the examples of reasons that may be given for declining to contract with an insurer since a longer list of examples is provided in new subsection (b)(5). New clauses (iv) and (v) are added to subsection (b)(1)(B) to align with new fields in the attempt to contract form and require the insurer to identify whether it offered commercially reasonable rates and contractual terms, and offered a different rate or contractual term after an initial offer was rejected. New subparagraph (C) in subsection (b)(1) aligns with a new field added to the cover page of the attempt to contract form and requires the insurer to explain the methodology they use to ensure the rate and contractual terms offered are commercially reasonable.

The current text of subsection (b)(2), which requires the insurer's waiver request to state if there are no providers or physicians available to resolve a network gap, is removed because it duplicates a requirement for information that must be provided within the network compliance and waiver request form under 28 TAC §3.3712(c)(2)(C)(i). New text in subsection (b)(2) requires the insurer to maintain documentation that substantiates the information submitted in the attempt to contract form, and provide that documentation to TDI on request.

New subsection (b)(3) specifies that, to demonstrate a good faith effort to contract, an insurer must attempt to contract with each available physician or provider that would allow the insurer to meet the standard or increase the percentage of enrollees for whom the standard is met. Contract attempts must meet the statutory definition of a good faith effort. New subsection (b)(4) specifies nonexclusive factors that TDI will consider in evaluating whether an insurer has made a good faith effort to contract. New subsection (b)(5) provides examples of circumstances when the insurer may be considered to have demonstrated a good faith effort. New subsection (b)(6) explains how TDI determinations about good faith efforts to contract will impact the statutory limits on waivers under Insurance Code §1301.0055(a)(5). New subsection (b)(7) provides definitions for the terms "commercially reasonable" and "similarly situated." New subsection (b)(8) requires issuers to review determinations and notify TDI within 15 calendar days if a correction is needed based on a clear factual error made by TDI.

Proposed amendments to subsections (c) and (m) clarify the instruction to file the access plan within the network configuration filing, and provide a more general rule citation, since §3.3712 references access plan requirements in multiple locations. Subsection (m) is also amended to require the insurer's access plan to demonstrate how the plan will facilitate access to care and a choice of physicians or providers for any insured that does not have access to at least two preferred providers within the network's service area and the applicable time and distance requirements under §3.3704(f)(2) or (4). Such an insured can request a network gap exception and receive the protections under §.3707(j) and (k).

Nonsubstantive amendments in subsections (d), (j), and (k) respectively add a section symbol to a statute citation, correct punctuation, and update a reference to "physician or provider" for clarity.

The 2024 Rules require insurers to use electronic forms published on TDI's website at www.tdi.texas.gov to provide the information specified in the rules. The required forms include the attempt to contract (ATC), network compliance and waiver request (NCWR), annual network adequacy report (LHL706), and provider listing forms. TDI proposes updates to the forms to align them with the proposed rule amendments and to improve clarity and ease of use. Some changes have been implemented to improve the instructions, formatting, layout, and utility of the forms to insurers.

The ATC form documents an insurer's good faith efforts to contract and is used by TDI to evaluate whether good cause for a waiver is shown. TDI proposes the following changes to the ATC form:

- adding a field in the "Cover Page" tab for a description of the insurer's methodology for ensuring that offered reimbursement rates and other contractual terms are commercially reasonable, consistent with new §3.3707(b)(1)(C);

- renaming the "Providers Attempted to Contract" tab as "Attempts to Contract";

- adding a "Drop-down" reference tab to list the options in the drop-down menus for the columns for specialty types, counties, provider reasons for declining to contract, and contact methods; and

- updating the "Attempts to Contract" tab with the following changes:

- removing the "SERFF tracking No." column;

- removing the "Deficient county waiver is being requested for" column;

- removing "County type" column and associated County Designation tab;

- adding "Major Medical or FB Physician and Provider?" and "NCWR row number where deficiency is reported" columns to allow staff to identify the waiver request that the attempts to contract relate to and prevent overreporting of attempts to contract, such as attempts that are unrelated to a waiver request;

- renaming "Phone number" column as "Telephone";

- renaming the "Additional information demonstrating that the insurer made a good faith effort to contract, as defined in Insurance Code TIC 1301.00565(a)" column as "Comments";

- renaming the "The reason given for declining to contract" column as "Provider's reason for declining to contract" and changing the column to allow selection from a drop-down menu instead of free-text entry, consistent with the examples specified in new §3.3707(b)(5);

- adding a column for information on whether the offered rates and contractual terms were commercially reasonable, consistent with new §3.3707(b)(1)(B)(iv); and

- adding a column for information on whether the insurer offered different rates or contractual terms after its initial offer was rejected by the provider, consistent with new §3.3707(b)(1)(B)(v).

The NCWR form documents network compliance and summarizes network waiver requests and associated access plans. TDI proposes the following changes to the NCWR form:

- applying conditional formatting and macros automation functionalities throughout the form;

- adding interdependent "Facilities" tab to auto-populate certain fields in the "FB Physician & Provider" tab;

- removing the "County Designation" tab;

- adding the "Reference" tab that includes lists that populate drop-down options within the "Major Medical" and "FB Physician & Provider" tabs, such as county and county designations, specialty types, compliance statuses, deficiency reasons, and access plan summaries. Previously, open-ended responses were permitted in most columns, with drop-down options provided only for specialty types and compliance statuses;

- adding the "Help" tab to provide additional technical guidance for completing the NCWR form;

- updating the "Cover Page" tab with the following changes:

- Adding a field for the insurer to include a hyperlink to its access plan, consistent with §3.3705(d) and §3.3712(c)(2)(C)(iv); and

- Relabeling "Counties in Service Area" section to "Service area designation instructions" and adding instructions and checkboxes to the list of counties;

- updating the "Major Medical" tab with the following changes:

- restricting the "Compliant with appointment wait time" field to only the specialties providing routine and preventive care (e.g., diagnostic radiology, gastroenterology, gynecology and obstetrics, inpatient or residential behavioral health facility services, mammography, outpatient clinical behavioral health, adult or pediatric primary care, and psychiatry). The field defaults to "N/A" for all other specialty types. Related to this update, a note is added to the "NA Standards" tab to clarify that specialty types subject to appointment wait time reporting are shown in green text. Since the applicable specialties are not relevant for vision plans, the "Compliant with appointment wait time" column is removed from the "Vision" tab of the NCWR form for vision care plans; and

- replacing "Percentage of insureds with sufficient choice (at least two)" column with two new columns: "Percentage of enrollees with access to at least 1 preferred provider" and "Percentage of enrollees with access to 2 or more preferred providers," consistent with proposed amended §3.3704(f)(2); and

- updating the "Major Medical" and "FB Physician & Provider" tabs with the following changes:

- expanding or renaming the agency-locked columns that display data that is auto-populated or added by TDI;

- removing the "Reason preferred providers not available" column and replacing it with a "Reason for deficiency" column; and

- removing "Is waiver needed because there are no physicians or providers available to contract within the service area and applicable time and distance standards?" and "Comments" columns; and

- updating the NCWR Instructions Guide with the following changes:

- add instructions to specify that for the purposes of measuring compliance with Insurance Code §1301.0055(b)(4), an insurer should report the number of individual physicians and providers, rather than the number of organizations or groups of physicians or providers; and

- add instructions to clarify that for the purposes of measuring compliance with the time and distance standards for the permitted licensure types specified in Insurance Code §1301.00553, an insurer should report the number of individual physicians or providers as applicable, rather than the number of organizations or groups. For example, for the purposes of measuring compliance for the physician specialty for "Primary Care: Adults," an insurer should only report the number of physicians, even though many advanced practice registered nurses also provide primary care services.

The LHL706 form provides additional demographic and utilization data related to network adequacy. TDI proposes the following changes to the LHL706 form:

- updating the "Network Info and Checklist" tab with the following changes:

- removing the Life and Health Transmittal Form LAH310 from the list of filing requirements;

- adding a field to capture the number of counties within the service area; and

- adding a field to allow an insurer to indicate if they are "Accredited per §3.3706(c)," because §3.3706(c) allows an insurer to be presumed to be in compliance with credentialing requirements; and

- updating the "Claims Data" tab by adding rows for the following additional specialty types: durable medical equipment, optometrists, pharmacy, and therapeutic optometrists.

The provider listing form lists the physicians and health care providers in the plan's network. TDI proposes the following changes to the provider listings form:

- replacing the "Individual" tab with a "Physician" tab and a "Non-Physician" tab to provide separate lists of physicians and non-physician providers;

- adding drop-down options to list each applicable specialty type, including 27 physician specialty types, 11 non-physician specialty types, 12 facility types, and 10 facility-based physician and provider types;

- adding an "Additional Providers" tab to allow reporting of other provider types that are in the network but are not subject to spe-

cific network adequacy standards or constrained to a drop-down listing of specialty types;

- adding an "Instructions" section within the "Cover Page" tab to provide instructions explaining which providers should be reported on each tab.

TDI also proposes the following changes to the specialty type lists and "NA Standards" tab in the ATC, NCWR, and provider listing forms:

- reorganizing the specialty type lists and NA standards to separate physicians, non-physicians, and facilities;

- removing "Home Health;" and

- modifying the list of "Facility types for evaluating facility-based providers" by removing "Critical Care Services - Intensive Care Units (ICU)" and adding "Hospitals (other)," since facility-based providers would be evaluated across the facility as a whole.

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 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 §§1301.0047, 1301.0055, 1301.00553, 1301.00554, 1301.00555, 1301.0056, 1301.00565, and 1301.00566. The proposed rules will also help regulated entities understand the criteria that TDI will use to evaluate waiver requests for health plan networks, including good cause and good faith efforts, and how statutory limits on the ability to renew a waiver may apply if the insurer does not demonstrate good faith efforts.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance with Insurance Code Chapter 1301 because they do not impose requirements beyond those in statute. Insurance Code §1301.0055 requires TDI to adopt rules for network adequacy that ensure enrollees can access all covered services from preferred providers within the service area, allow waivers for good cause, and limit renewal of waivers if an insurer does not make good faith efforts to contract. Insurance Code §1301.0056 requires TDI to adopt a process for evaluating network adequacy before a plan can be offered, and for insurers to submit all information necessary for TDI to evaluate compliance. Insurance Code §1301.00565 provides a definition of "good faith effort" and requires TDI to hold a hearing before granting a waiver and to consider all pertinent information submitted by the insurer and the public. As a result, the cost associated with the additional information required within the waiver request filings that supports evaluation of good faith efforts does not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS.

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

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045.

TDI has determined that this proposal does not impose a possible cost on regulated persons. However, even if the proposal did impose a cost on regulated persons, 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 §1301.0047 as added by SB 926, and §§1301.0055 - 1301.00565 as added and amended by HB 3359.

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 limit 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 29, 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. 2868. This proposal will be part of a rule hearing docket that will begin at 1:00 p.m., central time, on June 15, 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 2.029. Visit www.tdi.texas.gov/alert/event/index.html for more information on the proposed rule, hearing, and comment submission.

STATUTORY AUTHORITY. TDI proposes amendments to §3.3704 and §3.3707 under Insurance Code §§1301.0055, 1301.0056, 1301.007, and 36.001.

Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards that include requirements set out in the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider 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 proposed amendments to §3.3704 and §3.3707 implement HB 3359 and SB 926.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code Chapter 1701, concerning Policy Forms, or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, or Chapter 544, Subchapter B, concerning Other General Prohibitions Against Discrimination by Insurers, or to violate Insurance Code Chapter 1451, Subchapter A, concerning General Provisions; Subchapter B, concerning Designation of Practitioners Under Accident and Health Insurance Policy; or Subchapter C, concerning Selection of Practitioners, provided that:

(1) in accordance with Insurance Code §§1251.005, concerning Payment of Benefits; 1251.006, concerning Policy May Not Specify Service Provider; 1301.003, concerning Preferred Provider Benefit Plans and Exclusive Provider Benefit Plans Permitted, 1301.006, concerning Availability of and Accessibility to Health Care Services; 1301.051, concerning Designation as Preferred Provider; 1301.053, concerning Appeal Relating to Designation as Preferred Provider; 1301.054, concerning Notice to Practitioners of Preferred Provider Benefit Plan; 1301.055, concerning Complaint Resolution; 1301.057 - 1301.062, concerning Termination of Participation; Expedited Review Process, Economic Profiling, Quality Assessment, Compensation on Discounted Fee Basis, Preferred Provider Networks, and Preferred Provider Contracts Between Insurers and Podiatrists; 1301.064, concerning Contract Provisions Relating to Payment of Claims; 1301.065, concerning Shifting of Insurer's Tort Liability Prohibited; 1301.151, concerning Insured's Right to Treatment; 1301.156, concerning Payment of Claims to Insured; and 1301.201, concerning Contracts with and Reimbursement for Nurse First Assistants, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in Insurance Code §§1301.152 - 1301.154, concerning Continuing Care in General, Continuity of Care, and Obligation for Continuity of Care of Insurer, respectively;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care; and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims and Related Disclosures);

(6) the out-of-network (basic) level of coverage, excluding a reasonable difference in deductibles, is not more than 50% less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer, including by requiring an insured to select a primary care physician or provider or obtain a referral before seeking care;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the out-of-network level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan are taken 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) and the insurer does not penalize an insured solely on the basis of a failure to obtain a preauthorization;

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and out-of-network level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accordance with Insurance Code §1301.005, concerning Availability of Preferred Providers, and §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services, and §3.3708 of this title, as applicable.

(b) Exclusive provider benefit plans. Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code Chapter 1701; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or Chapter 544, Subchapter B; or to violate Insurance Code Chapter 1451, Subchapter C, provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) - (10) and (12) of this section; and

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must [~~only~~] ensure only that preferred provider benefits are reasonably available to all insureds within a designated service area.

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Steering and tiering. An insurer that encourages ~~uses steering or a tiered network to encourage~~] an insured to obtain a health care service from a particular physician or health care provider[~~, as defined under Insurance Code Chapter 1458, concerning Provider Network Contract Arrangements,~~] must comply [~~do so in a manner that complies~~] with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §1301.0047, concerning Incentives to Use Certain Physicians or Health Care Providers, and §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the insured or policyholder. [~~For the purposes of this section:~~]

[~~(1) "steering" refers to offering incentives to encourage enrollees to use specific providers;~~]

[~~(2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred 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 assessment of the insurer's conduct. Examples of conduct that would violate the insurer'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 in violation of state or federal law;~~]

[~~(B) failing to implement reasonable processes to ensure that the preferred providers that insureds are encouraged to use within any steering approach or tiered network are not of a materially lower quality as compared with preferred providers that insureds are not encouraged to use;~~]

[~~(C) failing to implement reasonable processes to ensure that the insurer does not make materially false statements or representations about a physician's or health care 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.~~]

(f) Network requirements.

(1) Each preferred provider benefit plan must include a health care service delivery network that complies with:

(A) Insurance Code §1301.005;

(B) Insurance Code §1301.0055, concerning Network Adequacy Standards;

(C) Insurance Code §1301.00553, concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, which applies maximum travel time in minutes and maximum distance in miles for a county based on the county's classification as specified in the network compliance and waiver request form available at www.tdi.texas.gov;

(D) Insurance Code §1301.00554, concerning Other Maximum Distance Standard Requirements; Commissioner Authority;

(E) Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards[~~, effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025~~]; and

(F) Insurance Code §1301.006.

(2) An adequate network must, for each insured residing in the service area, ensure that all insureds can access at least one preferred provider and 90% of insureds can access a choice of at least two preferred providers for each physician specialty and each class of health care provider, in both cases within the network's service area and within the time and distance standards specified in Insurance Code §1301.00553 and §1301.00554 and this section.

(3) To provide a sufficient number of the specified types of preferred providers with the specialty and diagnostic types listed in Insurance Code §1301.0055(b)(4), a network must include at least one preferred provider [~~two preferred physicians~~] for each applicable specialty and diagnostic type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility that credentials the particular specialty.

(4) For specialty care and specialty hospitals for which time and distance standards are not otherwise specified in Insurance Code §1301.00553, an adequate network must ensure that all insureds residing in the service area can access at least one preferred provider and 90% of insureds can access a choice of at least two preferred providers, in both cases within the network's service area and within a distance not greater than 75 miles.

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. Consistent with Insurance Code §1301.0055, an insurer must report any material deviation from the network adequacy standards to the department within 30 days of the date the material deviation occurred, by submitting a network configuration filing as specified in §3.3712 of this title (relating to Network Configuration Filings). Unless there are no uncontracted licensed physicians or providers within the service area to meet the standard in the affected county, or the insurer requests a waiver, the insurer must promptly take corrective action to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas[,] but may not divide a county. Any service areas that are smaller than statewide must be defined in terms of one or more Texas counties.

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) Consistent with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards, where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in

a county that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the commissioner may grant the waiver if the requestor shows good cause, subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver. In determining whether there is good cause to grant the waiver, the commissioner will consider the factors specified in Insurance Code §1301.00565(d) and all pertinent information, including whether:

(1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area;

(2) the insurer has made a good faith effort to contract with physicians and health care providers that could fill any network gaps, as determined under subsection (b) of this section;

(3) physicians or health care providers necessary for an adequate network have declined to contract with the insurer;

(4) the waiver would serve the public interest by maintaining health plan availability and competition in a local market; and

(5) the waiver would harm the public interest by allowing a health plan to be sold that fails to ensure enrollees reasonable access to covered services.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department.

(1) For each waiver requested with respect to a type of physician or provider in a given service area where there are uncontracted physicians or providers available that could help fill a network gap, as reported in the network compliance and waiver request form [~~county~~], the insurer must provide [~~either~~] the information specified by this paragraph [~~(1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.~~]

[~~(1)~~] [~~If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include,~~] within the attempt to contract form:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type, and including the physician or provider's address and county; national provider identifier, contact name, email, and phone number; and for facility-based physicians or providers, the group name and associated facility;

(B) a description, including the date and contact method, of all attempts to contract that the insurer made during the reporting period with [~~how and when the insurer last contacted~~] each provider or physician that demonstrates that the insurer made a good faith effort to contract, as defined in Insurance Code §1301.00565(a), including:

(i) in the case of a waiver that is being requested more than two consecutive times for the same network adequacy standard in the same county, evidence that the insurer made multiple good faith attempts during each of the prior consecutive waiver periods;

(ii) in the case of a waiver that is being requested more than four times within a 21-year period for the same network adequacy standard in the same county, evidence that the insurer has been unable to remedy the issue through good faith efforts;

(iii) [~~(C)~~] a description of any reason each provider or physician gave for declining to contract with the insurer [~~, such as the provider's or physician's participation in any exclusivity arrangement or other external factors that affect the ability of the parties to contract~~];

(iv) whether the insurer offered commercially reasonable rates and contractual terms; and

(v) whether the insurer offered a different rate or contractual term after an initial offer was rejected;

(C) the methodology the insurer uses to ensure the rate and contractual terms offered are commercially reasonable;

(D) a description of all steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary;

(E) a description of the source or sources the insurer uses to identify physicians and providers that are available in the service area, and how often the insurer monitors these sources for new physicians and providers entering the service area; [~~and~~]

(F) a description of the insurer's policies and procedures for reaching out to available physicians and providers, including how many attempts the insurer makes and if different policies and procedures apply for different specialty types.

(2) The insurer must maintain documentation that substantiates the information submitted in the network configuration filing and make that documentation available to TDI upon request. [~~If there are no providers or physicians available within the relevant service area with whom a contract would allow the insurer to meet the specific standard for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.~~]

(3) To demonstrate a good faith effort to contract, an insurer must attempt to contract with each available physician or provider that would allow the insurer to meet the specific standard or increase the percentage of enrollees for whom the time and distance standard is met. Contract attempts must meet the definition of "good faith effort" in Insurance Code §1301.00565(a).

(4) In evaluating whether an insurer has made a good faith effort to contract, TDI will consider all pertinent evidence, including evidence concerning:

(A) whether the insurer offered to contract at a commercially reasonable rate, taking into account how the offered rate compares with rates accepted by similarly situated physicians and providers;

(B) whether the insurer offered commercially reasonable contractual terms, taking into account how the terms compare with those accepted by similarly situated physicians and providers;

(C) whether the insurer agreed to change a rate or contractual term after an initial offer was rejected;

(D) the extent of the insurer's efforts to find and contact all available physicians and providers;

(E) the physician's or provider's reason for declining;

(F) whether the physician or provider has agreed to contract with other insurers and how the accepted rates and contractual terms compare with the rates and terms offered by the insurer;

(G) the physician's or provider's efforts to contact the insurer about contracting;

(H) whether the insurer timely responded to concerns raised by the physician or provider; and

(I) whether the lack of contract is related to any credentialing issues.

(5) The following list provides examples of circumstances when the insurer may be considered to have demonstrated a good faith effort to contract with a physician or provider during a particular waiver period.

(A) The insurer has documented confirmation that the physician or provider declined the insurer's initial offer to contract with a clear indication that the physician or provider was not interested in contracting on any terms. Examples of circumstances when an insurer is not expected to make a subsequent offer include:

(i) the physician or provider has stated to the insurer that the physician or provider does not intend to enter any new contract on any terms; or

(ii) the physician or provider was not able to contract because the physician or provider participates in an exclusivity arrangement.

(B) The insurer has documented confirmation that the insurer offered commercially reasonable rates and contractual terms, the physician or provider declined the insurer's initial offer to contract, and the insurer subsequently made at least one additional attempt to contract offering a different rate or term. Examples of circumstances when the insurer is expected to make at least two offers include when the physician or provider declined the initial offer because:

(i) the insurer and the physician or provider were unable to agree on rates;

(ii) the physician or provider were unable to agree on contractual terms; or

(iii) the insurer is too new or unknown.

(C) The insurer was unable to make contact with the physician or provider, despite making a reasonable search for contact information and using at least two different documented contact methods.

(D) The insurer's offer to contract was accepted but credentialing has not yet been completed, or the physician or provider failed to meet credentialing standards.

(6) A limit on the issuance of a waiver under Insurance Code §1301.0055(a)(5) may apply if, during the applicable waiver periods under review, considering all pertinent evidence, TDI determines that the insurer did not demonstrate a good faith effort to contract.

(A) A waiver that is requested more than twice consecutively will be granted only if the insurer demonstrates multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods.

(B) A waiver that is requested more than four times within a 21-year period will be granted only if the insurer demonstrates that it made good faith efforts to bring the plan into compliance with the network adequacy standard during the prior year and that the issue could not be remedied through good faith efforts.

(7) For the purposes of this section:

(A) "commercially reasonable" means that a rate or contractual term is at least as favorable as a rate or contractual term accepted by similarly situated physicians or providers; and

(B) "similarly situated" means that physicians or providers are similar across key factors that are relevant for the purposes of determining commercially reasonable rates and terms. Relevant factors include experience, credentials, performance standards, services provided, hours of operation, and geographic region. A comparable geographic region may be the same county or the same geographic rating area as defined in §3.504 of this title (relating to Geographic Regions), or a county or rating area with similar market conditions.

(8) An insurer must carefully review a determination issued under this section. If the determination is based on a clear factual error by TDI, the insurer must notify TDI that a correction is needed no later than 15 calendar days from the date the determination is issued.

(c) At the same time an insurer files a request for waiver or a request to renew a waiver, it must file an access plan, to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request, subject to Insurance Code §1301.00566, concerning Effect of Network Adequacy Standards Waiver on Balance Billing Prohibitions. The insurer must:

(1) develop access plan procedures consistent with subsection (j) of this section; and

(2) file the access plan within the network configuration filing as addressed in §3.3712 [~~as required in §3.3712(c)(2)(C)(iv)~~] of this title.

(d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code §1301.00565(g), [~~1301.00565(g),~~] certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any provider or physician named in the waiver request.

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by sending an email to networkwaivers@tdi.texas.gov within 15 days after receiving notice from the department. The response, if filed, must indicate whether the provider or physician consents to being identified at a hearing related to the waiver request and may include evidence that is pertinent to the waiver request for the commissioner's consideration.

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, consistent with Insurance Code §1301.0055(a)(3).

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section and submitted

at the time the insurer files its annual report under §3.3709 of this title (relating to Annual Network Adequacy Report).

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must develop and file any applicable access plan the insurer uses in accordance with the waiver, in the manner specified by subsection (c) of this section.

(h) When granting a waiver, the department will specify the one-year period for which the waiver will apply. A waiver will expire at the end of the period specified by the department unless the insurer requests a renewal under subsection (g) of this section and the department approves the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific county, the insurer must establish an access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver in accordance with subsection (a) of this section requesting that the department approve the continued use of the access plan.

(j) An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which an access plan is submitted, as required by subsections (c), (i), or (m) of this section. These procedures must be made available to the department upon request. When a preferred provider is not available within the network adequacy standards under §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) to provide a medically necessary covered service, the insurer must use a documented procedure to:

(1) identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(2) upon request by an insured or an individual acting on behalf of an insured, and 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, approve a network gap exception and facilitate access to care by recommending at least two physicians or providers that:

(A) have expertise in the necessary specialty;

(B) are reasonably available considering the medical condition and location of the insured; and

(C) the insured may choose to use without being liable for any amount charged by the physician or provider that exceeds the insured's cost-sharing responsibilities under the preferred provider benefit level;

(3) furnish to insureds, prior to the services being rendered, an explanation of their rights, consistent with §3.3708(b)(1)(B) of this title (relating to Payment of Certain Out-of-Network Claims);

(4) except when a physician or provider is prohibited from balance billing, as specified in §3.3708(a)(1) - (4) of this title, notify insureds that they may be liable for any amounts charged by the physician or provider that are more than the insurer's reimbursement rate, unless the insured uses a physician or provider recommended by the insurer;[.]

(5) identify claims filed by nonpreferred providers in instances in which no preferred provider was available to the insured; and

(6) make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(k) For the purposes of subsection [~~paragraph~~] (j)(2) of this section, a network gap exception means an insurer's approval for an insured to receive care from a nonpreferred provider under the preferred provider benefit level because access to care through a preferred provider is not available within network adequacy standards. When facilitating care as required under subsection [~~paragraph~~] (j)(2) of this section, a recommended physician or provider is reasonably available if the physician or provider is [~~they are~~]:

(1) a nonpreferred provider within the network adequacy standards in §3.3704(f) of this title; or

(2) a preferred or nonpreferred provider outside of the network adequacy standards in §3.3704(f) of this title, only if the distance to reach the recommended physician or provider is not more than 15% farther than the distance to reach the nearest available physician or provider.

(l) An access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, consistent with §3.3712 [~~and includes the information specified in §3.3712(c)(2)(C)(iv)~~] of this title. With respect to the requirements in §3.3704(f)(2) and (f)(4) of this title, the access plan must demonstrate how the plan will facilitate access to care and a choice of physicians or providers as required under subsections (j) and (k) of this section for any insured that does not have access at least two preferred providers within the network's service area and the applicable time and distance 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.

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Jessica Barta
General Counsel
Texas Department of Insurance
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For further information, please call: (512) 676-6555

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER I. VALUATION PROCEDURES

34 TAC §9.4001

The Comptroller of Public Accounts proposes amendments to §9.4001, concerning valuation of open-space and agricultural lands.

Legislation enacted within the last four years that provides the statutory authority for this section is House Bill 1244, 89th Legislature, R.S., 2025 and House Bill 260, 88th Legislature, R.S., 2023. Pursuant to Tax Code, §23.52(d), these rules have been approved by the comptroller with the review and counsel of the Department of Agriculture.

These amendments are to reflect updates and revisions to the manual for the appraisal of agricultural land. The proposed updated manual may be viewed at https://comptroller.texas.gov/taxes/property-tax/docs/96-300p.pdf.

The manual sets forth the methods to apply and the procedures to use in qualifying and appraising land used for agriculture and open-space land under Tax Code, Chapter 23, Subchapters C and D. The amendments update and revise the October 2024 manual for the appraisal of agricultural land including updating footnotes, years and values. The amendments also incorporate legislative changes regarding change for ownership and late application for special appraisal.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed amendment is in effect, the amended rule: will not create or eliminate a government program; will not require the creation or elimination of 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 increase or decrease the number of individuals subject to the rule's applicability; and will not positively or adversely affect this state's economy. This proposal amends an existing rule.

Mr. Reynolds also has determined that the proposed amendment would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed amendment would benefit the public by improving the clarity and implementation of the section. There would be no anticipated significant economic cost to the public. The proposed amendment would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal or information related to the cost, benefit, or effect of the proposal, including any applicable data, research or analysis, to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments or other information no later than 30 days from the date of publication of the proposal in the *Texas Register*.

These amendments are proposed under Tax Code, §§5.05 (Appraisal Manuals and Other Materials); 23.41 (Appraisal); and 23.52 (Appraisal of Qualified Agricultural Land), which provide the comptroller with the authority to prepare and issue publications relating to the appraisal of property and to promulgate rules specifying the methods to apply and the procedures to use in appraising qualified agricultural and open-space land for ad valorem tax purposes.

These amendments implement Tax Code, Chapter 23, Subchapters C and D.

§9.4001. Valuation of Open-Space and Agricultural Lands.

Adoption of the "Manual for the Appraisal of Agricultural Land." This manual specifies the methods to apply and the procedures to use in qualifying and appraising land used for agriculture and open-space land under Tax Code, Chapter 23, Subchapters C and D. Appraisal districts are required to use this manual in qualifying and appraising open-space land. The Comptroller of Public Accounts adopts by reference the Manual for the Appraisal of Agricultural Land dated January 2026 [~~October~~ ~~2024~~]. The manual is accessible on the Property Tax Assistance Division website. [~~Copies of the manual can be obtained from the Comptroller of Public Accounts, Property Tax Assistance Division, P.O. Box 13528, Austin, Texas 78711-3528. Copies also may be requested by calling our toll-free number 1-800-252-9121. In Austin, call (512) 305-9999.~~]

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 May 18, 2026.

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Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
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34 TAC §9.4011

The Comptroller of Public Accounts proposes amendments to §9.4011, concerning appraisal of timberlands.

Legislation enacted within the last four years that provides the statutory authority for these sections is House Bill 3370, 89th Legislature, R.S., 2025. Pursuant to Tax Code, §23.73(b), these rules have been approved by the comptroller with the review and counsel of the Texas A&M Forest Service.

These amendments are to reflect updates and revisions to the manual for the appraisal of timberland. The proposed updated manual may be viewed at https://comptroller.texas.gov/taxes/property-tax/docs/96-357p.pdf.

The manual sets forth the methods to apply and the procedures to use in qualifying and appraising timberland and restricted-use timberland under Tax Code, Chapter 23, Subchapters E and H. The amendments update and revise the October 2024 manual for the appraisal of timberland including updating footnotes, years and values. The amendments also incorporate legislative changes regarding the late application for appraisal as timberland.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed amendment is in effect, the amended rule: will not create or eliminate a government program; will not require the creation or elimination of 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 increase or decrease the number of individuals subject to the rule's applicability; and will not positively or adversely affect this state's economy. This proposal amends an existing rule.

Mr. Reynolds also has determined that the proposed amendment would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed amendment would benefit the public by improving the clarity and implementation of the section. There would be no anticipated significant economic cost to the public. The proposed amendment would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal or information related to the cost, benefit, or effect of the proposal, including any applicable data, research or analysis, to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments or other information no later than 30 days from the date of publication of the proposal in the *Texas Register*.

These amendments are proposed under Tax Code, §§5.05 (Appraisal Manuals and Other Materials); 23.73 (Appraisal of Qualified Timber Land); and 23.9803 (Appraisal of Qualified Restricted-Use Timber Land), which authorize the comptroller to prepare and issue publications relating to the appraisal of property and to promulgate rules specifying the methods to apply and the procedures to use in appraising timberland and restricted-use timberland for ad valorem tax purposes.

These amendments implement Tax Code, Chapter 23, Subchapters E and H.

§9.4011. Appraisal of Timberlands.

Adoption of the Manual for the Appraisal of Timberland. This manual sets out both the eligibility requirements for timberland to qualify for productivity appraisal and the methodology for appraising qualified timberland and restricted use timberland. Appraisal districts are required by law to follow the procedures and methodology set out in this manual. The Comptroller of Public Accounts adopts by reference the Manual for the Appraisal of Timberland dated January 2026 [~~October~~ 2024]. Copies of this manual [~~can be obtained from the Comptroller of Public Accounts, Property Tax Assistance Division, P.O. Box 13528, Austin, Texas 78711-3528 or from the Property Tax Assistance Division website. Copies may also be requested by calling our toll-free number 1-800-252-9121. In Austin, call (512) 305-9999. From a Telecommunications Device for the Deaf (TDD), call 1-800-248-4099, toll free. In Austin, the local TDD number is (512) 463-4621. This manual~~] and those that have been superseded are available from the Comptroller's office as well as the State Archives.

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

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PART 3. TEACHER RETIREMENT SYSTEM OF TEXAS

CHAPTER 41. HEALTH CARE AND INSURANCE PROGRAMS

SUBCHAPTER A. RETIREE HEALTH CARE BENEFITS (TRS-CARE)

34 TAC §41.17

The Board of Trustees of the Teacher Retirement System of Texas (TRS) proposes to amend §41.17 (relating to Limited-time Enrollment Opportunity for Medicare-eligible Retirees) under Subchapter A (relating to Retiree Health Care Benefits (TRS-CARE)) of Chapter 41 in Part 3 of Title 34 of the Texas Administrative Code.

BACKGROUND AND PURPOSE

In 2024, the trust fund of the Texas Public School Retired Employees Group Benefits Program ("TRS-Care"), administered under Chapter 1575 of the Insurance Code, experienced growth stemming from federal changes to Medicare, TRS' improved contracts with Medicare Advantage and Part D drug benefits, and other factors. TRS received correspondence from legislative leadership directing TRS to use the growth in the TRS-Care fund to reduce premiums and allow for a one-time enrollment opportunity for eligible TRS-Care Medicare Advantage (TRS-Care MA) participants. Considering the legislators' request, TRS reduced the premiums of the TRS-Care MA plan for the 2025 plan year and enacted Rule 41.17.

Rule 41.17 offered a limited-time enrollment opportunity for Medicare-eligible retirees and their eligible dependents, surviving spouses, and surviving dependent children. The rule provided these individuals with an opportunity to take advantage of the reduced premiums under the TRS-Care MA plan. Rule 41.17 addressed the duration of the limited-time enrollment opportunity, eligibility and effective dates of coverage. This limited-time enrollment opportunity began on Oct. 1, 2024, and ended on March 31, 2026.

The TRS-Care trust fund continues to experience significant positive growth, which allows TRS to maintain the lower TRS-Care MA plan premiums. Therefore, TRS proposes offering another limited-time enrollment opportunity for the 2027 TRS-Care MA plan year by proposing to amend Rule 41.17 to offer a limited-time enrollment opportunity that will begin on Oct. 1, 2026, and end on March 31, 2028. The proposed amendments will change the original dates written in the rule to the new enrollment opportunity dates. The proposed amendment also makes a nonsubstantive change to correct a typographical spacing error in the existing rule language. These will be the only changes made.

FISCAL NOTE

Don Green, TRS Chief Financial Officer, has determined that for each year of the first five years the proposed amended rule will be in effect, there will be no foreseeable negative fiscal implications for state governments and no foreseeable fiscal implications for local governments as a result of administering the proposed amended rule. While opening the enrollment for otherwise eligible retirees, dependents, surviving spouses, and surviving dependent children increases the risk to the TRS-Care trust fund, that risk increase is offset by the premiums that amended and existing enrollees will be paying for their coverage and other sources of income of the trust fund. Because health benefit plans are inherently risk-based businesses, this limited-time enrollment opportunity does not pose a risk to the trust fund that is atypical for its nature.

PUBLIC COST/BENEFIT

For each year of the first five years the proposed amended rule will be in effect, Mr. Green has also determined that the public benefit anticipated as a result of adopting the proposed amended rule will be to provide guidance with respect to how the limited-time enrollment opportunity will be implemented. Mr. Green has also determined that entities required to comply with the proposed amended rule will not incur any economic cost. Further,

Mr. Green has determined the amendment will not impose a cost on regulated persons.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

TRS has determined that proposed amended §41.17 will not have any adverse economic effect on small businesses, micro-businesses, or rural communities. As a result, the requirements for an economic impact statement or a regulatory flexibility analysis under Government Code §2006.002 do not apply in this case.

LOCAL EMPLOYMENT IMPACT STATEMENT

TRS has determined that there will be no effect on local employment because of the proposed amended rule. Therefore, no local employment impact statement is required under Government Code §2001.022.

GOVERNMENT GROWTH IMPACT STATEMENT

TRS has determined that for the first five years the proposed amended rule is in effect, the proposed amended rule will not create or eliminate any TRS programs; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to TRS; will not eliminate any fees currently paid to TRS; will not expand, limit or repeal the existing rule; will not increase or decrease the number of individuals subject to the rule's applicability; and will not affect the state's economy.

This proposal amends an existing regulation. TRS, as trustee of the Texas Public School Retired Employees Group Benefits Act created under Chapter 1575 of the Insurance Code, proposes to amend Rule 41.17 to provide a limited-time enrollment opportunity for eligible retirees, dependents, surviving spouses, and surviving dependent children who did not enroll when they had the opportunity to do so.

TAKINGS IMPACT ASSESSMENT

TRS has determined that there are no private real property interests affected by the proposed amended rule; therefore, a takings impact assessment is not required under Government Code §2007.043.

COSTS TO REGULATED PERSONS

TRS has determined that Government Code §2001.0045 does not apply to the proposed amended rule because it does not impose a cost on regulated persons.

COMMENTS

TRS requests written comments regarding the proposed amended rule. The comments may include information related to the costs, benefits or effects of the proposed amended rule, including any applicable data, research or analysis, from any person required to comply with the proposed amended rule or any other interested person.

Comments and information regarding the cost, benefit and effect of the rule may be submitted in writing to Brian Guthrie, TRS Executive Director, P.O. Box 149676, Austin, Texas 78714-0185. Written comments and cost/benefit information must be received by TRS no later than 30 days after publication of this notice in the *Texas Register*.

STATUTORY AUTHORITY

The proposed amended rule is authorized under Chapter 1575, Insurance Code, which establishes the Texas Public School Retired Employees Group Benefits Act (TRS-CARE); §1575.052, which allows the trustee to adopt rules, plans, procedures, and orders reasonably necessary to implement Chapter 1575, including periods of enrollment and selection of coverage and procedures for enrolling and exercising options under the group program; Chapter 825 of the Government Code, which governs the administration of TRS; and Government Code §825.102, which authorizes the Board to adopt rules for the transaction of the business of the Board.

CROSS-REFERENCE TO STATUTE

The proposed amended rule is issued under the authority of Insurance Code §1575.052, related to Authority to Adopt Rules and Procedures; Other Authority, which authorizes the trustee to adopt rules, plans, procedures, and orders reasonably necessary to implement Chapter 1575, including periods of enrollment and selection of coverage and procedures for enrolling and exercising options under the group program.

§41.17. Limited-time Enrollment Opportunity for Medicare-eligible Retirees.

(a) Eligibility.

(1) Retiree. A retiree who is eligible to enroll in the Medicare Advantage plan offered under TRS-Care in accordance with Section 1575.1582(b), Insurance Code (hereinafter referred to as "MA plan") and who is not currently enrolled in the MA plan, may enroll in the MA plan if the retiree applies for enrollment during the limited-time enrollment period. For the purpose of this section, the limited-time enrollment period is the period that begins on October 1, 2026 [~~2024~~], and extends through March 31, 2028 [~~2026~~].

(2) Surviving spouses or surviving dependent children. If a retiree has passed away, the retiree's surviving spouse or the retiree's surviving dependent child may enroll under this section, as long as:

(A) The surviving spouse or surviving dependent child qualifies as such under Section 1575.003, Insurance Code, and

(B) The surviving spouse or surviving dependent child is eligible for Medicare and is eligible to enroll in the MA plan offered under TRS-Care in accordance with Section 1575.1582(b), [~~Section1575.1582(b),~~] Insurance Code.

(3) Dependents. If the retiree's or surviving spouse's application to enroll under this section is approved, the retiree or surviving spouse may also enroll any eligible dependents.

(4) Single enrollment opportunity. A retiree, surviving spouse, or surviving dependent child may only enroll one time during the limited-time enrollment period.

(b) Effective Date of Coverage.

(1) January 1, 2027 [~~2025~~]. For those applications received and approved before January 1, 2027 [~~2025~~], coverage shall be effective on January 1, 2027 [~~2025~~].

(2) After January 1, 2027 [~~2025~~]. For those applications received after January 1, 2027 [~~2025~~], the effective date of coverage shall be the first day of the month after TRS receives and approves the request to enroll.

(3) Range. In no event shall the effective date be prior to January 1, 2027 [~~2025~~], or after April 1, 2028 [~~2026~~].

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 May 18, 2026.

TRD-202602065
Don Green
Chief Financial Officer
Teacher Retirement System of Texas
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 542-3528

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SUBCHAPTER C. TEXAS SCHOOL EMPLOYEES GROUP HEALTH (TRS-ACTIVECARE)

34 TAC §41.38

The Board of Trustees of the Teacher Retirement System of Texas (TRS) proposes to amend §41.38 (relating to Termination Date of Coverage) under Subchapter C (relating to Texas School Employees Group Health (TRS-ACTIVECARE)) of Chapter 41 in Part 3 of Title 34 of the Texas Administrative Code.

BACKGROUND AND PURPOSE

TRS proposes to delete §41.38(a)(7) to eliminate participants' ability to voluntarily terminate their TRS-ActiveCare enrollment in the middle of the plan year. This change addresses the instability to the TRS-ActiveCare trust fund that this conduct creates, including disruptions to premium collection, rate setting, increased risk of adverse selection, and administrative burden. As trustee of the program, TRS is proposing this amendment to protect the fiscal health and stability of the trust fund, which in turn serves the best interests of all plan participants. The following factors support this proposal.

First, allowing a participant to leave TRS-ActiveCare mid-year is inconsistent with industry standards. Typically, individuals enrolled in a health plan are required to remain enrolled until the end of that plan year, absent a qualifying mid-year life event that, under HIPAA regulations, require health plans to permit enrollment changes, such as termination of employment, reduction in work hours, death, divorce, marriage, or the birth or adoption of a child.

Second, allowing TRS-ActiveCare enrollees to voluntarily drop coverage throughout the year adversely affects rate calculation and premium collection. For example, participants that drop coverage after high-cost services are received no longer contribute to the risk pool placing upward pressure on the remaining participants' premiums to cover those expenses. As another example, healthier participants that end their coverage as a way of managing mid-plan-year financial constraints shift claim burdens to higher-cost participants and drive premium increases in subsequent plan years.

Also, allowing individuals to leave the TRS-ActiveCare program in the middle of the plan year increases the administrative burden of managing the program driving up administrative costs.

Therefore, TRS proposes to remove §41.38(a)(7) from §41.38 and renumber the rest of the rule accordingly. It is TRS' fiduciary duty to administer the program in a fiscally responsible manner and to safeguard the TRS-ActiveCare trust fund from the adverse selection and administrative burden resulting from voluntary mid-year enrollment drops. Protecting the trust fund helps maintain stable rates and premiums and supports the interests of all members and dependents who participate in the plan.

FISCAL NOTE

Don Green, TRS Chief Financial Officer, has determined that for each year of the first five years the proposed amendments to §41.38 will be in effect, there will be no foreseeable negative fiscal implications for state governments and no foreseeable fiscal implications for local governments as a result of administering proposed amended §41.38. Requiring members to stay in the TRS-ActiveCare program through their plan year will save costs to the program, which will ultimately aid the health of the TRS-ActiveCare trust fund.

PUBLIC COST/BENEFIT

For each of the first five years proposed amended §41.38 is in effect, Mr. Green anticipates significant public benefit. The change will create stable rate calculation and premium collection while also saving costs to the TRS-ActiveCare trust fund, which could be used to lower rates and premiums. Mr. Green has also determined that entities required to comply with the proposed amended rule will not incur any economic cost.

Mr. Green has determined this rule amendment will not imply economic costs to persons required to comply with the rule. While continued participation in the plan would require participants pay the cost of the premiums through the end of the plan year, they will also avoid greater financial risk associated with going without coverage. Therefore, the future costs for individual participants who wish to drop coverage mid-year cannot be determined.

In contrast, this rule amendment promotes financial stability in the TRS-ActiveCare risk pool, helping public education employers (local government/regulated persons) avoid the additional costs of adverse selection that can occur when a health plan member who has coverage, seeks care generating claims cost, then drops coverage after the treatment to avoid individual premium contributions for the balance of the year. The TRS-ActiveCare trust fund operates as a pooled risk arrangement, with participant contributions priced on the assumption of stable enrollment for the full plan year to cover expected claims, volatility, and fixed administrative and reserve costs. As a fiduciary, TRS has a mandate to prudently administer the trust's resources to deliver reliable health benefits to Texas educators.

Allowing participants to exit mid-year ends their contributions without proportionally reducing the plan's risk, since claims remain unpredictable and fixed costs do not change. This shifts higher per-capita risk and volatility to remaining participants and exacerbates adverse selection. Depending on the extent of the claims cost incurred before the member drops, early exits may also contribute to future funding shortfalls, increasing contribution pressure in later years for both remaining participants and those who later re-enroll. Through this amendment, TRS seeks to balance individual flexibility with the collective benefit of a stable risk pool.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

TRS has determined that proposed amended §41.38 will not have any adverse economic effect on small businesses, microbusinesses, or rural communities. As a result, the requirements for an economic impact statement or a regulatory flexibility analysis under Government Code §2006.002 do not apply in this case.

LOCAL EMPLOYMENT IMPACT STATEMENT

TRS has determined that there will be no effect on local employment because of the proposed amended rule. Therefore, no local employment impact statement is required under Government Code §2001.022.

GOVERNMENT GROWTH IMPACT STATEMENT

TRS has determined that for the first five years proposed amended §41.38 is in effect, proposed amended §41.38 will not create or eliminate any TRS programs; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to TRS; will not eliminate any fees currently paid to TRS; will amend an existing regulation; will limit the existing rule by repealing a member's ability to terminate enrollment in the middle of the play year, without a special enrollment event, which is allowed by the existing rule; will not increase or decrease the number of individuals subject to the rule's applicability; and will not affect the state's economy.

This proposal amends an existing regulation. The proposed changes to §41.38 modify the rule through which TRS, as trustee of the Texas School Employees Uniform Group Health Coverage Act created under Chapter 1579 of the Insurance Code, will remove the ability for enrollees of the TRS-ActiveCare program to voluntarily drop coverage at the end of any month of their plan year. Specifically, by amending the rule to remove the option to leave mid-year, enrollees will be required to qualify for a special enrollment event under HIPAA to leave before the end of the plan year.

TAKINGS IMPACT ASSESSMENT

TRS has determined that there are no private real property interests affected by the proposed amended rule; therefore, a takings impact assessment is not required under Government Code §2007.043.

COSTS TO REGULATED PERSONS

TRS has determined that Government Code §2001.0045 does not apply to the proposed amended rule because it does not impose a cost on regulated persons.

COMMENTS

TRS requests written comments regarding the proposed amended rule. The comments may include information related to the costs, benefits or effects of the proposed amended rule, including any applicable data, research or analysis, from any person required to comply with the proposed amended rule or any other interested person.

Comments and information regarding the cost, benefit and effect of the rule may be submitted in writing to Brian Guthrie, TRS Executive Director, P.O. Box 149676, Austin, Texas 78714-0185. Written comments and cost/benefit information must be received by TRS no later than 30 days after publication of this notice in the *Texas Register*.

STATUTORY AUTHORITY

The proposed amended rule is authorized under Chapter 1579 of the Insurance Code, which establishes the Texas School Employees Uniform Group Health Coverage Act (TRS-ACTIVECARE). Specifically, §1579.052 grants the trustee the authority to adopt rules, plans, procedures, and orders reasonably necessary to implement Chapter 1579, including those related to enrollment periods coverage selection, and procedures for changing enrollment. Additionally, the proposed amended rule is supported by Chapter 825 of the Government Code, which governs the TRS administration, and §825.102 of the Government Code, which authorizes the Board to adopt rules for the transaction of the business of the Board.

CROSS-REFERENCE TO STATUTE

The proposed amended rule implements the Insurance Code § 1579.052, related to Authority to Adopt Rules and Procedures; Other Authority, which authorizes the trustee to adopt rules, plans, procedures, and orders reasonably necessary to implement Chapter 1579, including periods of enrollment and coverage selection and outlines the procedures for enrolling and exercising options under the group program.

§41.38. Termination Date of Coverage.

(a) Unless otherwise required by law or this section, coverage shall terminate at the earliest of:

(1) 11:59 p.m. Austin Time on the last calendar day of the month in which the covered individual's employer, or the employer of the individual under whom a dependent qualified for coverage, ceases to be a participating entity;

(2) 11:59 p.m. Austin Time on the last calendar day of the month in which a covered individual, or the individual under whom a dependent qualified for coverage, terminates employment as determined by the participating entity, except as otherwise provided under §41.39 of this title (relating to Coverage for Individuals Changing Employers);

(3) 11:59 p.m. Austin Time on the last calendar day of the month in which a covered individual, or the individual under whom a dependent qualified for coverage, is no longer eligible for coverage under TRS-ActiveCare under §41.34 of this title (relating to Eligibility for Coverage under the Texas School Employees Uniform Group Health Coverage Program);

(4) 11:59 p.m. Austin Time on the date specified by the trustee if the covered individual, or the individual under whom a dependent qualified for coverage, is expelled from the program;

(5) 11:59 p.m. Austin Time on the last calendar day of the month immediately preceding the month in which TRS receives a notification from a participating entity, in the form prescribed by TRS, that a covered individual failed to make a required monthly premium payment to the participating entity;

(6) 11:59 p.m. Austin Time on the last calendar day of the month in which a covered individual enters into active, full-time military, naval, or air service, except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law;

~~[(7) 11:59 p.m. Austin Time on the last calendar day of the month in which the administering firm or TRS receives notice, in a form acceptable to TRS, that a covered individual, or the individual under whom a dependent qualified for coverage, has chosen to voluntarily drop coverage under TRS-ActiveCare;]~~

(7) [~~(8)~~] 11:59 p.m. Austin Time on the last day of the month for which TRS-ActiveCare received payment if the participating entity employing the covered individual, or the individual under whom a dependent qualified for coverage, has failed to make all premium payments due for a period of 90 days or longer; or

(8) [~~(9)~~] the termination date and time that a health maintenance organization participating in TRS-ActiveCare provides for in its Evidence of Coverage for the reasons listed in that Evidence of Coverage.

(b) Notwithstanding subsection (a) of this section, a covered individual who resigns his employment position with a participating entity effective after the last day of an instructional year and who is in "good standing" with TRS-ActiveCare at the time of the effective date of resignation, is entitled to automatically remain enrolled in TRS-ActiveCare, through the earlier of (1) the first anniversary of the date participation in or coverage under TRS-ActiveCare was first made available to employees of that participating entity for the last instructional year in which the covered individual was employed by the participating entity, or (2) the last calendar day before the first day of the instructional year immediately following the last instructional year in which the employee was employed by the participating entity, provided none of the events described in provisions of subsection (a) of this section occur after the effective date of the covered individual's resignation. Consequently, if the employer of the covered individual became a participating entity in TRS-ActiveCare on or before the September 1st that immediately preceded the effective date of resignation by the covered individual, then the covered individual may automatically be entitled to coverage through the August 31st that immediately follows the effective date of resignation, assuming termination does not sooner occur due to the occurrence of an event described in provisions of subsection (a) of this section after the effective date of the covered individual's resignation. Alternatively, if the employer of the covered individual became a participating entity in TRS-ActiveCare after the September 1st that immediately preceded the effective date of resignation by the covered individual, then the covered individual may automatically be entitled to coverage through the end of the 12th month of that participating entity's participation in TRS-ActiveCare, assuming termination does not sooner occur due to the occurrence of an event described in provisions of subsection (a) of this section after the effective date of the covered individual's resignation. A dependent enrolled in TRS-ActiveCare under a covered individual who qualifies for continued coverage pursuant to this subsection is also automatically entitled to remain enrolled in TRS-ActiveCare only for such time as the covered individual remains enrolled in TRS-ActiveCare. For purposes of this subsection only, the following applies:

(1) A covered individual is in "good standing" with TRS-ActiveCare if, on the effective date of the individual's resignation:

(A) the covered individual has not been expelled from TRS-ActiveCare;

(B) TRS has not received a notification from the participating entity that employed the covered individual, in the form prescribed by TRS, that the covered individual failed to make a required monthly TRS-ActiveCare premium payment to the participating entity; and

(C) neither the participating entity that employed the covered individual, nor the covered individual under whom a dependent qualified for coverage, failed to make all premium payments due for a period of 90 days or longer.

(2) For each participating entity that provides instruction to students, the term "instructional year" shall be the locally established calendar period during which that participating entity holds classes, exclusive of summer school. In no event may this "instructional year" extend beyond June 30th.

(3) For each participating entity that does not provide instruction to students, the participating entity may establish an "instructional year" that begins no earlier than August 1st and does not extend beyond June 30th.

(4) If a participating entity does not establish an "instructional year," the "instructional year" shall be deemed to begin on September 1st and to extend through May 31st.

(5) Each participating entity shall have only one "instructional year," which shall be applicable to all covered individuals employed by the participating entity.

(c) For individuals receiving continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) ("COBRA"), coverage shall terminate the earlier of:

(1) 11:59 p.m. Austin Time on the last calendar day of the month immediately preceding the date on which TRS fails to receive a timely and complete monthly premium payment from an individual receiving COBRA continuation coverage; or

(2) 11:59 p.m. Austin Time on the last calendar day of the month in which an individual's eligibility for COBRA continuation coverage expires or otherwise terminates.

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 May 18, 2026.

TRD-202602066
Don Green
Chief Financial Officer
Teacher Retirement System of Texas
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 542-3528

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 702. GENERAL ADMINISTRATION
SUBCHAPTER O. OFFICE OF INTERAGENCY COORDINATION ON REPORTABLE CONDUCT

40 TAC §§702.1401, 702.1403, 702.1405

The Department of Family and Protective Services (DFPS) proposes new rules in Title 40, Texas Administrative Code (TAC), Part 19, Chapter 702, Subchapter O, relating to the creation of the Office of Interagency Coordination on Reportable Conduct (OICRC) to support the Search Engine for Multi-Agency Reportable Conduct (SEMARC).

BACKGROUND AND PURPOSE

In the 88th Regular Legislative Session, Senate Bill 1849 passed establishing SEMARC. SEMARC is an interagency search engine to help participating state agencies identify individuals with a history of reportable work conduct. Reportable conduct is defined in Section 810.001 of the Health and Safety Code. This tool aims to prevent individuals from being present in work roles where they could harm vulnerable populations, such as DFPS clients.

SECTION-BY-SECTION SUMMARY

Proposed new §702.1401 describes the establishment and operation of the newly statutorily created DFPS Office of Interagency Coordination on Reportable Conduct (OICRC).

Proposed new §702.1403 defines reportable conduct, what constitutes a DFPS final determination, and who reportable conduct applies to.

Proposed new §702.1405 describes when DFPS will conduct search queries using SEMARC to determine whether a proposed employee, volunteer, contractor, or other individual as listed in the rule engaged in reportable conduct and what DFPS does when there is a SEMARC match.

FISCAL NOTE

Lea Ann Biggar, Chief Financial Officer, has determined that for each year of the first five years that the section(s) will be in effect, there will be fiscal implications to state government as a result of enforcing and administering the new sections. There will be no effect on local government.

GOVERNMENT GROWTH IMPACT STATEMENT

DFPS has determined that during the first five years that the section(s) will be in effect:

(1) the new rule(s) will create or eliminate a government program;

(2) implementation of the new rule(s) will create new employee positions;

(3) implementation of the new rule(s) will require an increase in future legislative appropriations;

(4) the new rule(s) will not affect fees paid to the agency;

(5) the new rule(s) will create a new rule;

(6) the new rule(s) will not expand, limit, or repeal an existing rule;

(7) the new rule(s) will increase the number of individuals subject to the rule; and

(8) the new rule(s) will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Ms. Biggar has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities as the rule does not apply to small or micro-businesses, or rural communities.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the section(s) as proposed.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these new rules because DFPS is exempt per subsection (c) of §2001.0045.

PUBLIC BENEFIT

Vicki Kozikoujekian, DFPS General Counsel, has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be that the safety of children in care will be improved.

TAKINGS IMPACT ASSESSMENT

DFPS has determined that 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 Government Code, §2007.043.

PUBLIC COMMENT

DFPS invites comments on the new rule proposals. DFPS requests information related to the cost, benefit, or effect of the proposed new rules, including any applicable data, research, or analysis. To be considered, comments, questions, and information must be submitted no later than 30 days after the date of this issue to the *Texas Register*.

Electronic comments and questions may be submitted to Katharine Bradley, Policy Attorney at kathryn.bradley@dfps.texas.gov or RULES@dfps.texas.gov. Hard copy comments may be submitted to the DFPS Rules Coordinator, Legal Services Sanjuanita Maltos, Department of Family and Protective Services E-611, P.O. Box 149030, Austin, Texas 78714-9030.

STATUTORY AUTHORITY

The new rules are proposed under Human Resources Code §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matter within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

Additionally, Health and Safety Code Chapter 810 requires DFPS to create rules regarding the operation of the OICRC and periodic search queries using SEMARC.

CROSS REFERENCE TO STATUTES

The proposed new rules implement Texas Health and Safety Code Chapter 810.

§702.1401. What is the Office of Interagency Coordination on Reportable Conduct?

The Office of Interagency Coordination on Reportable Conduct (OICRC) within the Texas Department of Family and Protective Services (DFPS) is responsible for the administration and coordination of the Search Engine for Multi-Agency Reportable Conduct (SEMARC) program through the following actions:

(1) Implementing and coordinating a committee of participating state agencies through a Memorandum of Understanding (MOU) to strategize, plan activities, and resolve issues regarding the SEMARC program;

(2) Serving as a subject matter expert for the SEMARC program;

(3) Serving as the central point of contact to coordinate support for legislative, media, and general inquiries regarding SEMARC data, processes, and implementation;

(4) Coordinating the development and documentation of processes for data sharing and the exchange of records; and

(5) Partnering with DFPS Information Technology Services to ensure performance and ongoing management of the SEMARC program, in coordination with other participating agencies.

§702.1403. What is Reportable Conduct?

(a) Reportable Conduct means a participating state agency's determination:

(1) That an individual committed abuse, neglect, exploitation, or misconduct; and

(2) For which the participating state agency has issued a final determination.

(b) A DFPS final determination is when an individual has waived or exhausted all due process rights, including an administrative review and/or a due process hearing, and any subsequent right of appeal.

(c) Reportable Conduct does not apply to DFPS determinations resulting from investigations where the subject of the investigation is:

(1) A child's parent, guardian, managing or possessory conservator;

(2) A member of the child's family or household as defined in Texas Family Code, Chapter 71; or

(3) A person with whom the child's parent cohabits.

§702.1405. How will DFPS utilize information from SEMARC?

(a) DFPS Background Checks conducts Reportable Conduct searches through SEMARC for individuals seeking positions that have access to DFPS clients or resources under DFPS programs. Individuals include:

(1) Prospective and current DFPS employees;

(2) Prospective and current Single Source Continuum Contractors (SSCC) employees;

(3) Contractors or grantees who provide services to populations served by DFPS or who have direct access or direct contact to DFPS clients, participants, or resources;

(4) DFPS volunteers; and

(5) Individuals needing external access to DFPS data, systems and networks.

(b) A waiver of any Reportable Conduct search through SEMARC must be approved by the Commissioner, or the Commissioner's designee, to ensure the waiver does not conflict with state or federal law.

(c) DFPS Background Checks conducts Reportable Conduct renewal searches as follows:

(1) For contractors, no later than every 24 months from the request date of the previous background check; and

(2) For DFPS employees, volunteers, SSCC employees, and individuals with external access, no later than every 12 months from the date of the previous request.

(d) DFPS Background Checks will bar an individual and will not conduct a risk assessment under subsection (e) of this section if the individual described in subsection (a) of this section has Reportable Conduct identified through SEMARC that involves:

(1) Sexual abuse or sexual exploitation;

(2) Engaging in, soliciting, or attempting to engage in a romantic or sexual relationship with a student or minor;

(3) Inappropriate relationships or other conduct demonstrating boundary violations; and

(4) Physical abuse, including physical misconduct or the use of physical restraints that result in physical harm, within the last five years of the Reportable Conduct.

(e) If subsection (d) of this section does not apply and Reportable Conduct is identified in SEMARC, DFPS Background Checks will complete a risk assessment. Elements considered in a risk assessment include, but are not limited to:

(1) The type and severity of the Reportable Conduct;

(2) The length of time since the incident;

(3) Any prior history of misconduct;

(4) The roles and responsibilities of the position regarding clients and DFPS resources;

(5) Evidence of rehabilitation; and

(6) Potential safety risks to clients or resources.

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 May 13, 2026.

TRD-202602012
Sanjuanita Maltos
Rules Coordinator
Department of Family and Protective Services
Earliest possible date of adoption: June 28, 2026
For further information, please call: (512) 945-5978