TEXAS REGISTER

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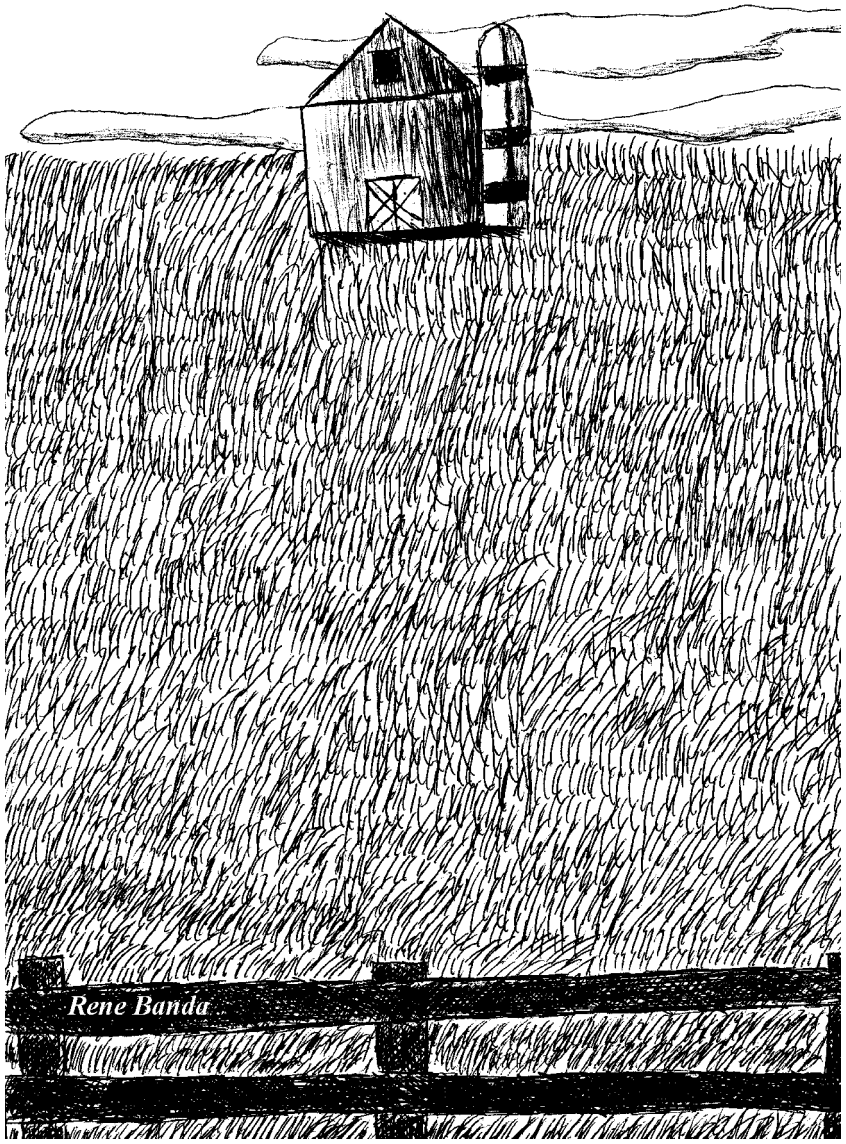

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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IN THIS ISSUE

THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Appointments

Appointments for October 21, 2004

Appointed to the Abraham Lincoln Bicentennial Commission, as a member of the Governor's Council, for a term at the pleasure of the Governor, Dr. H. W. Brands of Austin.

Appointed to the Texas Department of Criminal Justice Advisory Committee on Offenders with Medical or Mental Impairments, pursuant to SB 591, 78th Legislature, Regular Session, for a term to be decided by lot at the first meeting, Christopher C. Kirk of Bryan.

Appointed to the Texas Department of Criminal Justice Advisory Committee on Offenders with Medical or Mental Impairments, pursuant to SB 591, 78th Legislature, Regular Session, for a term to be decided by lot at the first meeting, Eulon Ross Taylor, M.D. of Lubbock.

Appointed to the Texas Department of Criminal Justice Advisory Committee on Offenders with Medical or Mental Impairments, pursuant to SB 591, 78th Legislature, Regular Session, for a term to be decided by lot at the first meeting, John Martin Bradley of Georgetown.

Appointed to the State Employee Charitable Campaign Policy Committee for a term to expire January 1, 2006, Deryl S. Creekmur of Austin (replacing Robert Skaggs of Galveston whose term expired).

Appointed to the State Employee Charitable Campaign Policy Committee for a term to expire January 1, 2006, Veronda L. Durden of Austin (replacing Mary Goldwater of Round Rock whose term expired).

Appointed to the State Employee Charitable Campaign Policy Committee for a term to expire January 1, 2006, David Wayne Standlee, Sr. of Huntsville (Reappointment).

Appointed to the Capital Area Regional Review Committee for a term to expire January 1, 2006, Floyd Cooley, Commissioner, of Johnson City (replacing O. J. Wade).

Appointed to the Nortex Regional Review Committee for a term to expire January 1, 2006, James D. Coltharp, Judge, of Seymour (replacing Carolyn McDermott).

Appointed to the Nortex Regional Review Committee for a term to expire January 1, 2006, Carolyn Sue Cox Steinberger, Mayor, of Windthorst (replacing Max Wood).

Appointed to the Nortex Regional Review Committee for a term to expire January 1, 2006, Dale M. Eaton, Mayor Pro-tem, of Quanah (replacing Ann Sparkman).

Appointments for October 26, 2004

Appointed to the San Jacinto River Authority Board of Directors for a term to expire October 16, 2009, John H. Stibbs, Jr. of The Woodlands (replacing John Draper who resigned).

Appointed as Presiding Judge of the Sixth Administrative Judicial Regional for a term to expire four years from date of qualification, Stephen B. Ables, Judge, of Kerrville (Judge Ables is being reappointed).

Appointed as Presiding Judge of the Ninth Administrative Judicial Region for a term to expire four years from date of qualification, Kelly G. Moore, Judge, of Brownfield (Judge Moore is being reappointed).

Rick Perry, Governor

TRD-200406580

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THE ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code, Title 4, §402.042, and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open records decisions are summarized for publication in the *Texas Register*. The attorney general responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the attorney general unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. You may view copies of opinions at http://www.oag.state.tx.us. To request copies of opinions, please fax your request to (512) 462-0548 or call (512) 936-1730. To inquire about pending requests for opinions, phone (512) 463-2110.

Request for Opinions

RQ-0281-GA

Requestor:

The Honorable Robert E. Talton

Chair, Urban Affairs Committee

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Applicability of section 643.204 of the Transportation Code to a municipality that regulates nonconsent towing (Request No. 0281-GA)

Briefs requested by November 28, 2004

RQ-0282-GA

Requestor:

The Honorable Troy Fraser

Chair, Business and Commerce Committee

Texas State Senate

Post Office Box 12068

Austin, Texas 78711

Re: Status of persons promoted under the civil service statutes to fill positions of officers on military leave of absence (Request No. 0282-GA)

Briefs requested by November 28, 2004

RQ-0283-GA

Not published - Request will be withdrawn by Requestor

RQ-0284-GA

Requestor:

The Honorable Leticia Van de Putte, R.Ph.

Chair, Veteran Affairs and Military Installations Committee

Texas State Senate

Post Office Box 12068

Austin, Texas 78711

Re: Whether land leased by the United States Army to a private corporation that provides military housing is subject to ad valorem taxation (Request No. 0284-GA)

Briefs requested by November 29, 2004

RQ-0285-GA

Requestor:

The Honorable Bill Hill

Dallas County District Attorney

Administration Building, 5th Floor

411 Elm Street, Suite 500

Dallas, Texas 75202-3384

Re: Constitutionality of section 6.025(d) of the Tax Code, which requires a chief appraiser to use the lowest appraisal value of property located in more than one appraisal district (Request No. 0285-GA)

Briefs requested by December 1, 2004

For further information, please access the website at www.oag.state.tx.us. or call the Opinion Committee at 512/463-2110.

TRD-200406600
Nancy S. Fuller
Assistant Attorney General
Office of the Attorney General
Filed: November 3, 2004

♦ ♦ ♦

EMERGENCY RULES

Emergency Rules include new rules, amendments to existing rules, and the repeals of existing rules. A state agency may adopt an emergency rule without prior notice or hearing if the agency finds that an imminent peril to the public health, safety, or welfare, or a requirement of state or federal law, requires adoption of a rule on fewer than 30 days' notice. An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days (Government Code, §2001.034). An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days. (Government Code, §2001.034).

TITLE 13. CULTURAL RESOURCES

PART 3. TEXAS COMMISSION ON THE ARTS

CHAPTER 35. A GUIDE TO OPERATIONS, PROGRAMS AND SERVICES

The Texas Commission on the Arts adopts on an emergency basis the repeal and replacement of §35.2, concerning A Guide to Programs and Services. Elsewhere in this issue of the *Texas Register*, the Texas Commission on the Arts contemporaneously proposes the repeal and replacement of §35.2 for permanent adoption.

The purpose of the repeal and replacement is to be consistent with changes to programs and services of the commission as outlined in the Texas Arts Plan as amended September 2004.

This section is adopted on an emergency basis to enable the Texas Commission on the Arts to get the word out to the arts field about our programs in a timely manner in anticipation of our upcoming annual grants deadline.

13 TAC §35.2

(Editor's note: The text of the following emergency adopted repeal will not be published. The section may be examined in the offices of the Texas Commission on the Arts or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is adopted on an emergency basis under the Government Code, §444.009, which provides the Texas Commission on the Arts with the authority to make rules and regulations for its government and that of its officers and committees.

§35.2. A Guide to Programs and Services.

This agency hereby certifies that the emergency adoption has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406491
Ricardo Hernandez
Executive Director
Texas Commission on the Arts
Effective Date: November 1, 2004
Expiration Date: February 27, 2005
For further information, please call: (512) 936-6564

♦ ♦ ♦

13 TAC §35.2

The new section is adopted on an emergency basis under the Government Code, §444.009, which provides the Texas Commission on the Arts with the authority to make rules and regulations for its government and that of its officers and committees.

§35.2. A Guide to Programs and Services.

The commission adopts by reference *A Guide to Programs and Services* (revised October 2004). This document is published by and available from the Texas Commission on the Arts, P.O. Box 13406, Austin, Texas 78711. This document is also available on line at www.arts.state.tx.us.

This agency hereby certifies that the emergency adoption has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406492
Ricardo Hernandez
Executive Director
Texas Commission on the Arts
Effective Date: November 1, 2004
Expiration Date: February 27, 2005
For further information, please call: (512) 936-6564

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PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

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

TITLE 13. CULTURAL RESOURCES

PART 3. TEXAS COMMISSION ON THE ARTS

CHAPTER 35. A GUIDE TO OPERATIONS, PROGRAMS AND SERVICES

The Texas Commission on the Arts proposes the repeal and replacement of §35.2, concerning A Guide to Programs and Services. Elsewhere in this issue of the *Texas Register*, the Texas Commission on the Arts contemporaneously adopts the repeal and replacement of §35.2 on an emergency basis.

The purpose of the repeal and replacement is to be consistent with changes to programs and services of the commission as outlined in the Texas Arts Plan as amended September 2004.

Mary Beck, Director of Finance and Administration, Texas Commission on the Arts, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing the section.

Ms. Beck also has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be the ability to utilize federal and state financial assistance funds in a more effective manner, thereby allowing more Texas organizations, communities, and citizens to participate in agency programs. There is no anticipated economic cost to persons who are required to comply with the section as proposed. There will be no effect to small or micro businesses.

Comments on the proposal may be submitted to Ricardo Hernandez, Texas Commission on the Arts, P.O. Box 13406, Austin, Texas 78711-3406. Comments will be accepted for 30 days after publication in the *Texas Register*.

13 TAC §35.2

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Commission on the Arts or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under the Government Code, §444.009, which provides the Texas Commission on the Arts with the authority to make rules and regulations for its government and that of its officers and committees.

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

§35.2. A Guide to Programs and Services.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406493
Ricardo Hernandez
Executive Director
Texas Commission on the Arts
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 936-6564

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13 TAC §35.2

The new section is proposed under the Government Code, §444.009, which provides the Texas Commission on the Arts with the authority to make rules and regulations for its government and that of its officers and committees.

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

§35.2. A Guide to Programs and Services.

The commission adopts by reference *A Guide to Programs and Services* (revised December 2004). This document is published by and available from the Texas Commission on the Arts, P.O. Box 13406, Austin, Texas 78711. This document is also available on line at www.arts.state.tx.us.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406494
Ricardo Hernandez
Executive Director
Texas Commission on the Arts
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 936-6564

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TITLE 22. EXAMINING BOARDS

PART 11. BOARD OF NURSE EXAMINERS

CHAPTER 214. VOCATIONAL NURSING EDUCATION

22 TAC §§214.1 - 214.13

The Board of Nurse Examiners proposes the adoption of new chapter 214, §§214.1 - 214.13, of 22 Texas Administrative Code, concerning Vocational Nursing Education. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. HB 1483 changed the Board's function of "accrediting" nursing education programs to "approving" nursing education programs. Concurrent with this proposed adoption is the proposed repeal of the existing chapter 233 (Education) which addresses vocational nursing education and the current chapter 215 (Nurse Education) which is applicable to professional nursing education. A new chapter 215 is simultaneously being proposed for adoption.

At the April 2004 Board meeting which was the first meeting of the board since the merger, the board instructed the Advisory Committee on Education (ACE) to review chapter 233 (Vocational Nursing) Education to determine how this rule would interface with the current chapter 215 (Professional) Nurse Education. ACE members include representatives from organizations and educational institutions representing both vocational and professional nursing education and practice and this committee is responsible for identifying, studying, and analyzing issues in the education and practice arenas that have impacted, or may potentially impact, the regulation of nursing education in Texas. The consolidation of the two boards created a need to promulgate rules applicable to vocational and professional nursing education programs.

ACE met on August 17, 2004, to formulate new rule language that addressed standards for vocational and professional nursing education. It reviewed the wording and intent of existing chapters 215 and 233 and determined that nursing education programs would be best served by having a separate rule, as occurred with the development of chapter 219, Advanced Practice Nurse (APN) Education. The members drafted language for the new chapters 214 and 215 and used the best wording from the existing chapters 233 and 215, but tried to maintain the essential integrity of the present chapters.

The language in the proposed chapter 214 addresses educational standards specific to vocational nursing education. The proposed new rule has been reorganized to clearly reflect regulation of the same thirteen (13) critical sections of nursing education as currently outlined in chapters 215 and 219. Consistency in rule language has been improved. Major revisions will provide positive changes for vocational nursing education. A petition process for Director and faculty has been added which will mirror the existing process found in chapter 215. The required NCLEX-PN pass rate has been increased to 80% from the current 75%. This will be consistent with the required NCLEX-RN pass rate for professional nursing programs. The student/faculty ratio in the clinical area has been reduced to 10:1 which is consistent with requirements in chapter 215 from the current 12:1 ratio. This proposed change is the result of increased patient acuity levels. The requirement for faculty to obtain 30 hours of continuing education every two years was deleted. Faculty will now only be required to meet the current licensure requirement for 20 hours of continuing education every two years. "Full approval with Warning" was added to the current two types of approval status, "full" and "conditional," to provide consistency with the language and requirements in chapter 215.

Katherine Thomas, executive director, has determined that for the first five-year period the proposed rules are adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Katherine Thomas, executive director, has determined that for each year of the first five years the proposed rules are adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the registered nurse is a safe practitioner. The proposed rules will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative options, such as adding the use of preceptors should prevent any adverse effects such as a decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed adoption.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed adoption of this chapter is pursuant to the authority of Texas Occupations Code §§301.151 and 301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act. The adoption of the proposed chapter will not affect any existing statute.

§214.1. General Requirements.

(a) The Director or Coordinator and faculty are accountable for complying with the Board's rules and regulations and the Nursing Practice Act.

(b) Rules for vocational nursing education programs shall provide reasonable and uniform standards based upon sound educational principles that allow the opportunity for flexibility and creativity.

§214.2. Definitions.

Words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

(1) Affidavit of Graduation--an official Board form containing an approved nursing education program's curriculum components and hours, a statement attesting to an applicant's qualifications for vocational nurse licensure in Texas, the official school seal and the signature of the nursing program director/coordinator.

(2) Affiliating Agency or Clinical Facility--a health care facility or agency which provides learning experiences for students.

(3) Annual Report--a document required by the Board to be submitted at a specified time by the nursing education program director or coordinator. This document serves as verification of the program's adherence to Chapter 214, Vocational Nursing Education.

(4) Approved vocational nursing education program--a vocational nursing education program approved by the Board of Nurse Examiners for the State of Texas.

(5) Assistant Program Coordinator--a registered nurse faculty member in the vocational nursing education program who is designated to assist with program management when the director or coordinator assumes responsibilities other than the program.

(6) Board--the Board of Nurse Examiners for the State of Texas composed of members appointed by the Governor for the State of Texas.

(7) Class Hours--those hours allocated to didactic instruction and testing in each subject.

(8) Clinical Conferences--scheduled presentations and discussions of aspects of client care experiences.

(9) Clinical Learning Experiences--faculty-planned and guided learning activities designed to assist students to meet stated program and course outcomes and to safely apply knowledge and skills when providing nursing care to clients across the life span as appropriate to the role expectations of the graduates. These experiences occur in nursing skills and computer laboratories; in simulated clinical settings; in a variety of affiliating agencies or clinical practice settings including, but not limited to: acute care facilities, extended care facilities, clients' residences, and community agencies; and in associated clinical conferences.

(10) Clinical Practice Hours--hours spent in actual client care assignments, simulated laboratory experiences, observations, clinical conferences and clinical instruction.

(11) Clinical Preceptor--a licensed nurse who meets the minimum requirements in §214.10(l)(5) of this chapter (related to Management of Clinical Learning Experiences and Resources), not paid as a faculty member by the controlling agency, and who directly supervises clinical learning experiences for no more than two students. A clinical preceptor facilitates student learning in a manner prescribed by a signed written agreement between the educational institution, preceptor, and affiliating agency (as applicable).

(12) Conceptual Framework--theories or concepts giving structure to the curriculum and enabling faculty to make consistent decisions about all aspects of curriculum development, implementation, and evaluation.

(13) Concurrent Theory and Skills Laboratory Experiences--planned experiences which coincide or operate at the same time to provide a common effect.

(14) Controlling Agency--institution that has direct authority and administrative responsibility for the operation of a board approved nursing education program.

(15) Correlated Theory and Clinical Practice--didactic and clinical experiences which have a reciprocal relationship or mutually complement each other.

(16) Course--organized subject content and related activities, which may include didactic, laboratory and/or clinical experiences, planned to achieve specific objectives within a given time period.

(17) Curriculum--course offerings which, in aggregate, make up the total learning activities in a program of study.

(18) Differentiated Entry Level Competencies--the expected educational outcomes to be demonstrated by nursing students at the time of graduation as published in *Differentiated Entry Level Competencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*.

(19) Director or Coordinator--denotes the nurse directly in charge chosen by the controlling agency, approved by the Board, and who is administratively responsible for the nursing education program.

(20) Examination Year--the period beginning January 1 and ending December 31 used for the purposes of determining programs' NCLEX-PN examination pass rates.

(21) Faculty member--an individual employed to teach in the vocational nursing education program who meets the requirements as stated in §214.7 of this chapter (relating to Faculty Qualifications and Faculty Organization).

(22) Faculty waiver--a waiver granted by the Board to an individual who is currently licensed as an LVN or RN, or has a privilege to practice, as appropriate, in Texas and who is approved to be employed as a faculty member for a specified period of time.

(23) Lead Instructor--a licensed nurse approved by the Board who has the delegated administrative authority for the program.

(24) Mobility--the ability to advance without educational barriers.

(25) Non-Nursing Faculty--instructors who teach non-nursing theory courses such as pharmacology, nutrition, and anatomy and physiology and who have educational preparation appropriate to the assigned teaching responsibilities.

(26) Objectives/Outcomes--clear statements of expected behaviors that are attainable and measurable.

(A) Program Objectives/Outcomes--broad statements used to direct overall student learning toward the achievement of expected program outcomes.

(B) Clinical Objectives/Outcomes--statements describing expected student behaviors throughout the curriculum and which represent progression of students' cognitive, affective and psychomotor achievement in clinical practice across the curriculum.

(C) Course Objectives/Outcomes--statements describing expected behavioral changes in the learner upon successful completion of specific curriculum content and which serve as the mechanism for evaluation of student progression.

(27) Observational experience--an assignment to a facility or unit where students observe activities within the facility and/or the role of nursing within the facility, but where students do not participate in patient/client care.

(28) Pass rate--the percentage of first-time candidates within one examination year who pass the National Council Licensure Examination for Vocational Nurses (NCLEX-PN).

(29) Philosophy/Mission--statement of concepts expressing fundamental values and beliefs regarding human nature as they apply to nursing education and practice and upon which the curriculum is based.

(30) Program of Study--the courses and learning experiences that constitute the requirements for completion of a vocational nursing education program.

(31) Proprietary Schools--educational entities defined by Texas Workforce Commission as "career schools and colleges."

(32) Recommendation--a suggestion based upon program assessment indirectly related to the rules to which the program must respond but in a method of their choosing.

(33) Requirement--mandatory criterion based on program assessment directly related to the rule that must be addressed in the manner prescribed.

(34) Shall--denotes mandatory requirements.

(35) Staff--Employees of the Board of Nurse Examiners.

(36) Supervision--immediate availability of a faculty member or clinical preceptor to coordinate, direct, and observe first hand the practice of students.

(37) Survey Visit--an on-site visit to a vocational nursing education program by a Board representative. The purpose of the visit is to evaluate the program of learning by gathering data to determine whether the program is meeting the Board's requirements as specified in §§214.2 - 214.13 of this chapter.

(38) Systematic Approach--the organized process in nursing which provides individualized, goal-directed nursing care which includes the vocational nurse's role in participating in data collection, assessment activities, planning and implementing client care, and evaluating the client's responses to nursing interventions and identification of client needs.

(39) Vocational Nursing Education Program--a unit or entity within an educational setting which provides a program of study preparing graduates who are competent to practice safely and who are eligible to take the NCLEX-PN examination. Types of programs:

(A) Extension program--a site other than the program's main location where the program of study is provided, duplicating the current curriculum and teaching resources.

(B) MEEP--Multiple Entry Exit Program that offers mobility options for students.

(C) New program--a newly created program of study in which the curriculum, teaching resources, or length of time required to complete the program differs from that of the main location.

§214.3. Program Development, Expansion, and Closure.

(a) New programs.

(1) Proposal to establish a new vocational nursing education program.

(A) An educational unit in nursing within the structure of a school, including a college, university, or proprietary school (career school or college), or a hospital is eligible to submit a proposal to establish a vocational nursing education program. Specialized institutions such as nursing homes, tuberculosis hospitals, and others do not qualify as controlling agencies, but may participate with a program as an affiliating health care facility. The process to establish a new vocational nursing education program shall be initiated with the Board office one year prior to the anticipated start of the program.

(B) The proposal shall be completed under the direction/consultation of a registered nurse who meets the Board-approved qualifications for a program director according to §214.6.

(C) Sufficient nursing faculty, with appropriate expertise, shall be in place for development of the curriculum component of the program.

(D) The proposal shall include information outlined in Board guidelines.

(E) After the proposal is submitted and reviewed, a preliminary survey visit shall be conducted by Board staff prior to presentation to the Board.

(F) The proposal shall be considered by the Board following a public hearing at a regularly scheduled meeting of the Board. The Board may approve the proposal and grant initial approval to the new program, may defer action on the proposal, or may deny further consideration of the proposal.

(G) The program shall not admit students until the Board approves the proposal and grants initial approval.

(H) Prior to presentation of the proposal to the Board, evidence of approval from the appropriate regulatory/funding agencies shall be provided.

(I) After the proposal is approved, an initial approval fee shall be assessed per §223.1 (related to Fees).

(J) A proposal without action for one calendar year shall be inactivated.

(2) Survey visits shall be conducted, as necessary, by staff until full approval status is granted.

(b) Extension Program.

(1) Only vocational nursing education programs which have full approval status are eligible to initiate an extension program.

(2) An approved vocational nursing education program desiring to begin an extension program which duplicates current curriculum and teaching resources shall:

(A) Notify the Board office at least four (4) months prior to implementation of the extension program;

(B) Submit required information according to Board guidelines; and

(C) Provide documentation of notification or approval from the controlling agency and other regulatory/funding agencies, as appropriate, at least four (4) months prior to implementation.

(3) When the extension program deviates from the original program in any way, the proposed extension is viewed as a new program and Board guidelines for a new program apply.

(4) Extension programs of vocational nursing education programs which have been closed may be reactivated by submitting notification of reactivation to the Board at least four (4) months prior to reactivation, using the Board guidelines for initiating an extension program.

(5) A program intending to close an extension program shall:

(A) Notify the Board office at least four (4) months prior to closure of the extension program.

(B) Submit required information according to Board-approved guidelines including:

(i) reason for closing the program;

(ii) date of intended closure;

(iii) academic provisions for students; and

(iv) provisions made for access to and storage of vital school records.

(c) Transfer of Controlling Agency. The authorities of the controlling agency shall notify the Board office in writing of an intent to transfer the administrative authority of the program. This notification shall follow Board guidelines.

(d) Closure of a Program. A program shall notify the Board office in writing of their intent to close the program. The controlling agency shall be responsible for graduating enrolled students or ensuring the satisfactory transfer of those students into another program. The controlling agency shall provide for permanent storage of student records. A program is deemed closed when the program has not enrolled students for a period of two years since the last graduating class or student enrollment has not occurred for a two-year period. Board-ordered enrollment suspensions may be an exception.

§214.4. Approval.

(a) The progressive designation of approval status is not implied by the order of the following listing. Approval status is based upon each program's performance and demonstrated compliance to the Board's requirements and response to the Board's recommendations. Change from one status to another is based on NCLEX-PN examination pass rates, annual reports, survey visits, and other factors listed under §214.4(b). Types of approval include:

(1) Initial Approval - Initial approval is written authorization by the Board for a new program to admit students and is granted if the program meets the requirements and addresses the recommendations issued by the Board. Initial approval begins with the date of the first student enrollment. The program shall not enroll more than one class per year while on initial approval. Change from initial approval status to full approval status cannot occur until the licensing examination result of the first graduating class is evaluated by the Board.

(2) Full Approval.

(A) Full Approval is granted by the Board to a vocational nursing education program that is in compliance with all requirements and has responded to all recommendations.

(B) Full Approval with Warning is issued by the Board to a vocational nursing education program that is not meeting legal and educational requirements. The program issued a warning is provided a list of the deficiencies and is given a specified time in which to correct the deficiencies.

(3) Conditional Approval - Conditional approval is issued by the Board for a specified time to provide the program opportunity to correct deficiencies.

(A) The program shall not admit students while on conditional status.

(B) The Board may establish specific criteria to be met in order for the program's conditional approval status to be changed.

(C) Depending upon the degree to which the Board's legal and educational requirements are met, the Board may change the approval status to full approval or full approval with warning, or may withdraw approval.

(4) Withdrawal of Approval - The Board may withdraw approval from a program which fails to meet legal and educational requirements within the specified time. The program shall be removed from the list of Board approved vocational nursing education programs.

(b) Factors Jeopardizing Program Approval Status - Approval may be changed or withdrawn for any of the following reasons:

(1) deficiencies in compliance with the rule;

(2) utilization of students to meet staffing needs in health care facilities;

(3) noncompliance with school's stated philosophy/mission, program design, objectives/outcomes, and/or policies;

(4) continual failure to submit records and reports to the Board office within designated time frames;

(5) failure to provide sufficient variety and number of clinical learning opportunities for students to achieve stated objectives/outcomes;

(6) failure to comply with Board requirements and to respond to Board recommendations within the specified time;

(7) student enrollments without sufficient faculty, facilities and/or patient census;

(8) failure to maintain a 80% passing rate on the licensing examination by first-time candidates;

(9) failure of program director to document annually the currency of faculty licenses; or

(10) other activities or situations that demonstrate to the Board that a program is not meeting legal requirements and standards.

(c) Approval procedures. Approval status is determined annually by the Board on the basis of the program's annual report, NCLEX-PN examination pass rate, and other pertinent data.

(1) Review of annual report. Each approved vocational nursing education program shall submit an annual report regarding its compliance with the Board's legal and educational requirements.

(2) Pass rate of graduates on NCLEX-PN examination.

(A) Eighty percent (80%) of first-time candidates who complete the program of study are required to achieve a passing score on the NCLEX-PN examination.

(B) When the passing score of first-time candidates who complete the vocational nursing education program is less than 80% on the NCLEX-PN examination during the examination year, the nursing program shall submit a self-study report that evaluates factors which contributed to the graduates' performance on the NCLEX-PN examination and a description of the corrective measures to be implemented. The report shall follow Board guidelines.

(C) A warning shall be issued to the program when the pass rate of first-time candidates, as described in subsection (c)(2)(A) of this section, is less than 80% for two consecutive examination years.

(D) A program shall be placed on conditional approval status if, within one examination year from the date the warning is issued, the performance of first-time candidates fails to be at least 80% on the NCLEX-PN examination, or the faculty fail to implement appropriate corrective measures.

(E) Approval status may be withdrawn if the performance of first-time candidates fails to be at least 80% during the examination year following the date that the program was placed on conditional approval.

(F) A program issued a warning or placed on conditional approval status may request a review of the program's approval status by the Board at a regularly scheduled meeting if the program's pass rate for first-time candidates during one examination year is at least 80%.

(d) Survey visit. Each vocational nursing education program shall be visited at least every six years after full approval has been granted, unless accredited by a Board-recognized voluntary accrediting body.

(1) The Board may authorize staff to conduct a survey visit at any time based upon established criteria.

(2) After a program is fully approved by the Board, a report from a Board-recognized voluntary accrediting body regarding a program's accreditation status may be accepted in lieu of a Board survey visit.

(3) A written report of the survey visit, annual report, and NCLEX-PN examination pass rate shall be reviewed by the Board at a regularly scheduled meeting.

(e) Notice of a program's approval status shall be sent to the director, chief administrative officer of the controlling agency, and others as determined by the Board.

§214.5. Philosophy/Mission and Objectives/Outcomes.

(a) The philosophy/mission and objectives/outcomes of the vocational nursing education program shall be consistent with the philosophy/mission of the controlling agency. They shall reflect the diversity of the community served and shall be consistent with professional, educational, and ethical standards of nursing.

(b) Program objectives/outcomes derived from the philosophy/mission shall reflect the *Differentiated Entry Level Competencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*.

(c) Clinical objectives/outcomes shall be stated in behavioral terms and shall serve as a mechanism for evaluating student progression.

(d) The conceptual framework shall provide the organization of major concepts from the philosophy/mission of the program that provides the underlying structure or theme of the curriculum and facilitates the achievement of program objectives/outcomes.

(e) The faculty shall periodically review the philosophy/mission and objectives/outcomes and shall make appropriate revisions to maintain currency.

§214.6. Administration and Organization.

(a) The controlling agency shall be licensed or accredited by a Board-recognized agency.

(b) There shall be an organizational chart indicating lines of authority between the vocational nursing education program and the controlling agency.

(c) The program shall have comparable status with other educational units within the institution (controlling agency).

(d) The controlling agency shall:

(1) be responsible for satisfactory operation of the vocational nursing program;

(2) meet rules and regulations as stated in this chapter;

(3) provide the number of faculty necessary to meet minimum standards set by the Board and to insure a sound educational program;

(4) provide for suitable classroom and clinical facilities;

(5) provide secretarial assistance;

(6) provide sufficient funds for operation and maintenance of the program to meet requirements set by the Board; and

(7) select and appoint a qualified registered nurse director or coordinator for the program who meets the requirements of the Board. The director shall:

(A) hold a current license or privilege to practice as a registered nurse in the state of Texas;

(B) have been actively employed in nursing for the past five years, preferably in supervision or teaching. If the director has not been actively employed in nursing for the past five years, the director's advanced preparation in nursing, nursing education, and nursing administration and prior relevant nursing employment may be taken into consideration by the Board staff in evaluating qualifications for the position;

(C) have a degree or equivalent experience that will demonstrate competency and advanced preparation in nursing, education, and administration; and

(D) have had five years of varied nursing experience since graduation from a professional nursing education program.

(e) When the director or coordinator of the program changes, the director or coordinator shall submit to the Board office written notification of the change indicating the final date of employment. The controlling agency shall ensure that:

(1) a new director or coordinator qualification form is submitted to the Board office for approval prior to being hired at an existing program or a new program;

(2) the director may have responsibilities other than the program provided that an assistant program coordinator/lead instructor is designated to assist with the program management;

(3) a director with responsibilities other than the program shall not have major teaching responsibilities; and

(4) written job descriptions exist which clearly delineate responsibilities of the director, coordinator and lead instructor, as appropriate.

(f) In a fully approved vocational nursing education program, if the individual to be appointed as director or coordinator does not meet the requirements for director or coordinator as specified in subsection (d)(7) of this section, the administration is permitted to petition for a waiver of the Board's requirements, according to Board guidelines, prior to the appointment of said individual.

(g) A newly appointed director or coordinator of a vocational nursing education program shall attend the next scheduled orientation provided by the Board staff.

(h) The director or coordinator shall have the authority to direct the program in all its phases, including approval of teaching staff, selection of appropriate clinical sites, admission, progression, probation, and dismissal of students. Additional responsibilities include but are not limited to:

(1) providing evidence of faculty expertise and knowledge to teach curriculum content;

(2) acting as agent of the Board and issuing temporary permits to eligible graduates, upon completion of the program;

(3) verifying student's completion of program requirements on the Affidavit of Graduation; and

(4) completing and submitting the Annual Report to the Board office by the required date.

§214.7. Faculty Qualifications and Faculty Organization.

(a) There shall be written personnel policies for nursing faculty that are in keeping with accepted educational standards and are consistent with the policies of the controlling agency. Faculty policies shall include, but not be limited to: qualifications, responsibilities, performance evaluation criteria, and terms of employment.

(1) Policies concerning workload for faculty and the director or coordinator shall be in writing.

(2) There shall be written plans for faculty orientation, development and evaluation.

(3) There shall be orientation of new faculty members at the onset of employment.

(4) A variety of means shall be used to evaluate faculty performance such as self, student, peer and administrative evaluation.

(b) Minimum Teaching Personnel - There shall be a minimum of one full-time nursing instructor for the program. A director/coordinator without major teaching or clinical responsibilities shall not be considered a full-time instructor. Use of part-time instructors is permissible.

(c) Faculty Qualifications and Responsibilities.

(1) Documentation of faculty qualifications shall be included in the official files of the program. Each faculty member shall:

(A) hold a current license or privilege to practice nursing in the State of Texas;

(B) have been actively employed in nursing for the past three years. If the instructor has not been actively employed in nursing for the past three years, the instructor's advanced preparation in nursing, nursing education, and nursing administration, and prior relevant nursing employment may be taken into consideration in evaluating qualifications for the position; and

(C) have had three years varied nursing experiences since graduation.

(2) In fully approved programs, if an individual to be appointed as faculty member does not meet the requirements for faculty as specified in subsection (c) of this section, the director or coordinator is permitted to petition for a waiver of the Board's requirements, according to Board guidelines, prior to the appointment of said individual.

(3) Faculty shall be responsible for:

(A) supervision of students in clinical learning experiences;

(B) all initial nursing procedures in the clinical area and ascertain that the student is competent before allowing the student to perform an actual nursing procedure independently;

(C) developing, implementing, and evaluating curriculum; and

(D) participating in the development of standards for admission, progression, probation, dismissal of students, and participation in academic guidance and counseling.

(4) Non-nursing faculty are exempt from meeting the faculty qualifications as long as the teaching assignments are not nursing didactic or clinical courses.

(5) Clinical preceptors shall be responsible for providing clinical instruction and/or supervision when a program faculty member is unavailable in clinical sites. The clinical preceptor shall meet the requirements of Rule 214.10(k)(1).

(6) Substitute faculty may be employed to meet emergent program needs. Substitute faculty beyond ten consecutive working days and/or on an interim basis shall meet qualifications as specified in Rule 214.7(c)(1).

(7) Part-time faculty may participate in all aspects of the program. Clear lines of communication of program policies, objectives and evaluative criteria shall be included in policies for part-time faculty.

(8) Military faculty - Federal laws and regulations regarding licensure of military nursing personnel shall apply to Texas based military faculty members functioning within vocational nursing programs.

(d) The faculty shall meet regularly and function in such a manner that all members participate in planning, implementing and evaluating the nursing program. Such participation includes, but is not limited to the initiation and/or change in program policies, personnel policies, curriculum, utilization of affiliating agencies, and program evaluation. Minutes of faculty organization and meetings shall document the reasons for actions and the decisions of the faculty and shall be available for reference.

§214.8. Students.

(a) The program shall have well defined student policies based upon statutory and Board requirements.

(b) Individuals enrolled in approved vocational nursing education programs preparing students for licensure shall be provided verbal and written information regarding conditions that may disqualify graduates from licensure and of their rights to petition the Board for a Declaratory Order of Eligibility. Required eligibility information includes:

(1) Texas Occupations Code §§301.252, 301.257, and 301.452-.469; and

(2) Sections §§213.27 - 213.30 of the Texas Administration Code (relating to Good Professional Character, Licensure of Persons with Criminal Convictions, Criteria and Procedure Regarding Intemperate Use and Lack of Fitness in Eligibility and Disciplinary Matters, and Declaratory Order of Eligibility for Licensure).

(c) Admission requirements shall be stated in the student policies. Programs shall set reasonable educational requirements for admission. Applicants shall present evidence of being able to meet objectives/outcomes of the program. All students shall be pretested. Tests shall measure reading comprehension and mathematical ability.

(d) Reasons for dismissal shall be stated in student policies.

(e) Copies of the student policies shall be furnished to all students at the beginning of the school year. The school shall maintain a signed receipt of student policies in all students' records. It is the school's responsibility to define and enforce student policies.

(f) The number of students admitted to the program shall be determined by the number of qualified faculty, adequate educational facilities and resources, and the availability of appropriate clinical learning experiences for students. Programs shall not accept admissions after the third day of class.

(g) Students shall be allocated at least 18 days leave for vacation and/or holidays. All scheduled holidays are to be observed on the holidays designated by the controlling agency. Vacation time shall be scheduled at the same time for all students.

(h) Students shall meet the requirements of Rule 214.9(e) related to Program of Study to be eligible for graduation from an approved vocational nursing education program.

(i) Acceptance of transfer students and evaluation of allowable credit for advanced placement remains at the discretion of the coordinator or director of the program and the controlling agency. Upon completing the program's requirements, the individual is considered to be a graduate of the school.

(j) Records of student conferences shall be kept and made available to the student involved and all faculty members. Students shall be provided written documentation of all conferences.

(k) Students shall have the opportunity to evaluate faculty, courses, and learning resources and these evaluations shall be documented.

§214.9. Program of Study.

(a) The program of study shall be:

(1) a minimum of 1,398 clock hours: 558 hours for classroom instruction and 840 hours for clinical practice. Class hours shall include actual hours of classroom instruction in nursing and non-nursing Board-required courses/content. Clinical practice shall include actual hours of practice in clinical areas, clinical conferences, and/or simulated lab experiences;

(2) scheduled with the placement of courses or course content throughout the entire length of the program;

(3) organized by subject and content to meet the needs of the program;

(4) based on the philosophy/mission and objectives/outcomes;

(5) based on sound educational principles;

(6) designed to prepare graduates to practice according to The Nursing Practice Act, Standards of Nursing Practice, Unprofessional Conduct Rules, and other laws and regulations which pertain to various practice settings;

(7) designed and implemented to prepare students to demonstrate the *Differentiated Entry Level Competencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*; and

(8) designed to teach students to use a systematic approach to clinical decision making.

(b) The faculty shall be responsible for the development, implementation and evaluation of the curriculum based upon the following guidelines:

(1) Framework. The philosophy/mission shall be the basis for curriculum development and shall reflect the purpose of the organization, faculty beliefs, and education concepts. Clinical learning objectives/outcomes derived from the philosophy/mission shall be representative of the *Differentiated Entry Level Compentencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002* for preparation of a vocational nurse graduate. Clinical and course objectives/outcomes shall be stated in behavioral terms and shall serve as the mechanism for student progression. The conceptual framework shall define the internal and external influences impacting vocational nursing education and shall identify the educational method and focus.

(2) Design and Implementation. The curriculum shall be designed and implemented to prepare students to demonstrate the *Differentiated Entry Level Compentencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*. The curriculum design shall allow for flexibility to incorporate current nursing education theories and the implications of current developments in health care and health care delivery to assist graduates in meeting professional, legal, and societal expectations. Educational mobility shall also be a consideration in curriculum design.

(3) Specific Provisions. Instruction shall be provided in biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, and nutrition; signs of emotional health; and human growth and development. Vocational adjustments and nursing skills shall also be included. Courses may be integrated or separate. The selection and organization of the learning experiences in the curriculum shall provide continuity, sequence, and integration of learning. Didactic and skills laboratory experiences shall be concurrent. Correlated didactic and clinical practice shall be provided in the following areas, but not necessarily in separate courses:

(A) Nursing Care of Children. Experiences shall include care of children and meeting their needs in a variety of age groups in both the acute and non-acute care setting. Day care and clinic settings may be utilized as supplementary experience. Common health deviations, physical, psychological, and neurological handicaps, and nutritional needs shall be emphasized. Students shall have opportunities to develop understanding of normal growth and development and the influences of the family, home, church, school, and community. Student practice in caring for and understanding the needs of newborn infants shall also be included.

(B) Maternity Nursing. Opportunities shall be provided for students to gain an understanding of the psychological and physiological aspects of pregnancy, labor, and puerperium. Assisting mothers in the care of their infants shall be emphasized. A variety of settings, including clinics, organized maternity units, and maternity cases in non-segregated units, may be utilized for provision of maternity nursing experience.

(C) Nursing Care of the Aged. Opportunities shall be included for the care of individuals experiencing specific changes related to the aging process. Students shall develop an understanding of the physical and mental changes associated with aging and the implications of aging in planning nursing care.

(D) Nursing Care of Adults. Opportunities shall be provided to the student through the use of various resources to care for adults who have health deviations. Resources used shall include learning experiences to illustrate the individual as a member of the family, the responsibilities and functions of the community in the provision of nursing care, and the types of agencies where nursing is practiced. Preventive, therapeutic, and rehabilitative aspects shall be provided. Experiences shall also include the physical, psychological, and spiritual components of health and disease. Experience shall include, but not be limited to, the acute care settings.

(E) Nursing Care of Individuals With Mental Health Problems. Learning opportunities shall include an understanding of personality development, human needs, common mental mechanisms, and factors influencing mental health and mental illness. Common mental disorders and related therapy shall be included. Clinical experience in a unit or facility specifically designed for psychiatric care is optional.

(c) Classroom instruction shall include organized student/faculty interactive learning activities, formal lecture, audiovisual presentations, and simulated laboratory instruction.

(d) The curriculum plan, including course outlines, shall be kept current and available to faculty and Board representatives.

(e) A system of grading shall be in place which does not allow grades of less than a "C" on any subject area required for licensure eligibility listed in this chapter.

(f) Major revisions to the curriculum must be submitted to the Board office following Board guidelines for review and approval prior to implementation. Major revisions include:

(1) changes in philosophy/mission;

(2) revisions in program hours; and

(3) addition/reduction of courses in the program of study.

(g) All programs implementing a curriculum change shall provide an evaluation of the outcomes of these changes and submit them with the Annual Report through the first graduating class.

(h) There shall be provision for continuous development, implementation, and evaluation of the curriculum.

(i) Programs may allow individuals to challenge the vocational nursing education curriculum, and shall develop and define such policies to meet theory and practice requirements for challenging credit.

(j) Adaptation to the calendar in the college catalog is permissible.

(k) Programs shall apprise the Board office of any program changes.(Proposed amendment to Board to delete.)

§214.10. Management of Clinical Learning Experiences and Resources.

(a) Faculty shall be responsible for student clinical practice evaluations. Clinical practice evaluations shall be correlated with level and/or course objectives including formative and summative evaluation. Students shall receive a minimum of three clinical evaluations during the program year.

(b) Clinical practice shall include actual hours of practice in clinical areas, clinical conferences, and/or simulated lab experiences.

(c) Clinical experiences shall include the administration of medications, health promotion and preventive aspects, nursing care of persons throughout the life span with acute and chronic illnesses, and rehabilitative care. Students shall participate in instructor supervised patient teaching. Students shall also be provided opportunities for participation in clinical conferences. The focus of clinical conferences shall be student experiences in the clinical setting. Simulated laboratory experiences may also be utilized as a teaching strategy in classroom and clinical settings to meet objectives.

(d) Scheduling of student time and clinical rotations shall be made by the program faculty. Selected clinical learning experiences will remain unchanged unless a client's condition demands reassignment. Reassignment must be approved with prior consent of faculty.

(e) The student's daily client assignment shall be made in accordance with clinical objectives/outcomes and learning needs of the students. The total number of daily assignments shall not exceed five clients.

(f) Consideration of selection of a clinical site shall include:

(1) client census in sufficient numbers to meet the clinical objectives/outcomes of the program; and

(2) evidence of collaborative arrangements in those facilities, which support multiple nursing programs.

(g) There shall be a written affiliation agreement between the controlling agency and the affiliating agency before the affiliation begins. The agreement shall outline the responsibilities of each agency entering the agreement. The agreement shall contain a withdrawal of participation clause indicating a minimum period of time to be given for notice of such withdrawal.

(h) Affiliation agreements are optional for those clinical experiences which are observation only.

(i) The affiliating agency shall:

(1) provide clinical facilities for student experiences;

(2) provide space for conducting clinical conferences for use by the school if classrooms are located elsewhere;

(3) provide assistance with clinical supervision of students, including preceptorships, by mutual agreement between the affiliating agency and controlling agency; and

(4) have no authority to dismiss faculty or students. Should the affiliating agency wish to recommend dismissal of faculty or students, such recommendation(s) shall be in writing.

(j) The faculty member shall be responsible for the supervision of students in clinical learning experiences.

(1) When a faculty member is the only person officially responsible for a clinical group, then the group shall total no more than ten (10) students. Patient safety shall be a priority and may mandate lower ratios, as appropriate. The faculty member shall supervise that group in only one facility at a time, unless some portion or all of the clinical group are assigned to observational experiences in additional settings.

(2) Direct faculty supervision is not required for an observational experience. Observational experiences may be used to supplement, but not replace patient care experiences, and must serve the purpose of student attainment of clinical objectives.

(k) Faculty may use clinical preceptors to enhance clinical learning experiences and to assist faculty in the clinical supervision of students.

(1) Faculty shall develop written criteria for the selection of clinical preceptors.

(2) When clinical preceptors are used, written agreements between the vocational nursing education program, clinical preceptor, and the affiliating agency, when applicable, shall delineate the functions and responsibilities of the parties involved.

(3) Faculty shall be readily available to students and clinical preceptors during clinical learning experiences.

(4) The designated faculty member shall meet periodically with the clinical preceptors and student(s) for the purpose of monitoring and evaluating learning experiences.

(5) Written clinical objectives, evaluation criteria, and written description of expectations shall be shared with the clinical preceptors prior to or concurrent with the experience.

(l) Clinical preceptors may be used to enhance clinical learning experiences after a student has received clinical and didactic instruction in all basic areas of nursing or within a course after a student has received clinical and didactic instruction in the basic areas of nursing for that course or specific learning experience.

(1) In courses which use clinical preceptors for a portion of clinical learning experiences, faculty shall have no more than 12 students in a clinical group.

(2) In a course which uses clinical preceptors as the sole method of student instruction and supervision in clinical settings, faculty shall coordinate the preceptorship for no more than 24 students.

(3) The preceptor may supervise student clinical learning experiences without the physical presence of the faculty member in the affiliating agency or clinical practice setting.

(4) The preceptor shall be responsible for the clinical learning experiences of no more than two students per clinical day.

(5) The preceptor shall be accountable for evaluating the student using clinical objectives developed by vocational nursing faculty.

(6) Clinical preceptors shall have the following qualifications:

(A) competence in designated areas of practice;

(B) philosophy of health care congruent with that of the nursing program; and

(C) current licensure or privilege to practice nursing in the State of Texas.

(m) The total weekly schedule throughout the length of the program shall not exceed 40 hours per week including both class and clinical practice hours. Class and clinical practice hours shall be continuous. Students shall be assigned two consecutive non-class days off each week.

(n) Programs shall not permit utilization of students for health care facility staffing.

§214.11. Facilities, Resources, and Services.

(a) Classrooms and nursing skills laboratory facilities shall be provided to accommodate the learning needs of the students.

(b) An appropriately equipped skills laboratory shall be provided to accommodate maximum number of students allowed for the program. The laboratory shall be equipped with hot and cold running water. The laboratory shall have cabinets for storage of equipment.

(c) The director or coordinator and faculty shall have office space provided, other than the classroom. There shall be privacy for counseling of students.

(d) The learning resources, library, and departmental holdings shall be current, use contemporary technology appropriate for the level of the curriculum, and be sufficient for the size of the student body and the needs of the faculty.

(1) Provisions shall be made for accessibility, availability, and timely delivery of information resources.

(2) Facilities and policies shall promote effective use, i.e. environment, accessibility, and hours of operation.

(e) Teaching aids shall be provided to meet the objectives of the program.

(f) Adequate restrooms and lounges shall be provided convenient to the classroom.

§214.12. Records and Reports.

(a) Student Forms - Student records shall be maintained on all students and shall be accessible to all faculty members and to Board representatives. Record forms may be developed by an individual school. Hospital employment forms are not to be used for student records.

(b) Required Student Forms - The required student forms are the student application, evidence of student's ability to meet objectives/outcomes of the program, clinical practice evaluation, transcript, signed receipt of written student policies, evidence of student receipt of eligibility information, and statement of withdrawal.

(c) Record Storage - Records shall be safely stored to prevent loss, destruction, or unauthorized use. Records of all graduates must be completed prior to permanent storage. Records on students who withdraw from the program shall be completed up to the date of withdrawal.

(d) Retention of Student Records - All records shall be maintained for two years. At minimum, a transcript shall be retained as a permanent record on all students.

(e) Copies of the program's Annual Reports and important Board communication shall be maintained as appropriate.

§214.13. Total Program Evaluation.

(a) There shall be a written plan for the systematic evaluation of the total program. The plan shall include evaluative criteria, methodology, frequency of evaluation, assignment of responsibility, and indicators (benchmarks) of program and instructional effectiveness. The following broad areas shall be periodically evaluated:

(1) organization and administration of the program;

(2) philosophy/mission and objectives/outcomes;

(3) program of study, curriculum, and instructional techniques;

(4) educational facilities, resources, and services;

(5) affiliating agencies and clinical learning activities;

(6) students' achievement;

(7) graduates' performance on the licensing examination;

(8) graduates' nursing competence;

(9) faculty members' performance; and

(10) extension programs.

(b) All evaluation methods and instruments shall be periodically reviewed for appropriateness.

(c) Implementation of the plan for total program evaluation shall be documented in the minutes.

(d) Major changes in the nursing education program shall be evidence-based and supported by rationale.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 26, 2004.

TRD-200406419
Katherine Thomas
Executive Director
Board of Nurse Examiners
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 305-6823

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CHAPTER 215. NURSE EDUCATION

22 TAC §§215.1 - 215.13

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code chapter 215 concerning Nurse Education, §§215.1 - 215.13. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative

Session, was the legislative action that implemented the consolidation. Concurrent with this proposed repeal is the proposal of a new chapter 215 (Professional Nursing Education) and chapter 214 (Vocational Nursing Education). This repeal is for the purpose of preventing conflicting rules and providing consistency in the education rules applicable to all nurses.

Katherine Thomas, executive director, has determined that for the first five-year period the proposed repeals are adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Katherine Thomas, executive director, has determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the registered nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of this chapter is pursuant to the authority of Texas Occupations Code §§301.151 and 301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act. The adoption of the proposed repeal will not affect any existing statute.

§215.1. General Requirements and Purpose of Standards.
§215.2. Definitions.
§215.3. Program Development, Expansion and Closure.
§215.4. Accreditation.
§215.5. Mission and Goals (Philosophy and Outcomes).
§215.6. Administration and Organization.
§215.7. Faculty Qualifications and Faculty Organization.
§215.8. Students.
§215.9. Program of Study.
§215.10. Management of Clinical Learning Experiences and Resources.
§215.11. Facilities, Resources, and Services.
§215.12. Records and Reports.
§215.13. Total Program Evaluation.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 26, 2004.

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Executive Director
Board of Nurse Examiners
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For further information, please call: (512) 305-6823

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CHAPTER 215. PROFESSIONAL NURSING EDUCATION

22 TAC §§215.1 - 215.13

The Board of Nurse Examiners (board) proposes the adoption a new chapter 215, §§215.1 - 215.13, of 22 Texas Administrative Code, concerning Professional Nursing Education. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. HB 1483 changed the Board's function of "accrediting" nursing education programs to "approving" nursing education programs. Concurrent with this proposed adoption is the proposed repeal of the existing chapter 215 (Nurse Education) and chapter 233 (Education) which addresses vocational nursing education. A new chapter 214 is being proposed for adoption which applies to vocational nursing education.

At the April 2004 Board meeting, the first meeting of the board since the merger, the board instructed the Advisory Committee on Education (ACE) to review Rule 233 (Vocational Nursing) Education to determine how this rule would interface with the current Rule 215 (Professional) Nurse Education. ACE members include representatives from organizations and educational institutions representing both vocational and professional nursing education and practice and the committee is responsible for identifying, studying, and analyzing issues in the education and practice arenas that have impacted, or may potentially impact, the regulation of nursing education in Texas. The consolidation of the two boards created a need to promulgate rules applicable to vocational and professional nursing education programs under the same title of the Texas Administrative Code, title 11.

ACE met on August 17, 2004, to formulate new rule language that addressed standards for vocational and professional nursing education. It reviewed the wording and intent of existing chapters 215 and 233 and determined that nursing education programs would be best served by having a separate rule, as occurred with the development of chapter 219, Advanced Practice Nurse (APN) Education. The members drafted language for the new chapters 214 and 215 and used the best wording from the existing chapters 233 and 215, but tried to maintain the essential integrity of the present chapters. Primarily, the committee changed the process for developing a new professional nursing education program from a two-step proposal process to a one-step process which would result in: a decrease in the number of times that new program representatives would have to appear before the Board; and a time-shortened process for approval from a maximum of 18 months to 12 months.

Katherine Thomas, executive director, has determined that for the first five-year period the proposed rules are adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Katherine Thomas, executive director, has determined that for each year of the first five years the proposed rules are adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the registered nurse is a safe practitioner. The proposed rules will also prevent conflicting rules. There will not be an effect on small businesses. There is no anticipated cost to affected individuals as a result of this proposed adoption.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed adoption of this chapter is pursuant to the authority of Texas Occupations Code §§301.151 and 301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act. The adoption of the proposed chapter will not affect any existing statute.

§215.1. General Requirements.

(a) The dean or director and faculty are accountable for complying with the Board's rules and regulations and the Nursing Practice Act.

(b) Rules for professional nursing education programs shall provide reasonable and uniform standards based upon sound educational principles that allow the opportunity for flexibility and creativity.

§215.2. Definitions.

Words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

(1) Accredited nursing education program--a professional nursing education program having voluntary accreditation by a Board-approved nursing accrediting body (i.e. NLNAC, CCNE).

(2) Affiliating Agency or Clinical Facility--a health care facility or agency which provides learning experiences for students.

(3) Alternative practice settings--settings which provide opportunities for clinical learning experiences although their primary function is not the delivery of health care.

(4) Annual Report--a document required by the Board to be submitted at a specified time by the nursing education program dean or director that serves as verification of the program's adherence to chapter 215, Professional Nursing Education.

(5) Approved professional nursing education program--a professional nursing education program approved by the Board of Nurse Examiners for the State of Texas.

(6) Articulation--a planned process between two or more educational systems to assist students to make a smooth transition from one level of education to another without duplication in learning.

(7) Board--the Board of Nurse Examiners for the State of Texas composed of members appointed by the Governor for the State of Texas.

(8) Clinical learning experiences--faculty-planned and guided learning activities designed to assist students to meet stated program and course outcomes and to safely apply knowledge and skills when providing nursing care to clients across the life span as appropriate to the role expectations of the graduates. These experiences occur in nursing skills and computer laboratories; in simulated clinical settings; in a variety of affiliating agencies or clinical practice settings including, but not limited to: acute care facilities, extended care facilities, clients' residences, and community agencies; and in associated clinical conferences.

(9) Clinical preceptor--a registered nurse or other licensed health professional who meets the minimum requirements in §215.10(f)(5) of this chapter (relating to Management of Clinical Learning Experiences and Resources), not paid as a faculty member by the governing institution, and who directly supervises a student's clinical learning experience. A clinical preceptor facilitates student learning in a manner prescribed by a signed written agreement between the educational institution, preceptor, and affiliating agency (as applicable).

(10) Clinical teaching assistant--a registered nurse licensed in Texas, who is employed to assist in the clinical area and work under the supervision of a Master's or Doctorally prepared nursing faculty member and who meets the minimum requirements in §215.10(g)(4) of this chapter.

(11) Conceptual Framework--theories or concepts giving structure to the curriculum and enabling faculty to make consistent decisions about all aspects of curriculum development, implementation, and evaluation.

(12) Course--organized subject content and related activities, which may include didactic, laboratory and/or clinical experiences, planned to achieve specific objectives within a given time period.

(13) Curriculum--course offerings, which in aggregate, make up the total learning activities in a program of study.

(14) Dean or Director--a registered nurse who is accountable for administering one or more of the following: a pre-licensure nursing education program or a post-licensure baccalaureate or higher degree program for registered nurses, who meets the requirements as stated in §216.6(f) of this chapter (relating to Administration and Organization), and who is approved by the Board.

(15) Differentiated Entry Level Competencies--the expected educational outcomes to be demonstrated by nursing students at the time of graduation as published in *Differentiated Entry Level Compentencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*.

(16) Examination year--the period beginning October 1 and ending September 30 used for the purposes of determining programs' NCLEX-RN examination pass rates.

(17) Extension Program--instruction provided by an approved professional nursing education program providing a variety of instructional methods to any location(s) other than the program's main campus and where students are required to attend activities such as testing, group conferences, and/or campus laboratory. An extension program may offer the entire identical curriculum or may offer a single course or multiple courses.

(A) Complete program--provides the entire program of study at a site other than the program's main campus.

(B) Partial program--provides a course, or courses, from the program of study at a site other than the program's main campus.

(18) Faculty member--an individual employed to teach in the professional nursing education program who meets the requirements as stated in §215.7 of this chapter (relating to Faculty Qualifications and Faculty Organization).

(19) Faculty waiver--a waiver granted by the Board to an individual who has a baccalaureate degree in nursing and is currently licensed in Texas, or has a privilege to practice, to be employed as a faculty member for a specified period of time.

(20) Governing institution--an accredited college, university, or hospital responsible for the administration and operation of a Board-approved nursing program.

(21) Health care professional--an individual other than a RN who holds at least a bachelor's degree in the health care field, including, but not limited to: respiratory therapists, physical therapists, occupational therapists, dieticians, pharmacists, physicians, social workers and psychologists.

(22) Mobility--the ability to advance without educational barriers.

(23) Non-Nursing Faculty--instructors who teach non-nursing theory courses such as pharmacology, pathophysiology, research, management and statistics, and who have educational preparation appropriate to the assigned teaching responsibilities.

(24) Objectives/Outcomes--clear statements of expected behaviors that are attainable and measurable.

(A) Program Objectives/Outcomes--broad statements used to direct the overall student learning toward the achievement of expected program outcomes.

(B) Clinical Objectives/Outcomes--statements describing expected student behaviors throughout the curriculum and which represent progression of students' cognitive, affective and psychomotor achievement in clinical practice across the curriculum.

(C) Course Objectives/Outcomes--statements describing expected behavioral changes in the learner upon successful completion of specific curriculum content and which serve as the mechanism for evaluation of student progression.

(25) Observational experience--an assignment to a facility or unit where students observe activities within the facility and/or the role of nursing within the facility, but where students do not participate in patient/client care.

(26) Pass rate--the percentage of first-time candidates within one examination year who pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN).

(27) Philosophy/Mission--statement of concepts expressing fundamental values and beliefs regarding human nature as they apply to nursing education and practice and upon which the curriculum is based.

(28) Professional Nursing Education Programs.

(A) Pre-licensure nursing education program--an educational entity that offers the courses and learning experiences that prepares graduates who are competent to practice safely and who are eligible to take the NCLEX-RN examination. Types of programs:

(i) Associate degree nursing education program--a program leading to an associate degree in nursing conducted by an educational unit in nursing within the structure of a college or university.

(ii) Baccalaureate degree nursing education program--a program leading to a bachelor's degree in nursing conducted by an educational unit in nursing which is a part of a senior college or university.

(iii) Master's degree nursing education program--a program leading to a master's degree, which is an individual's first professional degree in nursing, and conducted by an educational unit in nursing within the structure of a senior college or university.

(iv) Diploma nursing education program--a program leading to a diploma in nursing conducted by a single purpose school usually under the control of a hospital.

(v) MEEP--a Multiple Entry-Exit Program which allows students to challenge the NCLEX-PN examination when they have completed sufficient course work in a professional nursing program that will meet all requirements for the examination.

(B) Post-Licensure nursing education program--an educational unit the purpose of which is to provide mobility options for registered nurses to attain undergraduate academic degrees in nursing. Post-licensure programs may be components of educational units within pre-licensure nursing education programs or independent baccalaureate degree programs for registered nurses as defined in this section.

(29) Program of study--the courses and learning experiences that constitute the requirements for completion of a pre-licensure nursing education program (associate degree nursing education program, baccalaureate degree nursing education program, master's degree nursing education program, or diploma nursing education program) or a post-licensure nursing education program.

(30) Recommendation--a suggestion based upon program assessment indirectly related to the rules to which the program must respond but in a method of their choosing.

(31) Requirement--mandatory criterion based upon program assessment directly related to the rules that must be addressed in the manner prescribed.

(32) Shall--denotes mandatory requirements.

(33) Staff--employees of the Board of Nurse Examiners.

(34) Supervision--immediate availability of a faculty member, clinical preceptor, or clinical teaching assistant to coordinate, direct, and observe first hand the practice of students.

(35) Survey Visit--an on-site visit to a professional nursing education program by a Board representative. The purpose of the visit is to evaluate the program of learning by gathering data to determine whether the program is meeting the Board's requirements as specified in §§215.2 - 215.13 of this chapter.

(36) Systematic Approach--the organized process in nursing which provides individualized, goal-directed nursing care by performing comprehensive nursing assessments regarding the health status of the client, making nursing diagnoses that serve as the basis for the strategy of care, developing a plan of care based on the assessment and nursing diagnosis, implementing nursing care, and evaluating the client's responses to nursing interventions.

§215.3. Program Development, Expansion, and Closure.

(a) New programs.

(1) Proposal to establish a new professional pre-licensure or post-licensure nursing education program.

(A) A governing institution accredited by a Board-recognized accrediting body is eligible to submit a proposal to develop a professional nursing education program. The process to establish a new professional nursing education program shall be initiated with the Board office one year prior to the anticipated start of the program.

(B) The proposal shall be completed under the direction/consultation of a registered nurse who meets the approved qualifications for a program director according to §215.6.

(C) Sufficient nursing faculty with appropriate expertise shall be in place for development of the curriculum component of the program.

(D) The proposal shall include information outlined in Board guidelines.

(E) After the proposal is submitted and reviewed, a preliminary survey visit shall be conducted by Board staff prior to presentation to the Board.

(F) The proposal shall be considered by the Board following a public hearing at a regularly scheduled meeting of the Board.

The Board may approve the proposal and grant initial approval to the new program, may defer action on the proposal, or may deny further consideration of the proposal.

(G) The program shall not admit students until the Board approves the proposal and grants initial approval.

(H) Prior to presentation of the proposal to the Board, evidence of approval from the appropriate regulatory/funding agencies shall be provided.

(I) After the proposal is approved, an initial approval fee shall be assessed per §223.1 (related to Fees).

(J) A proposal without action for one calendar year shall be inactivated.

(2) Survey visits shall be conducted, as necessary, by staff until full approval status is granted.

(b) Extension Program.

(1) Only nursing programs that have full approval are eligible to initiate or modify extension programs.

(2) Instruction provided for the extension program may include a variety of instructional methods, shall be congruent with the program's curriculum plan, and shall enable students to meet the goals, objectives, and competencies of the educational program and requirements of the Board as stated in §§215.2 - 215.13 of this chapter.

(3) A program intending to establish an extension program shall:

(A) Notify the Board office at least four (4) months prior to implementation of extension programs by any approved program;

(B) Submit required information according to Board-approved guidelines;

(C) Provide documentation of notification to the Regional Council of the governing institution about plans for establishment of extension programs to the Board office at least four (4) months prior to implementation, as appropriate; and

(D) Provide evidence of approval from the Texas Higher Education Coordinating Board and other regulating/accrediting bodies to the Board four (4) months prior to implementation, as appropriate.

(4) Extension programs of pre-licensure nursing education programs which have been closed may be reactivated by submitting notification of reactivation to the Board at least four (4) months prior to reactivation, using the Board guidelines for initiating an extension program.

(5) A program intending to close an extension program shall:

(A) Notify the Board at least four (4) months prior to closure of the extension program; and

(B) Submit required information according to Board-approved guidelines including:

(i) reason for closing the program;

(ii) date of intended closure;

(iii) academic provisions for students; and

(iv) provisions made for access to and storage of vital school records.

(c) Transfer of Administrative Control by Governing Institutions. The authorities of the governing institution shall notify the Board office in writing of an intent to transfer the administrative authority of the program. This notification shall follow Board guidelines.

(d) Closing a Program.

(1) When the decision to close a program which provides the entire program of study has been made, the director must notify the Board and submit a written plan for closure which includes the following:

(A) reason for closing the program;

(B) date of intended closure;

(C) academic provisions for students;

(D) provisions made for access to and safe storage of vital school records, including transcripts of all graduates; and

(E) methods to be used to maintain requirements and standards until the program closes.

(2) The program shall continue within standards until all classes, which are enrolled at the time of the decision to close, have graduated. In the event this is not possible, a plan shall be developed whereby students may transfer to other approved programs.

§215.4. Approval.

(a) The progressive designation of approval status is not implied by the order of the following listing. Approval status is based upon each program's performance and demonstrated compliance to the Board's requirements and responses to the Board's recommendations. Change from one status to another is based on NCLEX-RN examination pass rates, annual reports, survey visits, and other factors listed under §215.4(b). Types of approval include:

(1) Initial approval.

(A) Initial approval is written authorization to admit students and is granted if the program meets the requirements and addresses the recommendations of the Board.

(B) Change from initial approval status to full approval status cannot occur until the program has met requirements and responded to all recommendations issued by the Board and the licensing examination result of the first graduating class is evaluated by the Board.

(2) Full approval.

(A) Pre-licensure nursing education program. Full approval is granted by the Board to a pre-licensure nursing education program that is in compliance with all requirements and has responded to all recommendations. Only programs with full approval status may propose extension programs and petition for faculty waivers.

(B) Post-licensure nursing education programs. Full approval is granted by the Board to a post-licensure nursing education program after one class has completed the program and the program meets the Board's legal and educational requirements.

(3) Full approval with warning is issued by the Board to a professional nursing education program that is not meeting legal and educational requirements. The program is issued a warning, provided a list of the deficiencies, and given a specified time in which to correct the deficiencies.

(4) Conditional approval. Conditional approval is issued by the Board for a specified time to provide the program the opportunity to correct deficiencies.

(A) The program shall not admit students while on conditional status.

(B) The Board may establish specific criteria to be met in order for the program's conditional approval status to be removed.

(C) Depending upon the degree to which the Board's legal and educational requirements are met, the Board may change the approval status to full approval or full approval with warning, or may withdraw approval.

(5) Withdrawal of approval. The Board may withdraw approval from a program which fails to meet legal and educational requirements within the specified time. The program shall be removed from the list of Board-approved professional nursing education programs.

(b) Factors Jeopardizing Program Approval Status - Approval may be changed or withdrawn for any of the following reasons:

(1) deficiencies in compliance with the rule;

(2) utilization of students to meet staffing needs in health care facilities;

(3) noncompliance with school's stated philosophy/mission, program design, objectives/outcomes, and/or policies;

(4) continual failure to submit records and reports to the Board office within designated time frames;

(5) failure to provide sufficient variety and number of clinical learning opportunities for students to achieve stated objectives/outcomes;

(6) failure to comply with Board requirements or to respond to recommendations within the specified time;

(7) student enrollments without sufficient faculty, facilities and/or patient census;

(8) failure to maintain a 80% passing rate on the licensing examination by first-time candidates;

(9) failure of the program dean or director to document annually the currency of faculty licenses; or

(10) other activities or situations that demonstrate to the Board that a program is not meeting legal requirements and standards.

(c) Approval procedures. Approval status is determined annually by the Board on the basis of the program's annual report, NCLEX-RN examination pass rate, and other pertinent data.

(1) Review of annual report. Each approved professional nursing education program shall submit an annual report regarding its compliance with the Board's legal and educational requirements.

(2) Pass rate of graduates on NCLEX-RN examination.

(A) Eighty percent (80%) of first-time candidates who complete the program of study are required to achieve a passing score on the NCLEX-RN examination.

(B) When the passing score of first-time candidates who complete the professional nursing education program of study is less than 80% on the NCLEX-RN examination during the examination year, the nursing program shall submit a self-study report that evaluates factors which contributed to the graduates' performance on the NCLEX-RN examination and a description of the corrective measures to be implemented. The report shall follow Board guidelines.

(C) A warning shall be issued to the program when the pass rate of first-time candidates, as described in subsection (c)(2)(A) of this section, is less than 80% for two consecutive examination years.

(D) A program shall be placed on conditional approval status if, within one examination year from the date of the warning, the performance of first-time candidates on the NCLEX-RN examination fails to be at least 80%, or the faculty fails to implement appropriate corrective measures.

(E) Approval may be withdrawn if the performance of first-time candidates fails to be at least 80% during the examination year following the date that the program is placed on conditional approval.

(F) A program placed on warning or conditional approval status may request a review of the program's approval status by the Board at a regularly scheduled meeting if the program's pass rate for first-time candidates during one examination year is at least 80%.

(d) Survey visit. Each professional nursing education program shall be visited at least every six years after full approval has been granted, unless accredited by a Board-recognized voluntary accrediting body.

(1) The Board may authorize staff to conduct a survey visit at any time based upon established criteria.

(2) After a program is fully approved by the Board, a report from a Board-recognized voluntary accrediting body regarding a program's accreditation status may be accepted in lieu of a Board survey visit.

(3) A written report of the survey visit, annual report, and NCLEX-RN examination pass rate shall be reviewed by the Board at a regularly scheduled meeting.

(e) Notice of a program's approval status shall be sent to the director, chief administrative officer of the governing institution, and others as determined by the Board.

§215.5. Philosophy/Mission and Objectives/Outcomes.

(a) The philosophy/mission and objectives/outcomes of the professional nursing education program shall be consistent with the philosophy/mission of the governing institution. They shall reflect the diversity of the community served and shall be consistent with professional, educational, and ethical standards of nursing.

(b) Program objectives/outcomes derived from the philosophy/mission shall reflect the *Differentiated Entry Level Compentencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*.

(c) Clinical objective/outcomes shall be stated in behavioral terms and shall serve as a mechanism for evaluating student progression.

(d) The conceptual framework shall provide the organization of major concepts from the philosophy/mission of the program that provides the underlying structure or theme of the curriculum and facilitates the achievement of the program objectives/outcomes.

(e) The faculty shall periodically review the philosophy/mission and objectives/outcomes and shall make revisions to maintain currency.

§215.6. Administration and Organization.

(a) The governing institution shall be accredited by a Board-recognized agency.

(b) There shall be an organizational chart which demonstrates the relationship of the professional nursing education program to the governing institution, and indicates lines of responsibility and authority.

(c) In colleges and universities, the program shall have comparable status with other academic units in such areas as rank, promotion, tenure, leave, benefits and professional development.

(d) Salaries shall be adequate to recruit, employ, and retain sufficient qualified faculty members with graduate preparation and expertise necessary for students to meet program goals.

(e) The governing institution shall provide financial support and resources needed to operate a program which meets the legal and educational requirements of the Board and fosters achievement of program goals. The financial resources shall support adequate educational facilities, equipment and qualified administrative and instructional personnel.

(f) Each professional nursing education program shall be administered by a qualified individual who is accountable for the planning, implementation and evaluation of the professional nursing education program. The dean or director shall:

(1) hold a current license or privilege to practice as a registered nurse in the state of Texas;

(2) hold a master's degree in nursing;

(3) hold a doctoral degree, if administering a baccalaureate or master's degree program;

(4) have a minimum of three years teaching experience in a professional nursing education program; and

(5) have demonstrated knowledge, skills and abilities in administration within a professional nursing education program.

(g) When the dean or director of the program changes, the dean or director shall submit to the Board office written notification of the change indicating the final date of employment.

(1) A new dean or director qualification form shall be submitted to the office by the governing institution for approval prior to appointment in an existing program or a new nursing program.

(2) A vitae and all official transcripts shall be submitted with the new dean or director qualification form.

(3) If an interim dean or director is appointed to fill the position, this appointment shall not exceed one year.

(4) In a fully approved professional nursing education program, if the individual to be appointed as dean or director does not meet the requirements for dean or director as specified in subsection (f) of this section, the administration is permitted to petition for a waiver of the Board's requirements, according to Board guidelines, prior to the appointment of said individual.

(h) A newly appointed dean, director, interim dean, or interim director of a professional nursing education program shall attend the next scheduled orientation provided by the Board.

§215.7. Faculty Qualifications and Faculty Organization.

(a) There shall be written personnel policies for nursing faculty that are in keeping with accepted educational standards and are consistent with those of the governing institution. Policies which differ from those of the governing institution shall be consistent with nursing unit mission and goals (philosophy and outcomes).

(1) Policies concerning workload for faculty and the dean or director shall be in writing.

(2) Sufficient time shall be provided faculty to accomplish those activities related to the teaching-learning process.

(3) Teaching activities shall be coordinated among full-time, part-time faculty, clinical preceptors and clinical teaching assistants.

(4) If the dean or director is required to teach, he or she shall carry a teaching load of no more than three clock hours per week.

(b) A professional nursing education program shall employ sufficient faculty members with graduate preparation and expertise necessary to enable the students to meet the program goals. The number of faculty members shall be determined by such factors as:

(1) The number and level of students enrolled;

(2) The curriculum plan;

(3) Activities and responsibilities required of faculty;

(4) The number and geographic locations of affiliating agencies and clinical practice settings; and

(5) The level of care and acuity of clients.

(c) Faculty Qualifications and Responsibilities.

(1) Documentation of faculty qualifications shall be included in the official files of the programs. Each nurse faculty member shall:

(A) Hold a current license or privilege to practice as a registered nurse in the State of Texas;

(B) Show evidence of teaching abilities and maintaining current knowledge, clinical expertise, and safety in subject area of teaching responsibility;

(C) Hold a master's degree, preferably in nursing. A nurse faculty member holding a master's degree in a discipline other than nursing shall hold a bachelor's degree in nursing from an approved or accredited baccalaureate program in nursing; and

(i) if teaching in a diploma or associate degree nursing program, shall have at least six semester hours of graduate level content in nursing appropriate to assigned teaching responsibilities, or

(ii) if teaching in a baccalaureate level program, shall have at least 12 semester hours of graduate-level content in nursing appropriate to assigned teaching responsibilities.

(D) In fully approved programs, if an individual to be appointed as faculty member does not meet the requirements for faculty as specified in this subsection, the dean or director is permitted to petition for a waiver of the Board's requirements, according to Board guidelines, prior to the appointment of said individual.

(E) In baccalaureate programs, an increasing number of faculty members should hold doctoral degrees appropriate to their responsibilities.

(2) All nursing faculty, as well as non-nursing faculty, who teach theory nursing courses, e.g., pathophysiology, pharmacology, research, management and statistics, shall have graduate level educational preparation verified by the program dean or director as appropriate to these areas of responsibility.

(3) Non-nursing faculty assigned to teach didactic nursing courses shall be required to co-teach with nursing faculty in order to meet nursing course objectives.

(d) Teaching assignments shall be commensurate with the faculty member's education and experience in nursing.

(e) The faculty shall be organized with written policies and procedures and/or bylaws to guide the faculty and program's activities.

(f) The faculty shall meet regularly and function in such a manner that all members participate in planning, implementing and evaluating the nursing program. Such participation includes, but is not limited to the initiation and/or change of academic policies, personnel policies, curriculum, utilization of affiliating agencies, and program evaluation.

(1) Committees necessary to carry out the functions of the program shall be established with duties and membership of each committee clearly defined in writing.

(2) Minutes of faculty organization and committee meetings shall document the reasons for actions and the decisions of the faculty and shall be available for reference.

(g) There shall be written plans for faculty orientation, development, and evaluation.

(1) Orientation of new faculty members shall be initiated at the onset of employment.

(2) A program of faculty development shall be offered to encourage and assist faculty members to meet the nursing program's needs as well as individual faculty member's professional development needs.

(3) A variety of means shall be used to evaluate faculty performance such as self, student, peer and administrative evaluation.

§215.8. Students.

(a) Students shall have mechanisms for input into the development of academic policies and procedures, curriculum planning, and evaluation of teaching effectiveness.

(b) The number of students admitted to the program shall be determined by the number of qualified faculty, adequate educational facilities and resources, and the availability of appropriate clinical learning experiences for students.

(c) Written policies regarding nursing student admission and progression shall be developed and implemented in accordance with the requirements that the governing institution must meet to maintain accreditation. Student policies which differ from those of the governing institution shall be in writing and shall be made available to faculty and students.

(d) Policies shall facilitate mobility/articulation, be consistent with acceptable educational standards, and be available to students and faculty.

(e) Students shall have the opportunity to evaluate faculty, courses, and learning resources and these evaluations shall be documented.

(f) Individuals enrolled in approved professional nursing education programs preparing students for initial licensure shall be provided verbal and written information regarding conditions that may disqualify graduates from licensure and of their rights to petition the Board for a Declaratory Order of Eligibility. Required eligibility information includes:

(1) Texas Occupations Code §§301.252, 301.257 and 301.452 - .469; and

(2) Sections 213.27-213.30 of the Texas Administrative Code (relating to Good Professional Character, Licensure of Persons with Criminal Convictions, Criteria and Procedure Regarding Intemperate Use and Lack of Fitness in Eligibility and Disciplinary Matters, Declaratory Order of Eligibility for Licensure).

(g) The professional nursing education program shall maintain written receipt of eligibility notification for up to six months after the individual enrolled completes the nursing education program or permanently withdraws from the nursing education program.

§215.9. Program of Study.

(a) The program of study shall be:

(1) at least the equivalent of two academic years and shall not exceed four calendar years;

(2) planned, implemented, and evaluated by the faculty;

(3) based on the philosophy/mission and objectives/outcomes;

(4) organized logically, sequenced appropriately;

(5) based on sound educational principles;

(6) designed to prepare graduates to practice according to the Standards of Nursing Practice as set forth in the Board's Rules and Regulations; and

(7) designed and implemented to prepare students to demonstrate the *Differentiated Entry Level Compentencies of Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree (Dip/ADN), Baccalaureate (BSN), September 2002*.

(b) There shall be a reasonable balance between non-nursing courses and nursing courses which are offered in a supportive sequence with rationale and are clearly appropriate for collegiate study.

(c) There shall be a rationale for the ratio of contact hours assigned to classroom and clinical learning experiences. The recommended ratio is three contact hours of clinical learning experiences for each contact hour of classroom instruction.

(d) The program of study should facilitate articulation among programs.

(e) The program of study shall include, but not be limited to the following areas:

(1) non-nursing courses, clearly appropriate for collegiate study, offered in a supportive sequence.

(2) nursing courses which include didactic and clinical learning experiences in the four content areas, medical-surgical, maternal/child health, pediatrics, and mental health nursing that teach students to use a systematic approach to clinical decision making and prepare students to safely practice professional nursing through the promotion, prevention, rehabilitation, maintenance, and restoration of the health of individuals of all ages.

(A) Course content shall be appropriate to the role expectations of the graduate.

(B) Professional values including ethics, safety, diversity, and confidentiality shall be addressed.

(C) The Nursing Practice Act, Standards of Nursing Practice, Unprofessional Conduct Rules, Delegation Rules, and other laws and regulations which pertain to various practice settings shall be addressed.

(3) Nursing courses shall prepare students to recognize and analyze health care needs, select and apply relevant knowledge and appropriate methods for meeting the heath care needs of individuals and families, and evaluate the effectiveness of the nursing care.

(4) Baccalaureate and entry-level master's degree programs in nursing shall include learning activities in basic research

and management/leadership, and didactic and clinical learning experiences in community health nursing.

(f) The learning experiences shall provide for progressive development of values, knowledge, judgment, and skills.

(1) Didactic learning experiences shall be provided either prior to or concurrent with the related clinical learning experiences.

(2) Clinical learning experiences shall be sufficient in quantity and quality to provide opportunities for students to achieve the stated outcomes.

(3) Students shall have sufficient opportunities in simulated or clinical settings to develop manual technical skills, using contemporary technologies, essential for safe, effective nursing practice.

(4) Learning opportunities shall assist students to develop communication and interpersonal relationship skills.

(g) Faculty shall develop and implement evaluation methods and tools to measure progression of students' cognitive, affective and psychomotor achievements in course/clinical objectives according to Board guidelines.

(h) Curriculum changes shall be developed by the faculty according to Board standards and shall include information outlined in the Board guidelines. The two types of curriculum changes are:

(1) Minor curriculum changes not requiring prior Board staff approval, and may include:

(A) editorial updates of philosophy/mission and objectives/outcomes; or

(B) redistribution of course content or course hours.

(2) Major curriculum changes requiring Board staff approval prior to implementation, including:

(A) changes in program philosophy/mission and objectives/outcomes which result in a reorganization or re-conceptualization of the entire curriculum, including but not limited to changing from a block to an integrated curriculum.

(B) the addition of transition course(s), tracks/alternative programs of study, including MEEP, that provide educational mobility.

(C) mobility programs desiring to establish a generic program are treated as a new program and the appropriate proposal should be developed.

(i) All programs implementing a curriculum change shall provide an evaluation of the outcomes of these changes and submit with the Annual Report through the first graduating class.

(j) Documentation of Governing Institution approval or Texas Higher Education Coordinating Board approval must be provided to the Board prior to implementation of changes, as appropriate.

(k) Nursing education programs that have full approval and are undergoing major curriculum changes shall submit an abbreviated proposal to the office for approval at least four (4) months prior to implementation. The abbreviated proposal shall contain at least the following:

(1) new and old philosophy/mission, major concepts, program objectives/outcomes, course objectives/outcomes;

(2) new and old curriculum plans;

(3) clinical evaluation tools for each clinical course; and

(4) additional information as requested in order to provide clarity for Board staff.

(l) Nursing education programs not having full approval but proposing a major curriculum change shall submit a full curriculum change proposal and meet the requirements as outlined in §215.9(h).

§215.10. Management of Clinical Learning Experiences and Resources.

(a) In all cases faculty shall be responsible and accountable for managing clinical learning experiences and observational experiences of students.

(b) Faculty shall develop criteria for the selection of affiliating agencies/clinical facilities or clinical practice settings which address safety and the need for students to achieve the program outcomes (goals) through the practice of nursing care or observational experiences.

(c) Faculty shall select and evaluate affiliating agencies/clinical facilities or clinical practice settings which provide students with opportunities to achieve the goals of the program.

(1) Written agreements between the program and the affiliating agencies shall specify the responsibilities of the program to the agency and the responsibilities of the agency to the program.

(2) Agreements shall be reviewed periodically and include provisions for adequate notice of termination.

(d) The faculty member shall be responsible for the supervision of students in clinical learning experiences.

(1) When a faculty member is the only person officially responsible for a clinical group, the group shall total no more than ten (10) students. Patient safety shall be a priority and may mandate lower ratios, as appropriate. The faculty member shall supervise that group in only one facility at a time, unless some portion or all of the clinical group are assigned to observational experiences in additional settings.

(2) Direct faculty supervision is not required for an observational experience.

(A) Observational experiences may be used to supplement, but not replace patient care experiences, and must serve the purpose of student attainment of clinical objectives.

(B) Observational experiences shall comprise no more than 20% of the clinical contact hours for a course and no more than 10% of the clinical contact hours for the program of study.

(e) Faculty may use clinical preceptors or clinical teaching assistants to enhance clinical learning experiences and to assist faculty in the clinical supervision of students.

(1) Faculty shall develop written criteria for the selection of clinical preceptors and clinical teaching assistants.

(2) When clinical preceptors or clinical teaching assistants are used, written agreements between the professional nursing education program, clinical preceptor or clinical teaching assistant, and the affiliating agency, when applicable, shall delineate the functions and responsibilities of the parties involved.

(3) Faculty shall be readily available to students and clinical preceptors or clinical teaching assistants during clinical learning experiences.

(4) The designated faculty member shall meet periodically with the clinical preceptors or clinical teaching assistants and student(s) for the purpose of monitoring and evaluating learning experiences.

(5) Written clinical objectives shall be shared with the clinical preceptors or clinical teaching assistants prior to or concurrent with the experience.

(f) Clinical preceptors may be used to enhance clinical learning experiences after a student has received clinical and didactic instruction in all basic areas of nursing or within a course after a student has received clinical and didactic instruction in the basic areas of nursing for that course or specific learning experience.

(1) In courses which use clinical preceptors for a portion of clinical learning experiences, faculty shall have no more than 12 students in a clinical group.

(2) In a course which uses clinical preceptors as the sole method of student instruction and supervision in clinical settings, faculty shall coordinate the preceptorship for no more than 24 students.

(3) The preceptor may supervise student clinical learning experiences without the physical presence of the faculty member in the affiliating agency or clinical practice setting.

(4) The preceptor shall be responsible for the clinical learning experiences of no more than two students per clinical day.

(5) Clinical preceptors shall have the following qualifications:

(A) competence in designated areas of practice;

(B) philosophy of health care congruent with that of the nursing program; and

(C) current licensure or privilege as a registered nurse in the State of Texas; or

(D) if not a registered nurse, a current license in Texas as a health care professional with a minimum of a bachelor's degree in that field.

(g) Clinical teaching assistants may assist qualified, experienced faculty with clinical learning experiences.

(1) In clinical learning experiences where a faculty member is supported by a clinical teaching assistant, the ratio of faculty to students shall not exceed 2:15 (faculty plus clinical teaching assistant:student).

(2) Clinical teaching assistants shall supervise student clinical learning experiences only when the qualified and experienced faculty member is physically present in the affiliating agency or alternative practice setting.

(3) When acting as a clinical teaching assistant, the RN shall not be responsible for other staff duties, such as supervising other personnel and/or patient care.

(4) Clinical teaching assistants shall meet the following criteria:

(A) hold a current license or privilege to practice as a registered nurse in the State of Texas;

(B) hold a bachelor's degree in nursing from an accredited baccalaureate program in nursing; and

(C) have the clinical expertise to function effectively and safely in the designated area of teaching.

§215.11. Facilities, Resources, and Services.

(a) The governing institution shall be responsible for providing:

(1) educational facilities,

(2) resources, and

(3) services which support the effective development and implementation of the nursing education program.

(b) The dean or director and faculty shall have adequate secretarial and clerical assistance to meet the needs of the program.

(c) The physical facilities shall be adequate to meet the needs of the program in relation to the size of the faculty and the student body.

(1) The dean or director shall have a private office.

(2) Faculty offices shall be conveniently located and adequate in number and size to provide faculty with privacy for conferences with students and uninterrupted work.

(3) Space for clerical staff, records, files, and equipment shall be adequate.

(4) There shall be mechanisms which provide for the security of sensitive materials, such as examinations and health records.

(5) Classrooms, laboratories, and conference rooms shall be conducive to learning and adequate in number, size, and type for the number of students and the educational purposes for which the rooms are used.

(d) The learning resources, library, and departmental holdings shall be current, use contemporary technology appropriate for the level of the curriculum, and be sufficient for the size of the student body and the needs of the faculty.

(1) Provisions shall be made for accessibility, availability, and timely delivery of information resources.

(2) Facilities and policies shall promote effective use, i.e. environment, accessibility, and hours of operation.

§215.12. Records and Reports.

(a) Accurate and current records shall be maintained in a confidential manner and be accessible to appropriate parties. These records shall include, but are not limited to:

(1) records of current students;

(2) transcripts/permanent record cards of graduates;

(3) faculty records;

(4) administrative records, which include minutes of faculty meetings for the past three years, annual reports, and school catalogs;

(5) the current program of study and curriculum including mission and goals (philosophy and outcomes), and course outlines;

(6) agreements with affiliating agencies; and

(7) the master plan of evaluation with most recent data collection.

(b) Records shall be safely stored to prevent loss, destruction, or unauthorized use.

(c) Copies of the program's Annual Reports and important Board communication shall be maintained as appropriate.

§215.13. Total Program Evaluation.

(a) There shall be a written plan for the systematic evaluation of the total program. The plan shall include evaluative criteria, methodology, frequency of evaluation, assignment of responsibility, and indicators (benchmarks) of program and instructional effectiveness. The following broad areas shall be periodically evaluated:

(1) organization and administration of the program;

(2) philosophy/mission and objectives/outcomes;

(3) program of study, curriculum, and instructional techniques;

(4) education facilities, resources, and services;

(5) affiliating agencies and clinical learning activities;

(6) students' achievement;

(7) graduates' performance on the licensing examination;

(8) graduates' nursing competence;

(9) faculty members' performance; and

(10) extension programs.

(b) All evaluation methods and instruments shall be periodically reviewed for appropriateness.

(c) Implementation of the plan for total program evaluation shall be documented in the minutes.

(d) Major changes in the nursing education program shall be evidence-based and supported by rationale.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 26, 2004.

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Katherine Thomas
Executive Director
Board of Nurse Examiners
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For further information, please call: (512) 305-6823

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PART 12. BOARD OF VOCATIONAL NURSE EXAMINERS

CHAPTER 233. EDUCATION

SUBCHAPTER A. DEFINITIONS

22 TAC §233.1

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code Chapter 233, concerning Education, and specifically Subchapter A (Definitions), §233.1. The other four subchapters in this chapter are being proposed for repeal concurrently with this subchapter. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. The repeal implements House Bill 1483 and the make-up and function of the new Board of Nurse Examiners. Concurrent with the proposed repeal is the proposal of a new Chapter 214 (Vocational Nursing Education) which incorporates the education rules for Licensed Vocational Nurses into the Board of Nurse Examiners' rules. This repeal is for the purpose of preventing conflicting rules and consolidating the rules applicable to all nurses under Title 22, Part 11 (Board of Nurse Examiners) of the Texas Administrative Code.

Katherine Thomas, Executive Director, has determined that for the first five-year period the proposed repeal is adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Ms. Thomas has also determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the vocational nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative options, such as adding the use of preceptors should prevent any adverse effects such as decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of this section is pursuant to the authority of Texas Occupations Code, §301.151 and §301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act.

The adoption of the proposed repeal will not affect any existing statute.

§233.1. Definitions.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 25, 2004.

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Katherine Thomas
Executive Director
Board of Nurse Examiners
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SUBCHAPTER B. OPERATION OF A VOCATIONAL NURSING PROGRAM

22 TAC §§233.11 - 233.26, 233.28 - 233.30

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code Chapter 233, concerning Education, and specifically Subchapter B (Operation of a Vocational Nursing Program), §§233.11 - 233.26 and §§233.28 - 233.30. The other four subchapters in this chapter are being proposed for repeal concurrently with this subchapter. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. The repeal implements House Bill 1483 and the make-up and function of the new Board of Nurse Examiners. Concurrent with the proposed repeal is the proposal of a new Chapter 214 (Vocational Nursing Education) which incorporates the education rules for Licensed Vocational Nurses into the Board of Nurse Examiners' rules. This repeal is for the purpose of preventing conflicting rules and consolidating the rules applicable to all nurses under Title 22, Part 11 (Board of Nurse Examiners) of the Texas Administrative Code.

Katherine Thomas, Executive Director, has determined that for the first five-year period the proposed repeal is adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Ms. Thomas has also determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the vocational nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative options, such as adding the use of preceptors should prevent any adverse effects such as decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of these sections is pursuant to the authority of Texas Occupations Code, §301.151 and §301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act.

The adoption of the proposed repeal will not affect any existing statute.

§233.11. Agencies Qualified to Operate a School.
§233.12. Controlling Agency.
§233.13. Affiliating Agency.
§233.14. Contractual Agreement.
§233.15. Establishment of a New Program.
§233.16. Establishment of Extension Programs.
§233.17. Transfer of Controlling Agency.
§233.18. Reopening or Reactivating a Program.
§233.19. Closure of a School.
§233.20. Program Design.
§233.21. Director.
§233.22. Instructors.
§233.23. Designate Supervisors.
§233.24. Minimum Teaching Personnel.
§233.25. Faculty Continuing Education Requirements.
§233.26. Clinical Facility.
§233.28. Updating Program Design.
§233.29. Substitute Faculty.
§233.30. Military Faculty.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Katherine Thomas
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SUBCHAPTER C. APPROVAL OF PROGRAMS

22 TAC §§233.41 - 233.43

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code Chapter 233, concerning Education, and specifically Subchapter C (Approval of Programs), §§233.41 - 233.43. The other four subchapters in this chapter are being proposed for repeal concurrently with this subchapter. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. The repeal implements House Bill 1483 and the make-up and function of the new Board of Nurse Examiners. Concurrent with the proposed repeal is the proposal of a new Chapter 214 (Vocational Nursing Education) which incorporates the education rules for Licensed Vocational Nurses into the Board of Nurse Examiners' rules. This repeal is for the purpose of preventing conflicting rules and consolidating the rules applicable to all nurses under Title 22, Part 11 (Board of Nurse Examiners) of the Texas Administrative Code.

Katherine Thomas, Executive Director, has determined that for the first five-year period the proposed repeal is adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Ms. Thomas has also determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the vocational nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative

options, such as adding the use of preceptors should prevent any adverse effects such as decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of these sections is pursuant to the authority of Texas Occupations Code, §301.151 and §301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act.

The adoption of the proposed repeal will not affect any existing statute.

§233.41. Types of Approval.

§233.42. Factors Jeopardizing School Approval.

§233.43. Withdrawal of Approval.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER D. VOCATIONAL NURSING EDUCATION STANDARDS

22 TAC §§233.51 - 233.54, 233.56 - 233.58, 233.60 - 233.69, 233.71 - 233.76

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code Chapter 233, concerning Education, and specifically Subchapter D (Vocational Nursing Education Standards), §§233.51 - 233.54, 233.56 - 233.58, 233.60 - 233.69, 233.71 - 233.76. The other four subchapters in this chapter are being proposed for repeal concurrently with this subchapter. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. The repeal implements House Bill 1483 and the make-up and function of the new Board of Nurse Examiners. Concurrent with the proposed repeal is the proposal of a new Chapter 214 (Vocational Nursing Education) which incorporates the education rules for Licensed Vocational Nurses into the Board of Nurse Examiners' rules. This repeal is for the purpose of preventing conflicting rules and consolidating the rules applicable to all nurses under Title 22, Part 11 (Board of Nurse Examiners) of the Texas Administrative Code.

Katherine Thomas, Executive Director, has determined that for the first five-year period the proposed repeal is adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Ms. Thomas has also determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the vocational nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative options, such as adding the use of preceptors should prevent any adverse effects such as decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of these sections is pursuant to the authority of Texas Occupations Code, §301.151 and §301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act.

The adoption of the proposed repeal will not affect any existing statute.

§233.51. Curriculum Organization.
§233.52. Student Time and Rotation Schedules.
§233.53. Student Patient Assignments.
§233.54. Class and Clinical Practice Hours.
§233.56. Innovative Curriculum Development.
§233.57. Challenging Curriculum.
§233.58. Curriculum Requirements.
§233.60. Teaching Facilities.
§233.61. Resource Materials.
§233.62. Restrooms and Lounges.
§233.63. Admission of Classes.
§233.64. Student Policies.
§233.65. Admission Criteria.
§233.66. Dismissal Criteria.
§233.67. Schedule of Hours.
§233.68. Schedule of Clinical Practice.
§233.69. Vacation and Holidays.
§233.71. System of Grading.
§233.72. Transfer and Advanced Placement of Vocational and Professional Nursing Students.
§233.73. Special Students.
§233.74. Clinical Practice Evaluations.
§233.75. Student Conferences.
§233.76. Minimum Standards/Guidelines.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER E. VOCATIONAL NURSE EDUCATION RECORDS

22 TAC §§233.81 - 233.85

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Board of Nurse Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Board of Nurse Examiners proposes the repeal of 22 Texas Administrative Code Chapter 233, concerning Education, and specifically Subchapter E (Vocational Nurse Education Records), §§233.81 - 233.85. The other four subchapters in this chapter are being proposed for repeal concurrently with this subchapter. Effective February 1, 2004, the Board of Nurse Examiners and the Board of Vocational Nurse Examiners were merged into one agency, the Board of Nurse Examiners. The Board of Vocational Nurse Examiners ceased to exist as an agency. House Bill 1483, passed by the 78th Regular Legislative Session, was the legislative action that implemented the consolidation. The repeal implements House Bill 1483 and the make-up and function of the new Board of Nurse Examiners. Concurrent with the proposed repeal is the proposal of a new Chapter 214 (Vocational Nursing Education) which incorporates the education rules for Licensed Vocational Nurses into the Board of Nurse Examiners' rules. This repeal is for the purpose of preventing conflicting rules and consolidating the rules applicable to all nurses under Title 22, Part 11 (Board of Nurse Examiners) of the Texas Administrative Code.

Katherine Thomas, Executive Director, has determined that for the first five-year period the proposed repeal is adopted there will be no fiscal implications for state or local government as a result of implementing the proposed repeal.

Ms. Thomas has also determined that for each year of the first five years the proposed repeal is adopted, the public benefit will be that the new rules will safeguard the welfare of the public of this State through implementation of educational standards that provide assurance that the vocational nurse is a safe practitioner. The proposed repeal will also prevent conflicting rules. The effect on small businesses is that the proposed new rules require reducing the student/faculty ratio to 10:1 from the previous 12:1 which may require hiring more educators, although alternative options, such as adding the use of preceptors should prevent any adverse effects such as decrease in student enrollment. There is no anticipated cost to affected individuals as a result of this proposed repeal.

Written comments on the proposal may be submitted to Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners, 333 Guadalupe, Suite 3-460, Austin, Texas 78701.

The proposed repeal of these sections is pursuant to the authority of Texas Occupations Code, §301.151 and §301.152 which authorizes the Board of Nurse Examiners to adopt, enforce, and repeal rules consistent with its legislative authority under the Nursing Practice Act.

The adoption of the proposed repeal will not affect any existing statute.

§233.81. Student Forms.

§233.82. Required Student Forms.

§233.83. Record Storage.

§233.84. Retention of Student Records.

§233.85. Required and Resource Program Documents.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Texas Department of Insurance (TDI) proposes amendments to §§11.1, 11.2, 11.101, 11.201 - 11.206, 11.301 - 11.303, 11.502 - 11.506, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 - 11.803, 11.806, 11.809, 11.810, 11.901, 11.904, 11.1001, 11.1301 - 11.1306, 11.1401 - 11.1404, 11.1500, 11.1600 - 11.1602, 11.1604 - 11.1607, 11.1702 - 11.1704, 11.1801 - 11.1806, 11.1901, 11.1902, 11.2101 - 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2501 - 11.2503, 11.2601, and 11.2602, and new §§11.902, 11.2207, 11.2208, and 11.2406, concerning regulation of health maintenance organizations (HMOs). These amendments and new sections are necessary to implement statutory changes from prior legislative sessions and to update procedures and requirements to conform to certain nationally recognized standards. In addition, because these sections have not undergone comprehensive revision for a number of years, the department believes it is necessary to streamline and consolidate requirements to more accurately reflect acceptable HMO practices and TDI's policies and procedures, and to clarify statutory requirements. The department also believes rule revision is necessary to respond to regulatory concerns that have arisen since the last revision. For example, many have questioned the necessity of the current rule's requirements concerning full-time clinical directors (currently medical directors). After encountering this concern many times, the department has determined that the requirements should be modified in a way that is more efficient

for HMOs to implement without compromising appropriate regulatory standards. Another example concerns the practice of "balance billing" of HMO enrollees, particularly where enrollees have in good faith utilized a contracted medical facility but have received services, such as ancillary services (e.g., anesthesiology, radiology, or pathology), from a non-contracted physician or provider. This issue has received considerable attention over the past several years, and the department believes that this revision of the HMO rules should clarify it. This issue, and the proposed rule revisions, are discussed more thoroughly herein.

The proposed amendments to §11.204(18) add a requirement that the HMO provide network configuration information, including maps demonstrating the location and distribution of the physician and provider network within the service area upon initial filing of an application for a certificate of authority. Proposed amendments to §§11.205(a)(6), 11.302(b)(3), and 11.303(c)(7) incorporate the requirement for this network configuration information. The changes are proposed to ensure full compliance with §843.078(k), which requires network configuration information to demonstrate network adequacy. The maps, by indicating where particular providers are located, are much more demonstrative of network sufficiency and accessibility than written descriptions. In addition, the proposed amendments also require that the HMO provide lists of physicians and individual and institutional providers, along with license type and specialization, and information concerning whether such physicians or individual providers are accepting new patients. The license type and specialization information allows TDI to more readily distinguish primary care physicians from specialists in determining network adequacy to support all types of covered services.

The proposed amendments to Subchapter C (§11.205(a)(4)), which set out ten prescribed categories of complaints that HMOs must make available during examinations prior to and subsequent to issuance of a certificate of authority, basically require greater detail in, and expand on, the four categories of complaints HMOs are currently required to maintain. These proposed complaint categories are also referenced in Subchapter D (§11.303(c)(4)). TDI believes these amendments are necessary to facilitate review of complaints during examinations and to allow TDI and the industry to more specifically monitor problems and concerns in the face of marketplace changes that could impact enrollees. However, in order to allow sufficient time to implement these changes, TDI will consider allowing HMOs additional time to implement this requirement and it solicits commenters' input on appropriate compliance dates.

The proposed changes to the Solvency Surveillance Committee (SSC) in Subchapter N (§11.1302) will provide a more flexible process that allows for better responsiveness to specific concerns regarding an HMO, while eliminating requirements for unnecessary meetings. Increased responsiveness and flexibility of the committee will ultimately better protect all enrollees receiving health care coverage from an HMO.

The proposed amendments to Subchapter Q (§11.1606) clarify the responsibilities of an HMO's Chief Executive Officer, Chief Operations Officer, and Clinical Director. Previously the rule emphasized factors such as full-time status and residence in the service area, while the proposal sets forth a description of the positions' practical and functional requirements and responsibilities. The proposed change reflects the department's understanding that executives can be responsible for operations in several states or several different service areas on less than a full-time basis in this state. TDI has, for many years, heard from some plans that the current rule's requirement was not necessary to their circumstances. The proposal, which the department derived from its regulatory experience, recognized national standards, as well as actual HMOs' job descriptions, gives HMOs the flexibility to determine how they can best manage and implement their executive duties, while making clear that the HMO must address and ensure satisfactory performance of the functions of the positions.

The proposed amendments to Subchapter S (§11.1802) prescribe a more comprehensive method for assessing the minimum capital or net worth of a Medicaid managed care organization (MCO) by incorporating Risk Based Capital (RBC) requirements, developed in coordination with the National Association of Insurance Commissioners (NAIC), for assessing capital adequacy. All HMOs, including those that are MCOs, must already comply with the RBC formula currently required in §11.809. Insurance Code Article 1.61 requires TDI, in conjunction with the Texas Health and Human Services Commission (HHSC), to establish fiscal solvency standards for MCOs, and these amendments are meant to ensure that MCOs that contract with the state operate in a fiscally sound manner. The proposed amendments to §11.1804 also allow a reduction in the special statutory deposit required for MCOs, taking into account certain guarantees from sponsoring organizations, and clarify that the reduction is unrelated to non-Medicaid business. The proposed amendments eliminate the automatic filing requirements for certain financial information and instead require that such information be filed only upon the department's request.

The proposed amendments to, and existing language in, Subchapter F (§11.506) and Subchapter Q (§11.1600(b)(11)(D)) address the issue of "balance billing" of HMO enrollees by physicians and providers. Pursuant to the HMO Act, an HMO must establish a network of physicians and other providers with which it contracts to provide basic covered services which are delivered to enrollees on a prepaid basis. Because of the prepaid nature of HMO coverage, §843.361 requires that "[a] contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the provider for those services." It is not, and has never been, in dispute that contracted physicians and providers may not charge enrollees for services other than agreed copayments. However, for several years the department has addressed issues concerning enrollees who are billed by non-contracted physicians and providers. The issue has arisen in two areas: where enrollees receive treatment at network hospitals or facilities by non-contracted ancillary providers, and where enrollees receive emergency treatment at a non-network facility.

TDI has received complaints from HMO enrollees who have been balance billed under these circumstances, but to date it has informally resolved them through negotiation with the HMO and the provider. While TDI has been successful at resolving complaints in this manner, the issue persists. A 2003 Attorney General's Opinion (Op. No. GA-0040) held that the HMO Act does not prohibit a physician not under contract with an HMO from billing an enrollee for charges in addition to those paid by the HMO for the services. The opinion also held that TDI is not authorized to enforce the act against such a physician. While TDI has never sought to take enforcement action against a physician, the issue became more prominent following this ruling.

Accordingly, TDI proposes amendments to reiterate the statutory requirement that HMOs, which by law must provide basic health care services to enrollees on a prepaid basis, must cover the cost of such services so that enrollees are not billed for any balance. Proposed amendments to Subchapter Q (§11.1607(i)(4)) thus require HMOs that have been required to file an access plan due to inadequate numbers or types of physicians in their networks to state in such plan that the HMO will ensure that enrollees will be "indemnified or otherwise held harmless when non-participating physicians and providers provide services to enrollees due to the unavailability of the service from a physician or provider in the HMO's network or network facility." This language is based on the prepaid nature of HMO coverage and the accessibility and availability requirements included in the HMO Act. Primarily, an HMO is defined as "a person who arranges for or provides to enrollees *on a prepaid basis* a health care plan, a limited health care service plan, or a single health care service plan." Texas Insurance Code §843.002 (emphasis added). The HMO Act requires that an HMO's health plan be "an appropriate mechanism through which the health maintenance organization will effectively provide or arrange for the provision of basic health care services . . . on a prepaid basis . . ." Texas Insurance Code §843.082(3). An HMO must therefore enable an enrollee to obtain basic health care services without cost except for stated copayments and deductibles. In addition, the HMO Act requires that the services offered by HMOs must be accessible and available. This is accomplished through the HMO's network of physicians and providers. The proposed amendments simply require that a network that does not meet the accessibility and availability standards of the statutes and regulations must have a backup or access plan that ensures enrollee access to the services for which they have prepaid and that they may do so without incurring additional cost.

To a great extent, the above proposal does not change the requirements of the current rule, which requires access plans to be filed under certain stated circumstances. For example, an HMO with an inadequate number of physicians of a certain specialty to serve the enrolled population would have to file a plan and agree to make these services available to enrollees as if the physicians had been on the HMO's network. The proposal's additional language basically restates the requirements of Article 20A.09(f) that, "If medically necessary covered services are not available through network physicians or providers, the health maintenance organization. . .shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate." The proposal also does not in any way change this statute's reimbursement provisions; an HMO is still free to attempt to contract with additional physicians and providers, or to negotiate a rate that is different from the prevailing rate in that area.

An HMO that has an adequate network and is therefore not required to file an access plan under §11.1607 is nevertheless subject to Article 20A.09(f) and existing §11.506(15). This means that an HMO must indemnify or otherwise hold harmless enrollees receiving covered services from out-of-network providers if the out-of-network services were necessary due to the unavailability of a network provider. If services are not available from network providers, the prepaid nature of HMOs dictates that enrollees receive these services without additional costs. This requirement does not affect services received without authorization from out-of-network providers, which are generally not covered by HMOs.

Proposed Subchapter F (§11.506) also clarifies that an HMO must cover an enrollee's emergency medical care services, whether performed by network or out-of-network physicians and providers, and indemnify or otherwise hold enrollees harmless for the cost of such services. As previously stated, the Insurance Code requires HMOs to provide or arrange for the provision of basic health care services on a prepaid basis. "Basic health care services" are defined in §11.508(a)(1)(J) to include emergency services. Because an HMO must provide emergency services on a prepaid basis, the proposal ensures that the enrollee can access such services without being liable for additional costs.

Proposed §11.1600(b)(11)(D) includes a notice provision which requires HMOs, within the required list of providers, to provide notice regarding payment of non-contracted physicians and providers who provide either emergency care or medically necessary covered services due to the unavailability of a participating physician or provider. The notice, which must inform enrollees that the HMO will indemnify or otherwise hold enrollees harmless for such services, must also be listed on the internet sites of HMOs that maintain such sites.

In addition, while this proposal revises the definition of consumer choice health benefit plans, generally it does not seek to identify provisions that may be exempt from regulation under, or otherwise subject to, Senate Bill 541. The regulations specifically applicable to consumer choice plans are located at Chapter 21, Subchapter AA of this title.

The proposed amendment to §11.1 revises the section's title. Proposed amendments to §11.2(b) add a new definition for clinical director, revise the existing titles of the definitions of consumer choice plan, referral specialists, and state-mandated plan, and revise the text of the existing definitions of agent, consumer choice plan, premium, and state-mandated plan.

Proposed amendments to §11.101 update the contact information for obtaining forms.

The proposed amendments to §§11.202(a), 11.203(a) and 11.204 reduce the number of additional copies required at the time of application for a certificate of authority and for revised filings to expedite review and eliminate filing of unnecessary copies. The proposed amendment to §11.202(f) reflects a requirement for one original application, and deletes an original signature requirement to accommodate electronic filings. The proposed amendment to §11.204(13)(B) and §11.205(a)(7) clarify that the contracts between the HMO and delegated entities and/or delegated networks be provided as part of the application process and that such agreements be available during qualifying examinations. The proposed amendment to §11.204(14) clarifies the required quality improvement plan description.

Proposed §11.204(23) clarifies that the applicant must demonstrate appropriate operational structure and adequate management and staff to operate an HMO and fully comply with all statutory and regulatory requirements applicable to the HMO and any contracting entities. The proposed amendments to §11.205 clarify that referenced documents must be available for review at the HMO's Texas office at time of examination, but may be physically maintained at a different site, add language about qualifications of management and staff, clarify complaints and appeals policies, and set out prescribed categories of complaints to facilitate analysis and provide for uniform categorization. The proposed amendments also clarify and simplify the reference to

health information systems records, clarify the reference to network configuration documents, and consolidate the categories of executed agreements to be available during examination. The proposed amendments to §11.205 also change the requirement that the entire physician or provider contract be made available for review during examination; because of confidentiality concerns, the proposal requires that only the first page and signature page be made available.

Proposed §11.205(a)(14) concerning claims systems is added to determine the HMO's capacity to comply with all applicable statutes and rules addressing claims payment. The proposed amendment to §11.205(a)(16) adds new language requiring the HMO, at the time of the qualifying examination, to demonstrate compliance with applicable laws, including audits or examination reports by other entities, which will provide TDI a more complete picture of the applicant and help the agency to pinpoint any areas requiring particular attention prior to licensing.

To make departmental review and storage of documents more efficient, the proposed amendments to §11.301 add requirements for filings; clarify that consistent with insurance form filing requirements, each form must have a printed unique form number; reduce the number of required form filings; and add the requirement that the HMO include a cover letter with such filings. The proposed amendments to §11.301 also add references to delegated entities and delegated networks and clarify that a filing must include a reconciliation of benefits to schedule of charges form. The proposed amendments to §11.301(5)(G) and §11.303(c)(8)(C) clarify that contracts between the HMO and delegated entities and/or delegated networks are included in the documents that an HMO must file pursuant to Insurance Code Article 20A.18C and 28 TAC §11.2611 for examinations, and subsequent to issuance of the certificate of authority. The proposed amendments to §11.302 clarify that, consistent with §843.080 and §843.078(h), a request for any modification of the service area, including a reduction, must be filed with and approved by the department. The proposed amendments to §11.302 and §11.303 also require the filing of network configuration information. The proposed amendments to §11.303 clarify that: the department may conduct complaint examinations in addition to other types of examinations; quality of care examinations, except those made pursuant to Insurance Code Article 1.15, may take place off-site; examinations may be conducted by examination teams rather than single examiners; and examination teams may conduct interviews of key management in connection with such examinations. Proposed amendments to §11.303 also identify the documents that should be available for review during examinations to include those documents that have been deleted from §11.205(a) as more appropriate for review after issuance of a certificate of authority. The proposed amendments change the timeframe for correcting serious deficiencies from 10 business days to 12 calendar days.

To expedite review and eliminate the filing of unnecessary copies, the department reduced the number of copies of documents an HMO must file relating to an evidence of coverage in proposed §11.502 and §11.503. Proposed §11.503 is changed to correct mail codes and clarify procedures for notifying HMOs of approval or disapproval. Proposed §11.505 clarifies that each form will have a different number, and expands the categories of variable language that can be included in form filings to include optional benefits and optional provisions. This flexibility will increase efficiency in form filings and facilitate greater speed to market. Proposed §11.506 clarifies the statutory directive in Article 20A.09(a)(1) that every enrollee residing in this state is entitled to an evidence of coverage, implements House Bill 1798 and House Bill 1800 (78th Legislature), which permit an HMO to deliver plan evidences of coverage electronically, and removes the reference to "standard language" because TDI reviews all forms for compliance. The proposed amendments to that section also change certain provisions relating to the cancellation of an enrollee in a group by clarifying that cancellation cannot be based on health status related factors, consistent with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191.

The proposed amendment to §11.506(2)(A) deletes the word "nominal" as an inaccurate description of a 50% copayment. Proposed §11.506(3)(A) is changed to conform to Insurance Code Articles 26.23, 26.86 and HIPAA. Proposed §11.506(3)(B) deletes the 60-day timeframe for prior notice to the group because there are no circumstances under which the 60-day notice would apply. Proposed §11.506(6)(C) clarifies that conversion coverage is an option; the continuation provision is mandatory. Proposed §11.506(9)(E) conforms to Insurance Code Article 20A.09H (to Children and Grandchildren), which refers to "enrollee." Proposed §11.506(10)(D)(i) and (ii) clarify that an HMO must cover enrollees' emergency medical care services, whether performed by network or out-of-network providers, and indemnify or hold enrollees harmless for the cost of such services. Proposed §11.506(16) implements House Bill 508 (78th Legislature) by increasing from 30 to 60 the number of days prior notice an HMO is required to give regarding a group plan premium rate increase. Proposed §11.506(19) increases the age for dependent coverage for a child from 21 to 25 years as required by House Bill 1446 (78th Legislature). Throughout proposed §11.506(23) the reference to an enrollee's choice of an obstetrician is changed from "designated" to "selected." Revised §11.506(25) references Article 21.52J rather than listing its requirements.

Proposed amendments to §11.901(a)(1) add provisions from Subchapter L, §11.1102, which is proposed for repeal elsewhere in this issue of the *Texas Register*, and contain the language in Insurance Code §843.361 that requires enrollees to be held harmless by a physician or provider for payment of the cost of covered health services if the HMO does not pay the physician or provider for those services. Proposed amendments to §11.901(a)(4) clarify that written notice to enrollees of termination of their physician or provider is governed by Insurance Code §843.308 and §843.309 and the proposed amendments to §11.901(5) clarify that written notice of termination to a physician or provider is governed by §843.306 and §843.307. Proposed amendments in §11.901(a)(5)(B) and (C) change the time allowed for a physician or provider to request an appeal of the termination from 60 days to 30 days from the notice of termination. This change will give the review panel enough time to review the termination within the 60 days mandated by Insurance Code §843.306(b). Proposed amendments to §11.901(a)(5)(C) require the review panel to review the physician or provider's termination within 60 days of the physician or provider's request for review.

Proposed amendments to §11.901(a)(12) add new language required by Senate Bill 781 (76th Legislature), as it amended Insurance Code Article 20A.18A (now §843.311(3)) relating to podiatrists. Proposed amendments to §11.901(a)(13) add language from Senate Bill 418 (78th Legislature), which added Insurance Code Article 21.52Z, §2 relating to electronic health care transactions. Proposed amendments to §11.902(a) add language from House Bill 606 (77th Legislature) that added new §18D to

Insurance Code Article 20A (now §843.320) relating to hospitalists. Proposed amendments to §11.902(b) and (c) add language from House Bill 803 (77th Legislature) that added subsection (o) to Insurance Code Article 20A.14 (now §843.3045) relating to nurse first assistants. Proposed amendments to §11.902(d) add language from House Bill 1163 (78th Legislature) that added Insurance Code §843.319 (Certain Required Contracts) relating to podiatrists. Proposed §11.902(e) adds language that implements Insurance Code §843.312 relating to physician assistants and advance practice nurses. Where appropriate, the proposed amendments refer to the statute rather than restating particular statutory requirements.

Proposed amendments to §11.1001 update the contact information for obtaining forms and update form numbers.

The proposed amendment to §11.1302(a)(1) clarifies that leaving the HMO, rather than leaving a particular plan within the HMO, triggers termination of appointment to the SSC. The proposed amendment to §11.1302(b) clarifies what constitutes a quorum. It also clarifies the circumstances requiring a majority vote of the total committee membership. The proposed amendment to §11.1302(c) changes the maximum interval between SSC meetings by providing for a regular annual meeting, rather than quarterly, as presently required, to provide greater scheduling flexibility. The proposed amendments to §11.1302(d) harmonize the subsection with the Open Meetings Act, remove the provision allowing meetings by telephone conference call, incorporate provisions concerning emergency meetings, and add a provision permitting a majority of members to call a special meeting to allow members other than the chairman to call such a meeting. The proposed amendment to §11.1302(e) adds the Open Meetings Act reference for notice requirements. The proposed amendment to §11.1302(f) makes clear that SSC meetings are generally open, and adds language setting out circumstances under which a closed meeting may be held. The proposed amendment to §11.1304(a) clarifies that the written record of SSC proceedings is subject to pertinent confidentiality laws.

The proposed amendment to §11.1403 updates the toll-free telephone number and updates the agency organizational reference. The proposed amendment to §11.1404(a) reflects present inapplicability of Article 21.52B provisions to the subsection, based on a Fifth Circuit opinion which rendered the article unenforceable.

The proposed amendments to §11.1500 incorporate in substance the federal standards for the term "similarly situated."

The proposed amendments to §11.1600(a) and (b) implement House Bill 1800 (78th Legislature), which allows HMOs to provide plan descriptions electronically to enrollees and contract holders. Proposed amendments to this section also consolidate notice requirements regarding current and prospective female enrollees' choice of obstetricians-gynecologists (OB-GYN) and clarify that female enrollees may select an OB-GYN without the requirement for formal designation. They also remove unnecessarily restrictive requirements for the provider directory that are not required by statute. Proposed §11.1600(b)(11)(D) adds the requirement that the HMO provide notice regarding the payment of noncontracted physicians and providers that perform either emergency services or medically necessary covered services due to the unavailability of a participating physician or provider. The proposed amendment to §11.1600(c) clarifies that HMOs are prohibited from making untrue or misleading statements to either current or prospective enrollees. The proposed amendment to §11.1600(d) clarifies that an HMO may use its handbook to satisfy the plan description requirements if it discloses information adequately and in accordance with §11.1600. The proposed amendment to §11.1600(e) requires the plan description to include a disclosure that the enrollee may receive care from a physician other than a primary care physician while in an inpatient facility. While this disclosure is already required in the Evidence of Coverage under §11.506(26), to ensure awareness of this critical provision, the department has added this requirement to the plan description. Proposed §11.1600(f) implements Senate Bill 494 (78th Legislature), which requires HMOs with an internet site to maintain a list of physicians and providers and to provide the same information that is required in a paper directory.

Proposed §11.1601(b) implements Senate Bill 418 (78th Legislature) regarding identification cards that must comply with §21.2820. Proposed §11.1601(c) implements Insurance Code Article 21.53L regarding standards for prescription drug identification cards. Proposed §11.1600(d) implements Senate Bill 473 (78th Legislature), which restricts the use of social security numbers on identification cards. Proposed §11.1605(b), (c), (d) and (e) consolidates all pharmacy services requirements and implements House Bill 2382 (77th Legislature) enacting Insurance Code Article 21.52L, which relates to health benefit plan coverage for prescription contraceptive drugs and devices.

Proposed amendments to §11.1606(b) and (c), concerning HMO chief executive officer, operations officer and clinical director (presently "medical director"), change the emphasis from full-time status and residence in the service area to detailed functional and practical requirements of the positions. The proposed amendments to §11.1607 consolidate accessibility and availability requirements from Subchapter U, §§11.2001 et seq. The remaining provisions of Subchapter U, which is proposed for repeal elsewhere in this issue of the *Texas Register*, are being moved to other sections of this rule, and some were changed to comply with certain national and industry standards. Proposed subsections (a) - (h) of §11.1607, concerning accessibility and availability requirements, add standards for availability of medical care consistent with national industry standards. Proposed §11.1607(g) specifies availability requirements for urgent behavioral health care, and consistent with the most recent National Committee on Quality Assurance (NCQA) and industry standards, changes the requirement to 48 hours, rather than 24, from time of request. For the same reason, the requirements for availability of routine behavioral health care were changed from three weeks to two weeks. Also consistent with industry standards, the requirements for availability of routine dental care were changed from three weeks to eight weeks, and the availability of preventive dental health services was changed from two or three months to four months. Proposed §11.1607(h) clarifies that an HMO must have a network that encompasses the entire service area and that access radii are to be measured from current enrollees to providers, not from providers to the boundaries of the service area. This is to clarify the expectation that an HMO have a network that encompasses its entire service area, not just the current enrollee population or area in which the plan is marketing.

Proposed §11.1607(i) clarifies that HMOs must not allow balance billing when non-participating providers provide services to enrollees due to unavailability of network services. Proposed §11.1607(j) clarifies that certain health care services, such as transplants or treatment for cancer, burns, or cardiac disease

may be provided outside the service area; however, an HMO may not require an enrollee to travel outside of the service area to receive such services unless the HMO provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options. Section 11.1608 is proposed for repeal elsewhere in this issue of the *Texas Register* because similar OB-GYN notice requirements are included in §11.1600(b)(11).

Current §11.1801(c) is proposed for deletion as it is fully executed. Proposed amendments to §11.1802 prescribe a more comprehensive method for assessing the minimum capital or net worth requirements of a Medicaid MCO and refer to amounts established by statute for required minimum capital and surplus, rather than stating specific amounts in the rule. Obsolete language that was superseded by §11.809 is proposed to be deleted from §11.1802(a)(2) and replaced by RBC requirements as the method, developed in coordination with the NAIC, for assessing capital adequacy. The proposed method would be phased in over three years. The proposed amendment to §11.1803(b) clarifies that the deposit is used to protect the interests of the enrollees.

Proposed §11.1804 allows a reduction in the special statutory deposit required for MCOs taking into account certain guarantees from sponsoring organizations. The proposal clarifies that the reduction relates only to the amount of the statutory deposit held under §11.1803 and does not relate to other requirements or unrelated non-Medicaid business. Proposed §11.1806(a) removes the automatic requirement for filing certain financial information with TDI and instead requires the information be filed only upon the department's request. Proposed §11.1806(b) clarifies that, concurrently with filing a Medicaid participation request with HHSC, Medicaid MCO candidates must file with TDI the financial projections related to that request; it also deletes the term "RFA" because it is not commonly used. Proposed §11.1806(c) clarifies that an MCO must notify TDI of any financial or statistical reports filed with other state agencies, but is not required to file such reports with TDI except upon TDI's request.

The proposed amendments to the titles of §11.1901 and §11.1902 clarify that the sections apply to both basic and limited service HMOs. The proposed amendment to §11.1901(c)(1)(B) clarifies that the committee is responsible for reporting to the quality improvement committee (QIC), which in turn is responsible for reporting to the governing body. Proposed amendments throughout §11.1902 are intended to accomplish the following: (1) implement Insurance Code Article 21.58D, as amended by House Bill 1095 (78th Legislature), relating to standardized forms for verification of certain credentials including those for advanced practice nurses and physician assistants; (2) fully update credentialing requirements to comply with NCQA standards as required by Insurance Code Article 20A.39; and (3) add requirements relating to initial credentialing site visits and tracking the opening of new offices to comply with NCQA requirements applicable to all primary care physicians and individual primary care providers. Although the NCQA standards do not specifically address primary care dentists, the department has applied those standards, pursuant to the direction of Article 20A.39, to dentists to ensure consistent quality in all areas of health care.

The proposed amendments to §11.1902(2) more accurately state criteria the work plan must meet. The proposed amendments to §11.1902(2)(B) expand updating intervals for those clinical guidelines that change more or less frequently, allow practicing physicians and providers to have input into clinical practice guidelines, and in accord with NCQA requirements, delete the requirement that practice guidelines be communicated to providers in a particular way. The proposed amendment to §11.1902(2)(B)(vi) clarifies that these provisions apply to individual providers rather than to hospitals. The proposed amendment to §11.1902(2)(B) adds clauses (xi) - (xiii) to include program areas that are essential to any quality improvement (QI) work plan. The proposed amendments to §11.1902(4)(B) add a reference to the provider directory to indicate which physicians and providers must be credentialed, and clarify that hospital-based physicians and providers, if they are not listed in the provider directory, and opticians, would not be required to be credentialed by the HMO. Proposed §11.1902(4)(B)(ii) is necessary to comply with NCQA standards concerning physician and practitioner rights. Proposed §11.1902(4)(B) requires appropriate, timely notice to applicants concerning credentialing and recredentialing to comply with NCQA standards and adds a specific timetable associated with NCQA-required monitoring of certain sanctions. The proposed amendment to §11.1902(4)(B)(viii) provides additional discrimination prohibitions to be included in HMO credentialing and recredentialing procedures to ensure compliance with NCQA requirements and other applicable law. The proposed amendment to §11.1902(4)(C)(iv) clarifies that site visits apply only to individual providers, and more clearly states that the HMO may conduct a single visit to accomplish on-site visit requirements for multiple providers. Proposed §11.1902(4)(D) provides that the items to be gathered at the time of recredentialing and the recredentialing timeframes are the same as for an original credentialing. The proposed amendment to §11.1902(4)(F) deletes reference to clause (v) because site visits for evaluation are no longer required at the time of recredentialing. Proposed §11.1902(7) restates the provisions for the delegation of credentialing functions from existing §11.1902(4)(B)(vi).

Proposed §11.2207 is adapted from revised Subchapter T to add specific quality improvement requirements for single service HMOs and to formalize consistent department practice to require single service HMOs to have a QI program, consistent with what is required in Subchapter T. In addition, the proposed amendments incorporate the single health care services availability and accessibility requirements from Subchapter U, §11.2006, so that all requirements relating to single service HMOs are contained in one subchapter.

Proposed amendments to §11.2314 add the words "opportunity for" to clarify that under §843.461(a)(1) only notice and an opportunity for a hearing must be available before the commissioner may suspend or revoke a certificate of authority.

Proposed §11.2406 specifies the statutory and regulatory standards for a limited service HMO providing long-term care services and benefits.

Proposed amendments to the subchapters, including Subchapters G, I, R, Z and AA, make editorial or grammatical changes for ease of reading or for clarity; update references to statutory authority; change specific references to more general references to avoid constant updating and revisions; add consistent abbreviations; eliminate redundant or unnecessary wording; and reflect accurate terminology.

Kim Stokes, Senior Associate Commissioner for Life, Health and Licensing, has determined that for each year of the first five years the amendments and new sections as proposed will be in effect, there will be no fiscal implications for state or local government as a result of enforcing and administering the amended and new

sections. The proposal will have no anticipated effect on local employment or local economy.

Ms. Stokes has determined that for each year of the first five years the amendments and new sections are in effect, the public benefits anticipated as a result of the proposed amendments and new sections will be a clearer, more efficient, and more standardized process for regulating HMOs, which results in ease of operations and processes for both the industry and enrollees.

Except as provided below, any cost to persons required to comply with the amendments and new sections for each year of the first five years the proposed amendments and new sections will be in effect is the result of statutory requirements and not the result of the adoption, enforcement, or administration of the sections.

The proposal concerning the requirements for network configuration maps will ensure accessibility and availability of services. Sections 11.204(18), 11.205(a)(6), 11.302(b)(1), and 11.303(c)(7) require the filing of maps demonstrating the location and distribution of the physician and provider network in order to obtain a certificate of authority, for service area modification requests, and for examinations. While the existing rule requires the filing of information concerning the service area and certain maps, the rule does not specifically require these particular types of maps. Nonetheless, many HMOs currently submit the required information in this format and for those HMOs, this requirement will not require any additional costs. For those that have not submitted this information previously, the anticipated costs for compliance with this requirement will vary depending on a number of factors. Because the rule has for some time required HMOs to provide service area maps for other purposes, most HMOs should already have the software necessary to generate them, or the ability to obtain them. Consequently, the cost for the proposed requirement should relate primarily to the time it takes a programmer to modify a carrier's existing software to enable it to provide this information. Some commercially available computer mapping programs already include this capability, thus HMOs using these programs would not incur additional cost. Should an HMO choose to perform programming to achieve this goal, the cost will vary depending on whether a carrier employs its own programmers or contracts with independent programmers. According to 2003 data from the U.S. Bureau of Labor Statistics Occupational Employment Statistics Survey, as reported by the Texas Workforce Commission (TWC), the mean hourly rate for a computer programmer in the insurance business is $31.89, and an HMO representative has estimated the rate at $30 per hour. The amount of time necessary to implement system changes will vary greatly depending on the number of hours it will take to program the software, and the HMOs the department surveyed already own commercially available software that includes this capability. The rule does not require computer-generated maps, however, and thus whether an HMO provides maps in this format is its option. An HMO may comply with the proposed requirements with manually-produced maps, so long as they contain the requisite information. The department estimates the cost of materials necessary to provide manually-produced maps at less than $50. While the production of such maps will require some staff time, the proposed requirement is in lieu of the existing rule's narrative description, so the cost saving from the elimination of this requirement should offset the cost of manually producing a map.

To facilitate review of the information and provide for uniform categorization, the proposed amendments to Subchapter C, §11.205(a)(4) and Subchapter D, §11.303(c)(4) expand the categories of complaints that the HMO must have available for review upon examination from four to ten. These amendments will facilitate review of complaints during examinations and allow TDI and the industry to more specifically monitor problems and concerns in the face of marketplace changes that could impact enrollees. This may result in additional costs relating to reprogramming complaint categorization. HMO representatives who maintain a local database for logging complaints have estimated that it would take a programmer 30 to 40 hours to implement the necessary changes, at an estimated cost of $30 per hour. A representative of a large HMO that maintains a national database estimates that it would take a programmer 12 months at 173 hours per month to implement the necessary changes. As set forth above, the mean hourly rate for a computer programmer in the insurance business is $31.89. For HMOs that categorize complaints manually, the only additional costs would be related to the personnel time required to re-categorize existing complaint categories. The amount of time involved will depend upon the complexity of the individual HMO's complaint processing. The cost to the HMO will vary depending upon the types of individual uitilized to oversee this process. The department estimates that the labor costs will average $38.91 per hour of labor. This cost is based upon the 2003 Occupational Wage Data collected by the TWC. The figure represents the average cost, per hour, for an administrative services manager to review existing systems and implement the changes.

The proposal includes a number of changes that will increase the options an HMO may exercise regarding its filings. To eliminate common problems related to form filings, proposed changes to §11.301 contain certain format requirements for filings, including requirements relating to paper size, that the filing not be bound, appearance of type, and inclusion of a printed unique form number and cover page. These requirements reflect changes in technology and will facilitate document storage, and increase efficiency of the department and HMOs. This efficiency will increase effective communication with industry and provide higher quality services to consumers, including enrollees. Legibility and printed text requirements will eliminate the source of past delays resulting from questions regarding handwritten text or numbers. Some HMOs may incur slight costs related to these requirements. For example, an HMO using other than letter sized (8 1/2 by 11 inches) paper for its filings may incur some costs related to its existing stock of other-sized paper, should the HMO be unable to find another use for that paper. The cost to the HMO will depend on the size of its obsolete paper stock. The department estimates the cost of such paper to be approximately $5 per ream. The proposal should offset any additional costs, however, due to the fact that, for all but certain specified filings, the department has reduced the number of copies to be filed from four to three. Proposed §11.505(f) expands an HMO's capability to vary language regarding optional provisions and optional benefits in a filing, which should reduce the number of filings an HMO will need to make and thus reduce costs.

Section 11.1600(e) requires that if an HMO or limited provider network provides for enrollee care by physicians other then the enrollee's primary care physician while the enrollee is in an inpatient facility, the plan description must disclose that fact. A similar disclosure is already required in the evidence of coverage; however, to ensure that all enrollees are informed,

the proposal requires that HMOs include the disclosure in the plan description. The proposal also clarifies an HMO's responsibilities with respect to payment of out-of-network providers in certain circumstances. While this merely clarifies existing law, the notice provisions will enhance the common understanding of these requirements. The proposal includes a new requirement in §11.1600(b)(11)(D) that the list of providers included in the plan description must also include a statement that enrollees must be indemnified or otherwise held harmless when out-of-network providers provide services due to the unavailability of network providers in certain circumstances. In order to comply, HMOs will be required to include these disclosures in all new plan descriptions and must print a plan description addendum and deliver the addendum to all current enrollees.

For plan descriptions given to new enrollees, adding the disclosures to the plan description will not result in additional cost if delivered electronically. For newly-printed disclosures, the HMO should not incur additional cost if the disclosures will fit on an existing page of the plan description. If the HMO needs to print the disclosures and they do not fit on an existing page, the HMO will be subject to the cost of one additional printed sheet of paper, which the department estimates will cost between one and four cents. If an HMO needs to distribute a printed addendum to existing enrollees, it will incur the cost of paper plus the cost of delivery to all existing enrollees, which should not exceed 40 cents per enrollee. The costs associated with delivery of the addendum may include postage or expenses related to facsimile or other electronic transmission. The department allows alternative means of delivery, such as facsimile or other electronic transmission, to reduce the cost of producing and delivering the document. To further reduce costs, an HMO may mail the printed addendum to enrollees along with other materials. The total cost to an HMO will depend on the number of disclosures it needs to print and distribute, and the method it uses for distribution.

The public benefit anticipated as a result of the proposals concerning solvency standards will be greater protection to the public through a more comprehensive method of assessing minimum capital requirements for MCOs that provide health care services to Medicaid beneficiaries under contracts with HHSC. There is no cost of compliance with the proposed section for MCOs that choose not to pursue a contract with the HHSC. Those MCOs that enter a contract with the HHSC will need to comply with these sections including compliance with new RBC requirements. Requiring this minimum level of RBC is intended to ensure that MCOs do not contract with the state while operating in a potentially hazardous or insolvent financial condition. The department notes that two MCOs have recently been placed into receivership in Texas; these failures resulted in disruptions in the provision of health care to enrollees and unpaid bills owed to health care providers. An MCO that does not have total adjusted capital equal to or greater than the RBC will have the options of increasing its net worth to comply with the section, or reduce the risks inherent in its operations. If an MCO elects to increase its capital to the amount required by the proposed section, the cost will be phased in over three years, with most of the costs incurred in 2007. The department notes that the proposed final phased-in requirement remains below the "company action level" RBC at which the company should be acting independently to increase its capital.

The proposed changes incorporating standards from the NCQA will provide greater efficiency and standardization for HMOs to comply with the rules, especially those that are required to comply with standards in multiple states. In turn, providers that contract with HMOs will be subject to a uniform and nationally recognized credentialing process and access parameters. The provisions also allow an enrollee more immediate access to routine behavioral health care. Section 11.1607 requires that routine behavioral health care be made available within two weeks of an enrollee's request for such care. Two-week availability for behavioral health care is an NCQA standard, as well as a general industry standard. Accordingly, HMOs will probably already have a sufficient number of providers to meet this new standard. Should an HMO not have a sufficient number of providers in the network to comply with this standard, the HMO will incur additional expenses related to recruiting, credentialing and contracting with new providers. Individual HMOs have provided the following estimates with regard to cost: $160.00 - $175.00; $250.00; $1100.00; and $1,922.00 per additional provider.

The proposed amendments to §11.1902(4)(C)(iv) and §11.2207(d)(4) are expected to result in a cost related to the requirement for initial site visits at new offices opened by primary care dentists. Article 20A.39 requires that departmental rules related to credentialing comply with NCQA standards and specifically requires an HMO, during an initial site visit, to evaluate a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures. While NCQA standards do not specifically address credentialing of dentists, the department believes the NCQA standards are appropriate to the practice of dentistry and their application will provide a consistent standard of quality in health care services. The department believes that these proposed sections are necessary to fulfill the statutory mandate to assure quality; thus any costs resulting from these provisions are the result of that mandate and not the rules. Nevertheless, the department obtained information about costs from several carriers. Based on this information, the cost for single-service dental HMOs to conduct a site visit when a contracted general dentist opens a new practice location would range from $45.00 to $124.00 per visit, depending upon whether an outside vendor or the HMO's in-house staff conducts the site visit. The number of new general dental practice location openings which would necessitate a site visit ranges from 4 - 22 per year.

Ms. Stokes has determined that the costs of compliance with those parts of the proposal that are not mandated by statute would be the same for HMOs that are large, small or micro-businesses. However, to the extent that the rule allows HMOs the flexibility to use different means to meet the rules' requirement, small or micro-businesses can take advantage of the most cost-efficient methods. For example, an HMO can choose whether to purchase computer mapping software, or can use a hand-drawn map. HMOs of every size also use varying means of obtaining information from dental providers who open new offices, i.e., by contract amendment, notice that may be mailed with other notices, or by other means. The department has solicited input from HMOs as to the appropriate compliance date for the proposed requirement for complaint categorization. It would be neither legal nor feasible to waive the rules' requirements for HMOs that are small or micro-businesses, as doing so would be contrary to standardizations contained in the proposal and could result in different efficiencies for HMOs and their enrollees.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 13, 2004, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code

113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted Kim Stokes, Senior Associate Commissioner for the Life, Health and Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The department will consider the adoption of the proposed amendments and new sections in a public hearing under Docket Number 2606, scheduled for 9:30 a.m., on December 9, 2004, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §11.1, §11.2

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.1. Purpose [~~and Scope~~].

This chapter implements the Texas Health Maintenance Organization Act, [~~Senate Bill 180, enacted by Acts, 1975, 64th Legislature, Chapter 214, Pages 514-530, first effective December 1, 1975, as amended, codified as the~~] Texas Insurance Code, Chapters [~~Chapter~~] 20A and 843.

(1) - (2) (No change.)

(3) Violation of rules. A violation of the lawful rules[~~, regulations,~~] or orders of the commissioner made pursuant to this chapter constitutes a violation of the Texas Health Maintenance Organization Act.

§11.2. Definitions.

(a) The definitions found in the Texas Health Maintenance Organization Act, Texas Insurance Code §843.002, are [~~hereby~~] incorporated into this chapter.

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

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

(5) Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued under Insurance Code Chapter 21 [~~As defined in the Insurance Code Article 21.07-1, §1(b), unless the context of the rule clearly indicates applicability to any agents licensed under one specific article~~].

(6) - (9) (No change.)

(10) Clinical director--A health professional who meets the following criteria:

(A) is appropriately licensed;

(B) is an employee of, or party to a contract with, a health maintenance organization; and

(C) is responsible for clinical oversight of the utilization review program, the credentialing of professional staff, and quality improvement functions.

(11) [~~(10)~~] Code--The Texas Insurance Code.

(12) [~~(11)~~] Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Article 3.80 or Article 20A.09N. [~~offered by an HMO, as described in Subchapter AA of Chapter 21 of this title (relating to Consumer Choice Health Benefit Plans);~~]

(13) [~~(12)~~] Contract holder--An individual, association, employer, trust or organization to which an individual or group contract for health care services has been issued.

(14) [~~(13)~~] Control--As defined in [~~the~~] Insurance Code §§823.005 and 823.151.

(15) [~~(14)~~] Controlled HMO--An HMO controlled directly or indirectly by a holding company.

(16) [~~(15)~~] Controlled person--Any person, other than an HMO, who is controlled directly or indirectly by a holding company.

(17) [~~(16)~~] Copayment--A charge in addition to premium to an enrollee for a service which is not fully prepaid.

(18) [~~(17)~~] Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

(19) [~~(18)~~] Dentist--An individual provider licensed to practice dentistry by the Texas State Board of Dental Examiners.

(20) [~~(19)~~] General hospital--A licensed establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

(21) [~~(20)~~] HMO--A health maintenance organization as defined in Insurance Code §843.002(14).

(22) [~~(21)~~] Health status related factor--Any of the following in relation to an individual:

(A) health status;

(B) medical condition (including both physical and mental illnesses);

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability (including conditions arising out of acts of domestic violence, including family violence as defined by [~~the~~] Insurance Code Article 21.21-5); or

(H) disability.

(23) [~~(22)~~] Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. Includes, but is not limited to, licensed doctor of chiropractic, dentist, registered nurse, advanced practice nurse, physician assistant, pharmacist, optometrist, registered optician, and acupuncturist.

(24) [~~(23)~~] Institutional provider--A provider that is not an individual. Includes any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage which may be provided by the HMO. Includes but is not limited to:

(A) General hospitals,

(B) Psychiatric hospitals,

(C) Special hospitals,

(D) Nursing homes,

(E) Skilled nursing facilities,

(F) Home health agencies,

(G) Rehabilitation facilities,

(H) Dialysis centers,

(I) Free-standing surgical centers,

(J) Diagnostic imaging centers,

(K) Laboratories,

(L) Hospice facilities,

(M) Infusion services centers,

(N) Residential treatment centers,

(O) Community mental health centers,

(P) Urgent care centers, and

(Q) Pharmacies.

(25) [~~(24)~~] Limited provider network--A subnetwork within an HMO delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations and/or physician groups which limit the enrollees' access to only the physicians and providers in the subnetwork.

(26) [~~(25)~~] Limited service HMO--An HMO which has been issued a certificate of authority to issue a limited health care service plan as defined in [~~the~~] Insurance Code §843.002.

(27) [~~(26)~~] NAIC--National Association of Insurance Commissioners.

(28) [~~(27)~~] Out of area benefits--Benefits that the HMO covers when its enrollees are outside the geographical limits of the HMO service area.

(29) [~~(28)~~] Pathology services--Services provided by a licensed laboratory which has the capability of evaluating tissue specimens for diagnoses in histopathology, oral pathology, or cytology.

(30) [~~(29)~~] Pharmaceutical services--Services, including dispensing prescription drugs, under the Pharmacy Act, Occupations Code, Subtitle J [~~Chapter 551~~], that are ordinarily and customarily rendered by a pharmacy or pharmacist.

(31) [~~(30)~~] Pharmacist--An individual provider licensed to practice pharmacy under the Pharmacy Act, Occupations Code, Subtitle J [~~Chapter 551~~].

(32) [~~(31)~~] Pharmacy--A facility licensed under the Pharmacy Act, Occupations Code, Subtitle J [~~Chapter 551~~].

(33) [~~(32)~~] Premium--All amounts payable by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer carrier, including any fees or other contributions associated with a health benefit plan [~~The prospectively determined rate that is paid by or on behalf of an enrollee for specified health services~~].

(34) [~~(33)~~] Primary care physician or primary care provider--A physician or individual provider who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(35) [~~(34)~~] Primary HMO--An HMO that contracts directly with, and issues an evidence of coverage to, individuals or organizations to arrange for or provide a basic, limited, or single health care service plan to enrollees on a prepaid basis.

(36) [~~(35)~~] Provider HMO--An HMO that contracts directly with a primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within the primary HMO's defined service area.

(37) [~~(36)~~] Psychiatric hospital--A licensed hospital which offers inpatient services, including treatment, facilities and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment and diagnostic services and psychiatric inpatient care and treatment for mental illness. Such services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults and/or children.

(38) [~~(37)~~] Qualified HMO--An HMO which has been federally approved under Title XIII of the Public Health Service Act, Public Law 93-222, as amended.

(39) [~~(38)~~] Quality improvement (QI)--A system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

(40) [~~(39)~~] RBC--Risk-based capital.

(41) [~~(40)~~] RBC formula--NAIC risk-based capital formula.

(42) [~~(41)~~] RBC Report--Health Risk-Based Capital Report including Overview and Instructions for Companies published by the NAIC and adopted by reference in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank).

(43) [~~(42)~~] Recredentialing--The periodic process by which:

(A) qualifications of physicians and providers are reassessed;

(B) performance indicators, including utilization and quality indicators, are evaluated; and

(C) continued eligibility to provide services is determined.

(44) [~~(43)~~] Reference laboratory--A licensed laboratory that accepts specimens for testing from outside sources and depends on referrals from other laboratories or entities. HMOs may contract with a reference laboratory to provide clinical diagnostic services to their enrollees.

(45) [~~(44)~~] Reference laboratory specimen procurement services--The operation utilized by the reference laboratory to pick up the lab specimens from the client offices or referring labs, etc. for delivery to the reference laboratory for testing and reporting.

[~~(45) Referral specialists (other than primary care)--Physicians or individual providers who set themselves apart from the primary care physician or primary care provider through specialized training and education in a health care discipline.~~]

(46) - (49) (No change.)

(50) Specialists--Physicians or individual providers who set themselves apart from the primary care physician or primary care provider through specialized training and education in a health care discipline.

(51) [~~(50)~~] State-mandated health benefit plan--As defined in §21.3502 of this title (relating to Definitions) [~~A health plan offered by an HMO, that contains coverage for all state-mandated benefits, including those as described in §§21.3515-21.3518 of this title (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Group HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO Plans) and offers basic health care services without limitation as to time and cost~~].

(52) [~~(51)~~] Statutory surplus--Admitted assets minus accrued uncovered liabilities.

(53) [~~(52)~~] Subscriber--If conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO; or if group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

(54) [~~(53)~~] Subsidiary--An affiliate controlled by a specified person directly or indirectly through one or more intermediaries.

(55) [~~(54)~~] Telehealth service--As defined in Section 57.042, Utilities Code.

(56) [~~(55)~~] Telemedicine medical service--As defined in Section 57.042, Utilities Code.

(57) [~~(56)~~] Total adjusted capital--An HMO's statutory capital and surplus/total net worth as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed pursuant to the Insurance Code, and such other items, if any, as the RBC instructions provide.

(58) [~~(57)~~] Urgent care--Health care services provided in a situation other than an emergency which are typically provided in a

setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

(59) [~~(58)~~] Utilization review--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(60) [~~(59)~~] Voting security--As defined in [~~the~~] Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406513
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER B. NAME APPLICATION PROCEDURE

28 TAC §11.101

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code,

§§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.101. How To Obtain Forms.

The name application form and all other HMO forms may be obtained by contacting the Company Licensing and Registration [~~Insurer Services~~] Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406514
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

28 TAC §§11.201 - 11.206

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.201. Filing Fee.

The filing fee required by [~~the~~] Insurance Code §843.154 [~~Article 20A.32(a)~~], as determined by §7.1301 of this title (relating to Regulatory Fees), must accompany the application. The fee is non-refundable.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) An original [~~and four complete copies~~] of the application must be submitted in one or more three-ring binders, so that pages may be easily replaced when necessary.

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

(f) The original [~~copy of the~~] application becomes the charter file[~~; therefore, all signatures on required forms in the original copy must be originals, not photocopies~~].

(g) - (h) (No change.)

§11.203. Revisions during Review Process.

(a) Revisions during the review of the application must be addressed to: Company Licensing and Registration [~~Insurer Services~~] Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The applicant must include an original [~~and four copies~~] of the transmittal letter, plus the original [~~and four copies~~] of any revision specified in this subchapter.

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

(d) Staff shall conduct qualifying examinations and notify the applicant of the need for revisions necessary to meet the requirements of the Act or this chapter. If the applicant does not make the necessary revisions, the department shall deny the application. [~~If, after the department's qualifying examinations, the department staff notifies the applicant of the need for revisions as a result of the examination, that application does not meet the requirements of the Act or this chapter and will have to be denied, absent corrections.~~] If the time required for the revisions will exceed the time limits set out in §1.809 of this title (relating to HMO Certificate of Authority), the applicant must request additional time within which to make the revisions. The applicant must specifically set out the length of time requested, which may not exceed 90 days. The commissioner may grant or deny the request for an extension of time at his or her discretion under §1.809 of this title. Additional extensions may be requested. The request for any additional extension must set out the need for the additional time, in writing, in sufficient detail for the commissioner to determine if good cause for the extension exists. The commissioner may grant or deny any additional request for an extension of time at his or her discretion.

§11.204. Contents.

Contents of the application must include the [~~following~~] items in the order listed in this section. The applicant must submit two additional copies of the application along with the original application. [~~:~~]

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

(4) the bylaws, rules [~~and regulations~~], or any similar document regulating the conduct of the internal affairs of the applicant;

(5) - (6) (No change.)

(7) fidelity bond or deposit for officers and employees, which must comply with either subparagraph (A) or (B) of this paragraph, as appropriate.

(A) A bond must be in compliance with [~~the~~] Insurance Code §843.402 [~~Article 20A.30~~], and must be either the original bond or a copy of the bond. The bonds shall not contain a deductible.

(B) A cash deposit must be held by the Comptroller of the State of Texas in the same amount and subject to the same conditions as a bond.

(8) information related to out-of-state licensure and service of legal process for all applicants must be submitted by using the attorney for service form.

(A) An applicant licensed as an HMO in another state must furnish a copy of the certificate of authority from the domiciliary state's licensing authority, and a power of attorney executed by the applicant appointing an agent for service, other than the commissioner as the attorney of such applicant in and for the state, upon whom all lawful processes in any legal action or proceedings against the HMO on a cause of action arising in this state may be served.

(B) All applicants must furnish a statement acknowledging that all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this state is valid if served in accordance with [~~the~~] Insurance Code Chapter 804 [~~Article 1.36~~].

(9) - (12) (No change.)

(13) [~~a copy of~~] the form of any contract or monitoring plan between the applicant and:

(A) any person listed on the officers and directors page;

(B) any physician, medical group, [~~or~~] association of physicians, delegated entity, as described in Insurance Code Article 20A.18C, delegated network, as described in Insurance Code Article 20A.18D, or any other provider, plus [~~a copy of~~] the form of any subcontract between such entities and [~~the medical group, physicians' association, any physician, or provider, who has contracted with~~] any physician, medical group, association of physicians, or any other provider to provide health care services. All contracts shall include a hold-harmless provision, as specified in §11.901(a)(1) [~~§11.1102~~] of this title (relating to Required Provisions [~~Hold-Harmless Clause~~]). Such clause shall be no less favorable to enrollees than that outlined in §11.901(a)(1) [~~§11.1102~~] of this title.

(C) any exclusive agent or agency;

(D) any person who will perform management, marketing, administrative, data processing services, or claims processing services. A bond or deposit meeting the requirements of [~~the~~] Insurance Code §843.105 [~~Article 20A.18~~], is required for management contracts. If submitting a bond, the original or a copy shall be submitted. The bond shall not include a deductible;

(E) - (F) (No change.)

(14) a description of the quality improvement [~~assurance~~] program that includes a process for medical [~~, including a~~] peer review [~~program~~] required by [~~the~~] Insurance Code §843.082[~~, Article 20A.05~~]. Arrangements for sharing pertinent medical records between physicians and/or providers contracting or subcontracting pursuant to paragraph (13)(B) of this section with the HMO and assuring the record's confidentiality must be explained;

(15) insurance, guarantees, and other protection against insolvency:

(A) any reinsurance agreement and any other agreement described in [~~the~~] Insurance Code §843.082(4)(C) [~~Article 20A.05(a)(4)(C)~~], covering excess of loss, stop-loss, and/or catastrophes. The agreement must provide that the commissioner and HMO will be notified no less than 60 days prior to termination or reduction of coverage by the insurer;

(B) - (C) (No change.)

(16) (No change.)

(17) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO pursuant to the requirements of [~~the~~] Insurance Code §843.078 and §843.079 [~~Article 20A.04(13)~~] and §11.1600 of this title (relating to Information to Prospective and Current Group Contract Holders and Enrollees);

(18) network configuration information, including maps demonstrating [an explanation of] the location and distribution [adequacy] of the physician, dentist and [other] provider network within the proposed service area by county(ies) or ZIP code(s) [configuration]; lists of physicians, dentists and individual providers, including license type and specialization and an indication of whether they are accepting new patients, and institutional providers [the information provided must include the names of primary care physicians, their hospital affiliations, referral specialists, and other providers by zip code or zip code map and indicate whether each physician or other provider is accepting new patients from the HMO];

(19) (No change.)

(20) documentation demonstrating that the HMO will pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate and that the health care plan contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to enrollees, the following provisions and procedures for coverage of emergency care services:

(A) any medical screening examination or other evaluation required by state or federal law which is necessary to determine whether an emergency medical condition exists will be provided to enrollees in a hospital emergency facility or comparable facility;

(B) necessary emergency care services will be provided to enrollees, including the treatment and stabilization of an emergency medical condition; and

(C) services originating in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the HMO, provided that the HMO is required to approve [approved] or deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the HMO must respond to inquiries from the treating physician or provider in compliance with this provision in the HMO's plan.

(21) a description of the procedures by which:

(A) a member handbook and materials relating to the complaint and appeal process and the [availability of the] independent review process will be provided to enrollees in languages [any language] other than English, pursuant to [the] Insurance Code §843.205 [Article 20A.11A(a)]; and

(B) access to a member handbook and materials relating to the complaint and appeal process and the [availability of the] independent review process will be provided to an enrollee who has a disability affecting communication or reading [the enrollee's ability to communicate or to read], pursuant to [the] Insurance Code §843.205 [Article 20A.11A(b)].

(22) notification of the physical address in Texas of all books and records described in §11.205 of this title (relating to Documents To Be Available for Qualifying [During] Examinations);

(23) a description of the information systems, management structure and personnel that demonstrates the applicant's capacity to meet the needs of enrollees and contracted physicians and providers, and to meet the requirements of regulatory and contracting entities [in place which demonstrates the applicant has adequate capacity to service enrollees, physicians and providers]; and

(24) (No change.)

§11.205. Documents To Be Available for Qualifying [during] Examinations.

(a) The following documents must be available for review [maintained for inspection at all times] at the HMO's office located within the State of Texas:

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials [information; enrollee newsletters; personnel manuals]; organizational charts; key personnel information, e.g., resumes and job descriptions [contracts with physicians and, if applicable, providers such as dentists and physician therapists]; and other items as requested [required];

(2) [the] quality improvement: program description and work plan as required by §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs) [review standards, quality improvement committee meeting minutes, internal quality review audits of each defined service area, quality of care assurance program description, medical peer review committee minutes, and utilization review system program description, including policies and procedures to evaluate medical necessity, criteria used, information sources, the process used to review and approve the provision of medical services and utilization review system data];

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and IRO logs;

(4) [(3)] complaints and appeals: policies [the complaint policy] and procedures, examples of letters and examples of complaint and appeal logs [procedure and forms to be used in the complaint resolution procedure]. Each complaint [All complaints] shall be categorized as one or more of the following types of complaint: [processed in accordance with the HMO's complaint policy and procedure which shall be developed in accordance with the Insurance Code Chapter 20A.]

(A) quality of care or services;

(B) accessibility/availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous;

[(4) the accessibility monitoring data;]

[(5) the enrollee satisfaction surveys, results of surveys and disenrollment and termination logs;]

(5) [(6)] health information systems: policies and procedures [a system] for accessing enrollee [medical, hospital and] health records and a [of all enrollees and records of all physicians and other providers providing service under independent contract with an HMO shall be subject to such examination as is necessary for an ongoing examination. The] plan to [shall] provide for [adequate protection of] confidentiality of those records [medical and health care information and shall only be disclosed] in accordance with applicable law;

(6) [~~(7)~~] network configuration information, as outlined in §11.204(18) of this title (relating to Contents) demonstrating [~~including an explanation of the~~] adequacy of the physician, dentist and [~~other~~] provider network [~~configuration. The information provided must include the names of physicians, referral specialists, and other providers by zip code or zip code map, and indicate whether each physician or other provider is accepting new patients from the HMO~~];

(7) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

(8) executed physician and provider contracts: copy of the first page, including the form number, and signature page of individual provider contracts and group provider contracts;

(9) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

[~~(8) lists of primary care and referral specialists, hospitals, laboratories, diagnostic imaging providers, radiologic oncology providers, and, if applicable, other providers such as dentists and physical therapists to be used by the applicant inside the service area, including their certification/accreditation and trauma level status as applicable;~~]

[~~(9) current files containing the form or template of all contracts, with copies of signature pages, for all participating physicians and, if applicable, other providers of care such as dentists and physical therapists that are updated on an ongoing basis;~~]

[~~(10) current files containing the form or template of all contracts, with copies of signature pages, on subcontracting physicians and, if applicable, providers such as dentists and physical therapists which contain sufficient information to assure current licensure or other authorizations to practice in the State of Texas;~~]

[~~(11) evidence that the HMO has a mechanism for maintaining, monitoring and implementing the quality improvement program, as required by §11.1902 of this title (relating to Quality Improvement Program) including procedures for data collection, analysis and reporting for all physicians and providers, including pharmacy or drug utilization review format, if applicable; utilization review; denials of coverage and a complaint system as required by this chapter;~~]

(10) [~~(12)~~] current physician manual and current provider manual which shall be provided to each contracting physician and other provider. The manuals shall contain details of the requirements by which the physicians and providers will be governed; [~~.~~]

(11) [~~(13)~~] credentialing files: as specified in §11.1902(4) [~~§11.1902(5)~~] of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs) and §11.2207(d)(4) of this title (relating to Quality Improvement Structure and Program for Single Service HMOs);

(12) [~~(14)~~] a copy of all printed materials to be presented to prospective enrollees, an enrollee handbook, and an evidence of coverage [~~and physician and provider manuals~~];

(13) [~~(15)~~] the statistical reporting system developed and maintained by the HMO which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services;

(14) claims systems: policies and procedures that demonstrate the capacity to pay claims timely and to comply with all applicable statutes and rules;

[~~(16) the HMO's financial statements;~~]

[~~(17) any report submitted by the HMO to the Texas Health Care Information Council;~~]

[~~(18) all complaints and complaint files;~~]

[~~(19) documentation of regular review of complaint reports by management and the governing body;~~]

[~~(20) the complaint and appeal log, including documentation on each complaint received and details of action taken on the complaint. Complaints and appeals must be categorized as follows:~~]

[~~(A) plan administration (e.g., marketing, policyholder service, billing, underwriting or similar administrative functions);~~]

[~~(B) benefit denial or limitation (e.g., denial of a benefit, refusal to refer or provide requested services);~~]

[~~(C) quality of the treating physician, dentist or provider care (e.g., misdiagnoses or lack of courteous treatment);~~]

[~~(D) enrollee services (e.g., lack of courteous treatment; appointment time or waiting room time);~~]

[~~(21) access to appointments (e.g., appointment time or waiting room time);~~]

(15) [~~(22)~~] financial records:[~~,~~] including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(16) [~~(23)~~] any other records demonstrating compliance with applicable statutes and rules, including audits or examination reports by other entities, including governmental authorities or accrediting agencies [~~concerning the operation of the HMO~~].

(b) The following documents may be maintained outside the State of Texas if the HMO has received prior approval by the commissioner pursuant to [~~the~~] Insurance Code §803.003 [~~Article 1.28~~]:

(1) - (5) (No change.)

§11.206. Review of Application.

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

(c) Following the completion of the qualifying examinations, if a hearing is scheduled, then it will be scheduled under the provisions of [~~the~~] Insurance Code §843.081 [~~Article 20A.05~~]. The hearing may be waived, if agreed to by the applicant and the department and if no reasonable request for a hearing by any other person has been received.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406515
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO SUBSEQUENT TO ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §§11.301 - 11.303

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. 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Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.301. Filing Requirements.

Subsequent to the issuance of a certificate of authority, each HMO is required to file certain information with the commissioner, either for approval prior to effectuation or for information only, as outlined in paragraphs (4) and (5) of this section and in §11.302 of this title (relating to Service Area Expansion or Reduction Applications [~~Requests~~]). These requirements include filing changes necessitated by federal or state law or regulations.

(1) Completeness and format of filings.

(A) The department shall not accept a filing for review until the filing is complete. An application to modify the approved application for a certificate of authority which requires the commissioner's approval in accordance with [~~the~~] Insurance Code §843.080[~~, Articles 20A.04(b)~~] and Article 20A.09(l) is considered complete when all information required by this section, §11.302 of this title, and §§11.1901 - 11.1902 [~~§§11.1901-11.1903~~] of this title (relating to Quality of Care) that is applicable and reasonably necessary for a final determination to be made by the department, has been filed [~~with the department~~].

(B) Filings shall:

(i) be submitted on 8-1/2 by 11 inch paper;

(ii) not be submitted in bound booklets;

(iii) be legible;

(iv) be in typewritten, computer generated, or printer's proof format; and

(v) except for maps, not contain any color highlighting unless accompanied by a clean copy without highlighting.

(2) Identifying form numbers required. Each item required to be filed pursuant to paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. Such identifying form numbers shall be composed of a total of no more than 40 letters, numbers, symbols, and spaces.

(A) - (B) (No change.)

(3) Attachments for filings. The filings required in paragraphs (4) and (5) of this section must be accompanied by the following:

(A) one [~~an~~] original [~~and four copies~~] of the HMO certification and transmittal form for each new, revised, or replaced item;

(B) one [~~an~~] original [~~and four copies~~] of such supporting documentation as considered necessary by the commissioner for review of the filing, along with a cover letter which includes the following:[~~, and~~]

(i) company name;

(ii) form numbers that are being submitted; and

(iii) a paragraph that describes the type of filing being submitted, along with any additional information that would aid in processing the filing.

(C) except for the filings outlined in paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section, the applicable filing fee for other filings as required by Insurance Code §843.154 [~~Article 20A.32~~], as determined by §7.1301 of this title (relating to Regulatory Fees). The [~~fee(s) for~~] filings outlined in paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section are subject to the fee amounts described in §7.1301(g) of this title, but such fees shall not be attached with the filing. Instead, the submission of such fee(s) is subject to the billing provisions of §7.1302 of this title (relating to Billing System).

(4) Filings requiring approval. Subsequent to the issuance of a certificate of authority, each HMO shall file for approval with the commissioner information required by any amendment to items specified in §11.204 of this title (relating to Contents) if such information has not previously been filed and approved by the commissioner. In addition, an HMO shall file with the commissioner a written request to implement or modify the following operations or documents and receive the commissioner's approval prior to effectuating such modifications:

(A) - (B) (No change.)

(C) the form of all contracts described in §11.204(13)(A), (C) and (D) [~~(C)~~] of this title, including any amendments to contracts described in §11.204(13)(A), (C) and (D) [~~(C)~~] of this title and prior notification of the cancellation of any management contracts in §11.204(13)(D) of this title;

(D) any change in more than 10% of control of the HMO, as specified in the definition of "control" in §11.2(b) [~~§11.2(b)(11)~~] of this title (relating to Definitions);

(E) - (F) (No change.)

(G) any new or revised loan agreements, or amendments thereto, evidencing loans made by the HMO to any affiliated person or to any medical or other health care provider, whether providing services currently, previously, or potentially in the future; and any guarantees of any affiliated person's or health care provider's obligations to any third party;

(H) - (M) (No change.)

(5) Filings for information. Material filed under this paragraph is not to be considered approved, but may be subject to review for compliance with Texas law and consistency with other HMO documents. Each item filed under this paragraph must be accompanied by a completed HMO certification and transmittal form in addition to those attachments required under paragraph (3) of this section. Within 30 days of the effective date, an HMO must file with the commissioner, for information only, deletions and modifications to the following previously approved or filed operations and documents:

(A) the list of officers and directors and a biographical data sheet for each person listed under [~~the~~] Insurance Code §843.078(b)[~~, Article 20A.04(a)(3)~~], on the officers and directors page and biographical affidavit forms in §11.204(5)(A) and (B) of this title;

(B) a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments thereto, for officers and employees, including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (13)(D) of this title;

(C) the formula or method for calculating the schedule of charges, as defined in §11.2(b) of this title. The filing must include the HMO reconciliation of benefits to schedule of charges form as described in §11.701 of this title (relating to Must be Filed Prior to Use);

(D) any change in the physical address of the books and records described in §11.205 of this title (relating to Documents To Be Available for Qualifying [~~During~~] Examinations);

(E) - (F) (No change.)

(G) a copy of the form of any new contract or subcontracts or any substantive changes to previously filed copies of forms of all contracts between the HMO and any physicians, delegated entities and delegated networks as defined in §11.2602 of this title (relating to Delegated Entities), or other providers described in §11.204(13)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether utilized with all contracts or on an individual basis. If such contracts are amended, each copy of such agreement must be marked to indicate revisions. In addition, questions listed on the HMO certification and transmittal form, must be answered;

(H) (No change.)

(I) changes to any of the requirements mandated for guarantees pursuant to §11.808 of this title [~~(relating to Guarantee from a Sponsoring Organization)~~];

(J) any change in the affiliate chart as described in §11.204(6)(A) of this title;

(K) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the enrollee handbook, pursuant to the requirements of [~~the~~] Insurance Code §843.201[~~, Article 20A.04(13)~~] and §11.1600 of this title (relating to Information to Prospective and Current Group Contract Holders and Enrollees);

(L) - (M) (No change.)

(N) a description of the quality assurance program, including a peer review program, as required by [~~the~~] Insurance Code §843.082(1)[~~, Article 20A.05(a)(1)~~]. Descriptions of arrangements for sharing pertinent medical records between physicians and/or providers contracting or subcontracting pursuant to paragraph (13)(B) of §11.204

of this title with the HMO and assuring the records' confidentiality must also be provided.

(6) (No change.)

(7) Filing review procedure [~~Review Procedure~~]. Within 20 days from the department's receipt of an initial filing for commissioner's approval under this section, the department shall determine whether the filing is complete or incomplete for purposes of acceptance for review and, if found to be incomplete, the department shall issue a written or electronic notice to the HMO of its incomplete filing. A filing under this subchapter that is subject to the billing provisions of §7.1302 of this title and which, upon receipt by the department, fails to comply with the requirements of that section, will be deemed to be incomplete for purposes of this subchapter.

(A) - (C) (No change.)

§11.302. Service Area Expansion or Reduction Applications [~~Requests~~].

(a) An HMO shall file an application for approval with the department before the HMO may expand [~~change~~] an existing service area, reduce an existing service area, or add a new service area.

(b) If any of the following items are changed by a service area expansion or reduction application [~~request~~], the new item or any amendments to an existing item must be submitted for approval or filed for information, as specified in §11.301 of this title (relating to Filing Requirements):

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area as required by §11.204(12) of this title (relating to Contents);

(2) a form of any new contracts or amendment of any existing contracts in the new area, as described in §11.204(13) of this title;

(3) network configuration information, as required by §11.204(18) of this title [~~a list of all physicians and/or other providers to provide services in the new area, including all information required by §11.205(8) of this title (relating to Documents To Be Available During Examinations~~];

(4) - (9) (No change.)

(10) any new or amended officers' [~~officers~~] and employees' [~~employees~~] fidelity bonds, in accordance with §11.204(7) and (13)(D) of this title;

(11) any new or amended reinsurance agreements, insurance or other protection against insolvency, as specified in §11.204(15) of this title; and

(12) a description of the method by which the complaint procedure, as specified in [~~the~~] Insurance Code §843.251 et seq. [~~Article 20A.12~~] and related regulations, will be made reasonably available in the new service area or division, including a toll free call, and the information and complaint telephone number required by the Insurance Code Article 21.71, where applicable. For HMOs subject to the Insurance Code Article 21.71, the toll free call required by this rule and the toll free information and complaint number required by the Insurance Code Article 21.71, may be the same number.

(c) The department shall not accept an application [~~a filing~~] for review until the application [~~filing~~] is complete. An application to modify the certificate of authority that [~~which~~] requires the commissioner's approval in accordance with [~~the~~] Insurance Code §843.080 [~~Articles 20A.04(b)~~] and Article 20A.09(l) is considered complete when all information required by §11.301 of this title, this section, and §§11.1901 - 11.1902 [~~§§11.1901-11.1903~~] of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department, has been filed with the department.

(d) Before consideration of a service area expansion or reduction application [~~request~~], the HMO must be in compliance with the requirements of §§11.1901 - 11.1902 [~~§§11.1901-11.1903~~] of this title in the existing service areas and in the proposed service areas.

§11.303. Examination.

(a) The department has authority to conduct examinations of HMOs under [~~the~~] Insurance Code §843.251 and §843.156 [~~Articles 20A.05, 20A.12 and 20A.17~~]. Such examinations may be conducted to determine the financial condition ("financial exams"), quality of health care services ("quality of care exams"), or [~~such other exams regarding~~] compliance with laws affecting the conduct of business ("market conduct exams" or "complaint exams") [~~of the HMO~~].

(b) On-site financial, [~~and~~] market conduct examinations, complaint or quality of care exams shall be conducted pursuant to [~~the~~] Insurance Code Article 1.15 and §7.83 of this title (relating to Appeal of Examination Reports [~~Examinations~~]).

(c) The following documents must be available for review at the HMO's office located within the State of Texas:

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, e.g., resumes and job descriptions; and other items as requested;

(2) quality improvement: program description, work plans, program evaluations, committee and subcommittee meeting minutes;

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(4) complaints and appeals: policies and procedures and templates of letters; and complaint and appeal logs, including documentation and details of actions taken. All complaints shall be categorized according to §11.205(a)(4)(A) - (J) of this title (relating to Documents to be Available for Qualifying Examinations); and complaint and appeal files;

(5) satisfaction surveys: enrollee, physician and provider satisfaction surveys, enrollee disenrollment and termination logs;

(6) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records;

(7) network configuration information as required by §11.204(18) of this title (relating to Contents) demonstrating adequacy of the physician, dentist and provider network;

(8) executed agreements: including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements.

(9) executed physician and provider contracts: copy of the first page, including form number, and signature page of individual provider contracts and group provider contracts;

(10) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(11) credentialing: credentialing policies and procedures and credentialing files;

(12) reports: any reports submitted by the HMO to a governmental entity;

(13) claims systems: policies and procedures and systems/processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers and enrollees;

(14) financial records: including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(15) other: any other records demonstrating compliance with applicable statutes and rules.

(d) [~~(c)~~] Quality [~~On-site quality~~] of care examinations shall be conducted pursuant to the following protocol:

(1) Entrance conference. The examination team or assigned examiner shall hold an entrance conference with the HMO's key management staff [~~administrative personnel or their designee~~] before beginning the [~~on-site~~] examination.

(2) Interviews. Examination team members or the examiner shall conduct interviews with key management staff or their designated personnel.

(3) [~~(2)~~] Exit conference. Upon completion of the examination, the examination team or examiner shall hold an exit conference with the HMO's key management staff [~~administrative personnel or their designee~~].

(4) [~~(3)~~] Written report of examination [~~outcome~~]. The examination team or examiner shall prepare a written report of the examination [~~outcome~~]. The department shall provide the HMO with the written report, and if any deficiencies are cited, then the department shall issue a letter outlining the timeframes [~~due dates~~] for the corrective action plan and corrective actions.

[~~(d) The HMO shall provide a plan of correction for each deficiency cited in the letter outlining corrective action described in subsection (c) of this section.~~]

(5) [~~(1)~~] If the examination team or examiner cites serious deficiencies, the HMO shall provide the examination team or examiner with a signed plan to correct deficiencies [~~of correction~~] within one business day of written notice of deficiencies. The HMO's plan of correction shall allow [~~provide~~] up to 12 [~~10 business~~] days for correction of the deficiencies in accordance with severity of the deficiencies.

[~~(2) If the examiner cites potentially serious deficiencies, the HMO shall provide the examiner with a signed plan of correction within 10 business days of receiving written notice from the examiner specifying the deficiencies. The HMO's plan of correction shall provide for correction of these deficiencies no later than 30 days from the date of the exit conference.~~]

(6) [~~(3)~~] Except as provided in paragraph (5) of this subsection, if [~~If~~] the examination team or examiner cites [~~non-serious~~] deficiencies, then the HMO shall provide a signed plan of correction to the department no later than 30 days from receipt of the written examination report. The HMO's plan [~~of correction~~] must provide for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

(7) [~~(e)~~] The department shall verify the correction of deficiencies by submitted documentation or by on-site examination.

[~~(f) This section does not apply to complaint investigations conducted under the Insurance Code Article 20A.12A.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406516
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER F. EVIDENCE OF COVERAGE

28 TAC §§11.502 - 11.506, 11.508, 11.509, 11.512

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health

maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.502. Filing Requirements for Evidence of Coverage.

Filing requirements for the evidence of coverage, when filed as part of the application for a certificate of authority, are as follows:

(1) (No change.)

(2) The department will notify the applicant of the department's action [~~Applicant will be notified~~] in accordance with §1.704 of this title (relating to Summary Procedure; Notice) [~~writing of any deficiencies~~].

(3) During the review period, applicant must submit the original [~~and four copies~~] of each new page or form reflecting any revisions.

§11.503. Filing Requirements for Evidence of Coverage Subsequent to Receipt of Certificate of Authority.

Subsequent to receipt of a certificate of authority, no evidence of coverage may be amended or altered in any manner, and no new evidence of coverage may be used, unless the proposed new or revised evidence of coverage has been filed for review and has received the approval of the commissioner. Filing requirements for the evidence of coverage when filed subsequent to receipt of a certificate of authority are as follows:

(1) The HMO must submit the original of the revised or new evidence of coverage, [~~and four copies of a~~] transmittal letter and the HMO transmittal and certification form, [~~shall be submitted. All submissions must be~~] addressed to the Texas Department of Insurance, Life, Health & [~~Life/Health~~] HMO Intake Unit, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104.

(2) The department will notify the HMO of the department's action [~~will be notified~~] in accordance with §1.704 of this title (relating to Summary Procedure; Notice) [~~writing of any deficiencies~~].

(3) The department will base its [~~An~~] approval or disapproval [~~will be based~~] on the content of drafts submitted to the department. [~~One stamped copy of the approved or disapproved form will be returned to the HMO for its permanent file.~~] Printing must comply with the specifications described in §11.505 of this title (relating to Specifications for the Evidence of Coverage). Any discrepancy in content between the final print to be issued and the approved draft is grounds for revocation of certificate of authority.

(4) - (6) (No change.)

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of any evidence of coverage [~~is disapproved~~], the department [~~commissioner~~] will specify the reason for the disapproval. The department [~~commissioner~~] is authorized to disapprove any form or withdraw any previous approval for any of the following reasons:

(1) - (2) (No change.)

(3) it contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate [~~the~~] Insurance Code Articles 21.21, 21.21A, 21.21-1, 21.21-2, 21.21-5, 21.21-6, or 21.55 in accordance with Article 20A.09Z [~~20A.09(j)~~] or any regulations thereunder or any other applicable law;

(4) - (7) (No change.)

(b) If the department disapproves a form, [~~is disapproved~~] the HMO may file a written request for a hearing on the matter. The department will schedule a [~~A~~] hearing [~~will be scheduled~~] within 30 days from the date it receives the request [~~is received~~].

§11.505. Specifications for the Evidence of Coverage.

(a) - (d) (No change.)

(e) An HMO must identify each [~~Each~~] form [~~must be identified~~] by a printed unique [~~suitable~~] form number in accordance with §11.301(2) of this title (relating to Filing Requirements). Any change in form number is considered a change in the form and requires approval as a new form.

(f) Certain language shall not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets and shall include the range of variable information or amounts and is limited to rates, dates, addresses, phone numbers, optional provisions as set forth in §11.511 of this title (relating to Optional Provisions) and optional benefits as set forth in §11.512 of this title (relating to Optional Benefits), and other such information, as approved by the commissioner.

(g) (No change.)

§11.506. Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate.

Each enrollee residing in this state is entitled to an evidence of coverage under a health care plan. By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under this subchapter and required by this section may be delivered electronically. Each group, individual and conversion contract and group certificate must contain the following provisions. [~~Use of the standard language for each provision as presented in Subchapter L of this chapter (relating to Standard Language for Mandatory and Other Provisions) shall exempt from review that portion of the evidence of coverage where standard language is contained. Such standard language shall not be the only language accepted by the commissioner for such provisions.~~]

(1) Name, address, and phone number of the HMO--The [~~the~~] toll-free number referred to in [~~the~~] Insurance Code Article 21.71, where applicable, must appear on the face page.

(A) - (B) (No change.)

(C) The HMO must provide the information regarding the toll-free number referred to in Article 21.71 [~~must be~~] in accordance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures [~~for Obtaining Information and Filing Complaints~~]).

(2) Benefits--A [~~a~~] schedule of all health care services that are available to enrollees under the basic, limited, or single health care service plan, including any copayments or deductibles and a description of where and how to obtain services. An HMO may use a [~~A~~] variable copayment or deductible schedule [~~may be used~~]. The copayment schedule must clearly indicate the benefit to which it applies. [~~No copayment or deductible shall be charged for immunizations as described in the Insurance Code Article 21.53F for a child from birth through the date the child is six years of age, except for small employer health benefit plans as defined by the Insurance Code Chapter 26.~~]

(A) Copayments. An HMO may require copayments to supplement payment [~~Payment~~] for health care services [~~may be supplemented by nominal copayments~~]. Each HMO may establish one or more copayment options. A basic service HMO may not impose copayment charges that exceed fifty percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent of the total cost to the HMO of providing all basic health care services. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. The HMO shall state the copayment [~~shall be stated~~] in the group, individual or conversion agreement and group certificate.

(B) Deductibles. A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall [~~only~~] charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Immunizations. An HMO shall not charge a copayment or deductible for immunizations as described in Insurance Code Article 21.53F for a child from birth through the date the child is six years of age, except that a small employer health benefit plan, as defined by Insurance Code Chapter 26, that covers such immunizations may charge a copayment or deductible.

(3) Cancellation and non-renewal--A [~~a~~] statement specifying the following grounds for cancellation and non-renewal of coverage and the minimum notice period that will apply.

(A) An [~~Cancellation by an~~] HMO may cancel a [~~of an enrollee in a group, or if a subscriber, the~~] subscriber in a group and subscriber's enrolled dependents under circumstances described in clauses (i) - (vii) of this subparagraph, so long as the circumstances do not include health status related factors[~~, in the case of~~]:

(i) For nonpayment of amounts due under the contract, coverage may be cancelled after not less than 30 days written notice, except no written notice will be required for failure to pay premium.[~~;~~]

(ii) In the case of fraud or intentional [~~material~~] misrepresentation of a material fact, except as described in paragraph (14) of this section, coverage may be cancelled after not less than 15 days written notice. [~~;~~]

(iii) In the case of fraud in the use of services or facilities, coverage may be cancelled after not less than 15 days written notice.[~~;~~]

(iv) For failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area, coverage may be cancelled immediately, subject to continuation of coverage and conversion privilege provisions, if applicable.[~~;~~]

(v) In the case of misconduct detrimental to safe plan operations and the delivery of services, coverage may be cancelled immediately. [~~;~~]

(vi) For failure of the enrollee and a plan physician to establish a satisfactory patient-physician relationship if it is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative plan physician, the enrollee is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the enrollee has failed to make such changes, coverage may be cancelled at the end of the 30 days.

(vii) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the HMO terminates coverage [~~is terminated~~] uniformly without regard to any health status-related factor of enrollees, coverage may be cancelled after 30 days written notice. An HMO shall not cancel coverage [~~Coverage~~] for a child who is the subject of a medical support order [~~cannot be cancelled solely~~] because the child does not reside, live or work in the service area.

(B) An [~~Cancellation by an~~] HMO may cancel [~~of~~] a group under circumstances described in clauses (i) - (vi) of this subparagraph [~~requires at least 60 days prior notice to the group except in the cases of~~]:

(i) For nonpayment of premium, all coverage may be cancelled at the end of the grace period as described in paragraph (13) of this section.[~~;~~]

(ii) In the case of fraud on the part of the group, coverage may be cancelled after 15 days written notice.[~~;~~]

(iii) For [~~for~~] employer groups, violation of participation or contribution rules, coverage may be cancelled in accordance with §26.8(h) and §26.303(j) of this title (relating to Guaranteed Issue; Contribution and Participation Requirements and Coverage Requirements).[~~;~~]

(iv) For [~~for~~] employer groups, in accordance with §26.16 and §26.309 of this title (relating to Refusal To Renew and Application To Reenter Small Employer Market and Refusal To Renew and Application To Reenter Large Employer Market), coverage may be cancelled upon discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage.

(v) Where no enrollee resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees, the HMO may cancel the coverage [~~may be cancelled~~] after 30 days written notice.

(vi) If membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an [~~a covered~~] enrollee, the HMO may cancel the coverage [~~may be cancelled~~] after 30 days written notice.

(C) In [~~Cancellation by a group or individual contract holder in~~] the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees pursuant to this chapter or other law, a group or individual contract holder may cancel the contract [~~may be canceled~~] after not less than 30 days written notice to the HMO.

(D) An [~~Cancellation by an~~] HMO may cancel [~~of~~] an individual contract under circumstances described in clauses (i)- (vi) of this subparagraph. [~~in the case of:~~]

(i) For nonpayment of premiums in accordance with the terms of the contract, including any timeliness provisions, coverage may be cancelled without written notice, subject to paragraph (13) of this section.

(ii) In the case of fraud or intentional material misrepresentation, except as described in paragraph (14) of this section, the HMO may cancel coverage [~~may be cancelled~~] after not less than 15 days written notice.

(iii) In the case of fraud in the use of services or facilities, the HMO may cancel coverage [~~may be cancelled~~] after not less than 15 days written notice.

(iv) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, coverage may be cancelled after 30 days written notice. An HMO shall not cancel the coverage [~~Coverage~~] for a child who is the subject of a medical support order [~~cannot be cancelled solely~~] because the child does not reside, live or work in the service area.

(v) In case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage [~~may be cancelled~~] after 90 days written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area.

(vi) In case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage [~~may be cancelled~~] after 180 days written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure--A [~~a~~] provision that sets forth the procedure for paying claims, including any time frame for payment of claims which must be in accordance with [~~the~~] Insurance Code Articles 21.55 and 20A.09Z [~~20A.09(j)~~] and the applicable rules.

(5) (No change.)

(6) Continuation of coverage--Group [~~group~~] agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by [~~the~~] Insurance Code Article 20A.09(k).

(A) An enrollee shall have the option to continue coverage as provided for by [~~the~~] Insurance Code Article 20A.09(k), upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.

(B) A dependent, upon completion of any continuation of coverage provided under [~~the~~] Insurance Code Article 3.51-6 §3B, shall have the privilege to continue coverage for the 6 months prescribed by [~~the~~] Insurance Code Article 20A.09(k).

(C) If an HMO offers conversion coverage, it [~~The mandatory continuation privilege and conversion option, if elected to be offered,~~] must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or Article 3.51-6 §3B continuation coverage period.

(D) A [~~Not less than 30 days before the end of the six months after the date an enrollee has elected continuation under Article 20A.09(k), a~~] basic service HMO shall notify the enrollee not less than 30 days before the end of the six months from the date continuation under Article 20A.09(k) was elected that the enrollee [~~he/she~~] may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under [~~the~~] Insurance Code Article 3.77, and shall provide the address and toll-free number of the pool.

(7) - (8) (No change.)

(9) Eligibility--A [~~a~~] statement of the eligibility requirements for membership, including:

(A) - (D) (No change.)

(E) a clear statement regarding the coverage of the enrollee's [~~subscriber's~~] grandchildren up to the age of 25 under the conditions under which such coverage is required by [~~the~~] Insurance Code Article 3.70-2, subsection (L) and Article 20A.09H (Children and Grandchildren).

(10) Emergency services--A [~~a~~] description of how to obtain services in emergency situations including:

(A) - (C) (No change.)

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition: [~~; and~~]

(i) whether such services are provided in network or out of network or in area or out of area; and

(ii) in such a manner as to ensure that enrollees are indemnified or otherwise held harmless; and

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or comparable facility, as defined in subparagraph (F) [~~(G)~~] of this paragraph [~~section~~], treatment subject to such stabilization shall be provided to enrollees as approved by the HMO, provided that the HMO is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider. An HMO shall approve [~~Approval~~] or deny [~~denial of~~] such treatment [~~shall be made~~] within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case shall approval or denial [~~is to~~] exceed one hour from the time of the request.

(F) (No change.)

(11) - (14) (No change.)

(15) Out-of-network services--Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, upon the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed [~~upon~~] rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO shall offer its [~~HMO's~~] entire network, rather than limited provider networks within the HMO delivery network[~~, shall be offered~~].

(B) The HMO shall not require the enrollee [~~shall not be required~~] to change his or her primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(16) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 [~~30~~] days written notice pursuant to [~~the~~] Insurance Code Article 3.51-10.

(17) (No change.)

(18) Termination due to attaining limiting age--A provision that a child's attainment of a limiting age does not operate to terminate the coverage of the child while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent upon the subscriber for support and maintenance. The HMO may require the subscriber [~~may be required~~] to furnish proof of such incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of such limiting age.

(19) Termination due to student dependent's change in status--Each group agreement and certificate that conditions dependent coverage for a child twenty-five [~~twenty-one~~] years of age or older on the child's being a full-time student at an educational institution shall contain a provision in accordance with [~~the~~] Insurance Code Article 21.24-2.

(20) (No change.)

(21) Conformity with Medicare supplement minimum standards and long-term care minimum standards--Each group, individual and conversion agreement and group certificate must comply with Chapter 3, Subchapter T of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y of this title (relating to [~~Minimum~~] Standards for [~~Benefits for~~] Long-Term Care Insurance Coverage Under Individual and Group Policies), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement rules and/or the long-term care rules and the HMO rules, the Medicare supplement rules or long-term care rules shall govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO shall follow both the Medicare supplement rules and/or the long-term care rules and the HMO rules [~~shall be followed~~] where applicable.

(22) Nonprimary care physician specialist as primary care physician--A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to utilize a nonprimary care physician specialist as a primary care physician as set forth in [~~the~~] Insurance Code Article 20A.09(g) [~~20A.09(g-i)~~].

(23) Selected [~~Designated~~] obstetrician or gynecologist--Individual, conversion and group agreements and certificates, except small employer plans as defined by [~~the~~] Insurance Code Chapter 26, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of [~~the~~] Insurance Code Article 21.53D. An HMO shall not preclude an enrollee [~~shall not be precluded~~] from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO shall permit an enrollee who selects [~~designates~~] an obstetrician or gynecologist direct access to the health care services of the selected [~~designated~~] obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) The access to health care services of an obstetrician or gynecologist, includes[~~, but is not limited to~~]:

(i) - *(iii)* (No change.)

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected [~~designated~~] professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning [~~the~~] breasts.

(C) An HMO may require an enrollee who selects [~~designates~~] an obstetrician or gynecologist to select [~~designate~~] the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected [~~designated~~] obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO shall not impose [~~failure to provide this information may not result in~~] any penalty, financial or otherwise, [~~being imposed~~] upon the obstetrician or gynecologist by the HMO for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good faith effort to provide the information to the primary care physician.

(E) (No change.)

(F) An HMO shall include in its enrollment form a space in which an enrollee may select an [~~a designated~~] obstetrician or gynecologist as set forth [~~required~~] in [~~the~~] Insurance Code Article 21.53D. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from her primary care physician or primary care provider. Such enrollee shall have the right at all times to select or change a selected [~~designated~~] obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) (No change.)

(24) (No change.)

(25) Drug Formulary [~~changes~~]--A group agreement and certificate, except small employer plans as defined by Insurance Code Chapter 26, that covers prescription drugs and uses one or more formularies must comply with Insurance Code Article 21.52J and Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits). [~~If the agreement or certificate includes benefits for prescription drugs, a provision that the drug formulary may change during the contract year. Before the drug formulary may be revised to remove a prescription drug, notice of the proposed revision must be sent to all physicians, providers, and enrollees affected by the proposed revision. The notice must be provided at least 90 days prior to the proposed revision, and must inform the physician, provider and enrollee of the right to appeal to use a drug to be discontinued, pursuant to the complaints/appeals process provided by the Insurance Code Article 20A.12. The notice may be provided as a separate notice, or included in a regular publication of the HMO, such as an enrollee newsletter. If the notice required by this paragraph is included in a regular publication of the HMO, the notice must be prominently displayed and titled to indicate a potential change in prescription drug benefits to enrollees. The notice required by this paragraph need not be provided if the drug is removed from the formulary by a regulatory agency or pharmaceutical company for safety reasons.~~]

(26) (No change.)

§11.508. Mandatory Benefit Standards: Group, Individual and Conversion Agreements.

(a) (No change.)

(b) In addition to the basic health care services in subsection (a) of this section, each evidence of coverage shall include coverage for services as follows [~~the following~~]:

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

(c) The benefits described in this section that [~~subsection (a)(1)(F) and (1)(H)(ii) and (vi) of this section~~] do not apply to small employer plans are not required to be included in such plans [~~as defined by the Insurance Code Chapter 26~~].

(d) A state-mandated health benefit plan defined in §11.2(b) of this title (relating to Definitions) shall provide coverage for the basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in §§21.3516 - 21.3518 of this title (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO Plans), and must provide the services without limitation as to time and cost, other than those limitations specifically prescribed in this section.

(e) (No change.)

§11.509. Additional Mandatory Benefit Standards: Group Agreement Only.

Group agreements must contain the following additional mandatory provisions.

(1) (No change.)

(2) New enrollees [~~members~~]. A provision specifying the conditions under which new enrollees [~~members~~] may be added to those originally covered, including effective date requirements. For coverage issued to employers, a provision for special enrollment in accordance with 45 C.F.R. 146.117 (Health Insurance Portability and Accessibility Act).

(3) Chemical dependency. A provision to provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors is required for state-mandated health benefit plans defined in §11.2(b) of this title (relating to Definitions). Dollar or durational limits which are less favorable than for physical illness generally may be set only if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under the Insurance Code Article 3.51-9, §2A(d), including §§3.8001 - 3.8022 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

(A) - (B) (No change.)

(4) Osteoporosis. A provision that provides coverage to a qualified individual as defined in the Insurance Code Article 21.53C for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis is required for state-mandated health benefit plans defined in §11.2(b) of this title.

(5) (No change.)

(6) Conditions affecting the temporomandibular joint. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title must include a provision that provides coverage for a condition affecting the temporomandibular joint as required by [~~the~~] Insurance Code Article 21.53A.

(7) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title, may not exclude from coverage under the plan an enrollee who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing the dental care. This benefit does not require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

§11.512. Optional Benefits.

An HMO may provide to its enrollees health services that [~~are not included as basic health care services under~~] §11.508 of this title (relating to Mandatory Benefit Standards; Group, Individual and Conversion Agreements) does not include as basic health care services. An HMO may limit these optional[~~. These~~] health services [~~may be limited~~] as to time and cost. Group, individual and conversion certificates may contain optional benefits, including [~~but not limited to~~]:

(1) - (15) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

28 TAC §11.602, §11.603

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR Chapter 146.

§11.602. Health Maintenance Organizations Subject to the Texas Insurance Code, Articles 21.21, 21.21-1, and 21.21-2, and Related Rules.

Health maintenance organizations must comply with the Texas Insurance Code Articles[, ~~Article~~] 21.21, 21.21-1, and [~~Article~~] 21.21-2, and rules promulgated by the Texas Department [~~State Board~~] of Insurance, pursuant to the Texas Insurance Code Articles[, ~~Article~~] 21.21, 21.21-1 [~~21.21-1~~], and [~~Article~~] 21.21-2, to the extent these rules may be applied in the same manner as insurance companies.

§11.603. Filings.

Any HMO licensed to do business in Texas which offers coverage to Medicare beneficiaries under the provisions of Subchapter XVIII of 42 United States Code, Health Insurance for the Aged and Disabled [~~Diabled~~], shall file with the department a copy of each advertisement related to such coverage which is produced by the HMO or its agents and which is an invitation to inquire or invitation to contract as defined in §21.113 of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising) no later than 45 days prior to its use. Material

shall be filed in accordance with §21.120 of this title (relating to Filing for Review). Material filed under this paragraph is not to be considered approved but may be subject to review for compliance with Texas law and consistency with other documents.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER I. FINANCIAL REQUIREMENTS

28 TAC §§11.801 - 11.803, 11.806, 11.809, 11.810

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.801. Minimum Net Worth.

(a) On or after September 1, 1999, at the time of the initial qualifying examination, an applicant for a certificate of authority to operate an HMO must have unencumbered assets of the type described in subsection (b) of this section in excess of all of its liabilities equal to or greater than the required net worth established in Insurance Code §843.403 [~~Article 20A.13A~~]. An HMO licensed before September 1, 1999, must comply with the minimum net worth requirement in Insurance Code §843.4031[~~, Article 20A.13B~~].

(b) (No change.)

(c) After the qualifying examination, the applicant must maintain unencumbered assets in excess of all of its liabilities by an amount equal to or greater than the minimum net worth requirement until it receives its certificate of authority, and thereafter, the HMO must meet the minimum net worth requirements of [~~the~~] Insurance Code §843.403 [~~Article 20A.13A~~], by maintaining unencumbered assets in excess of its liabilities equal to or greater than the minimum net worth requirement.

(d) Notwithstanding subsections (b) and (c) of this section, foreign HMOs seeking admission to this state which are actively conducting business in other states, in addition to approved non-profit health corporations authorized under [~~the~~] Insurance Code §844.005 [~~Article 21.52F~~], shall be required, at a minimum, to comply with [~~the~~] Insurance Code §843.403 [~~Article 20A.13A~~] at the time of the qualifying examination.

§11.802. Statutory Deposit Requirements.

(a) Statutory deposits made pursuant to [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~] must consist of funds in the form of lawful money of the United States of America, bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

(1) - (2) (No change.)

(b) Before the issuance of the certificate of authority, the HMO must submit funds as described in subsection (a) of this section in the amount required by [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~], with four completed originals of security deposit report form number 120, one original pledge document on bank letterhead, and the applicable fees pursuant to §7.1301(d) of this title (relating to Regulatory Fees) to the bond and securities officer of the department.

(c) Each HMO must annually determine the amount of statutory deposit required as specified in [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~] and deposit any required additional funds by March 15 in the manner set forth as follows:

(1) - (2) (No change.)

(d) (No change.)

(e) If the HMO wishes to request a release of all or part and/or a waiver of the statutory deposit requirements as permitted by [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~], the HMO must submit a written request [~~must be submitted~~] to the commissioner no less than 60 days prior to the March 15 due date. Such request for any release or waiver must provide adequate information, including the following, to justify the release:

(1) - (5) (No change.)

(6) If an HMO requests a release [~~is requested~~] under subsections (e) or (f) [~~(d) or (e)~~] of [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~]:

(A) - (B) (No change.)

(7) (No change.)

(f) Whenever conditions upon which a waiver were granted change to the extent that the HMO is no longer able to qualify for the waiver, the HMO must deposit adequate funds to comply with the requirements of [~~the~~] Insurance Code §843.405 [~~Article 20A.13~~], within 30 days.

(g) (No change.)

§11.803. Investments, Loans, and Other Assets.

The admitted assets of domestic and foreign HMOs must at all times comply with the provisions of this section.

(1) Investment of minimum net worth. An HMO must maintain assets in an amount equivalent to its required minimum net worth in accordance with Insurance Code §843.403 [~~Article 20A.13A(d)~~]. Demand deposits, savings deposits or time deposits, of the type that are federally insured in solvent banks and savings and loan associations and branches thereof, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

(A) - (B) (No change.)

(2) - (6) (No change.)

§11.806. Liabilities.

(a) Each HMO must establish and maintain records identifying and supporting each liability the HMO incurs. Each liability incurred by an HMO shall be reported on all financial statements filed with the department. A liability shall be incurred from the date a service was performed, a product was delivered, a title was transferred, or a contractual obligation entered into for an amount that is specified and unconditionally owed. Each HMO must segregate its liabilities into classification of "covered" or "uncovered." Agreements to loan money or to make future capital or surplus contributions do not, in themselves, cause liabilities to be covered. Any guarantee of future contributions to surplus which are directed and based on the payment of a debt will allow that debt to be reflected as a covered liability. A liability, for which provision is made other than by the assets of the HMO, may qualify as a covered liability if the amount owed:

(1) is based on a provider contract with a hold-harmless clause as provided in §11.901(a)(1) [~~§11.1102~~] of this title (relating to Required Provisions [~~Hold-Harmless Clause~~]);

(2) - (3) (No change)

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

§11.809. Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank.

(a) Health Maintenance Organizations. This section applies to all domestic and foreign HMOs subject to the provisions of [~~the~~] Insurance Code Chapters[~~, Chapter~~] 20A and 843.

(b) - (d) (No change.)

(e) Actions of commissioner. The commissioner may take the following actions against an HMO that fails to maintain, at a minimum, 70% of the authorized control level risk-based capital in the RBC Report as calculated in accordance with the RBC instructions:

(1) - (2) (No change.)

(3) find the HMO to be in hazardous financial condition as provided by [~~the~~] Insurance Code §843.406 [~~Article 20.19~~] and §11.810 of this title (relating to Hazardous Conditions for HMOs);

(4) find the HMO to be in violation of the minimum net worth requirements of Insurance Code §843.404 [~~Article 20A.13C~~] and take action as provided by Insurance Code §843.407 [~~Article 20A.31~~], or

(5) (No change.)

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

§11.810. Hazardous Conditions for HMOs.

(a) Purpose. The purpose of this section is to enumerate conditions which may indicate an HMO is in hazardous condition and which

authorize [~~may be a basis for~~] the commissioner of insurance to initiate an action against an HMO under Insurance Code §843.461 or §843.157 [~~Articles 20A.20 or 20A.21~~]. In evaluating any of the conditions in this section, the commissioner must evaluate all circumstances concerning the HMO's operation [~~must be evaluated~~] in making an ultimate conclusion that an HMO is in hazardous condition. The evaluation of the information relating to these conditions is a part of the examination process. The conditions enumerated in this section do not conclusively indicate that an HMO is in hazardous condition. One or more of the conditions can exist in an HMO which is in satisfactory condition; however, one or more of these conditions has often been found in an HMO which was unable to perform its obligations to enrollees, creditors or the general public, or has required the commissioner to initiate regulatory action to protect enrollees, creditors and the general public.

(b) An HMO may be found to be in hazardous condition, after notice and opportunity for hearing, when the commissioner finds one or more of the following conditions [~~are found~~] to exist [~~by the commissioner~~]:

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

(5) an HMO fails to comply with the Texas Health Maintenance Organization Act (Insurance Code Chapters [~~Chapter~~] 20A and 843) or Title 28, Texas Administrative Code, Chapter 11;

(6) - (13) (No change.)

(14) an HMO does not maintain books and records sufficient to permit examiners to determine the financial condition of the HMO, examples of which include[~~, but are not limited to~~]:

(A) a domestic HMO maintains books and records [~~of a domestic HMO are maintained~~] outside the State of Texas in violation of [~~the~~] Insurance Code Chapter 803 [~~Article 1.28~~]; or

(B) an HMO moves, or maintains, the location of the books and records necessary to conduct an examination without notifying the department of such location;

(15) - (19) (No change.)

(20) an HMO does not have the minimum net worth required by Insurance Code §843.403 or §843.4031 [~~Articles 20A.13A or 20A.13B~~];

(21) an HMO does not meet the requirements of §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); or

(22) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

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Gene C. Jarmon
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Texas Department of Insurance
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SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

28 TAC §§11.901, 11.902, 11.904

The amendments and new section are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6,

provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new section affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.901. Required Provisions.

(a) Physician and provider contracts and arrangements shall include [~~the following~~] provisions:

(1) regarding a hold harmless clause as described in [~~the~~] Insurance Code §843.361: [~~Article 20A.18A(g) and §11.1102 of this title (relating to Hold Harmless Clause);~~]

(A) A hold harmless clause is a provision, as required by Insurance Code §843.361, in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(B) In accordance with Insurance Code §843.002 relating to an "uncovered expense," if a physician or health care provider agreement contains a hold harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405.

(C) The following language is an example of an approvable hold-harmless clause: (Physician/Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency, or breach of this agreement, shall (physician/provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than HMO acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with the terms of (applicable agreement) between HMO and subscriber/enrollee. (Physician/Provider) further agrees that:

(i) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee; and

(ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (physician/provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the commissioner has received written notice of such proposed changes;

(2) regarding retaliation as described in [~~the~~] Insurance Code §843.281 [~~Article 20A.14(k)~~];

(3) regarding continuity of treatment, if applicable, as described in [~~the~~] Insurance Code §843.309 and §843.362 [~~Article 20A.18(A)(c)~~];

(4) regarding written notification to enrollees receiving care from a physician or provider of the HMO's termination of that physician or provider in accordance with §843.308 and §843.309 [~~of termination to a physician or provider at least 90 days prior to the effective date of the termination of the physician or provider, except in the case of imminent harm to patient health, action against license to practice, or fraud pursuant to Insurance Code Article 20A.18A(b), in which case termination may be immediate. Upon written notification of termination, a physician or provider may seek review of the termination within a period not to exceed 60 days, pursuant to the procedure set forth in the Insurance Code Article 20A.18A(b). The HMO must provide notification of the termination of a physician or provider to its enrollees receiving care from the provider being terminated at least 30 days before the effective date of the termination. Notification of termination of a physician or provider to enrollees for reasons related to imminent harm may be given to enrollees immediately~~];

(5) regarding written notification of termination to a physician or provider in accordance with Insurance Code §843.306 and §843.307:

(A) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days prior to the effective date of the termination;

(B) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel;

(C) within 60 days following receipt of the provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider;

(6) [~~(5)~~] regarding posting of complaints notice in physician/provider offices as described in [~~the~~] Insurance Code §843.283 [~~Article 20A.18A(i)~~]. A representative notice that complies with this requirement may be obtained from the HMO Division, Mail Code 103-6A, Texas Department of Insurance, [~~HMO/UR/QA Group~~], P.O. Box 149104, Austin, Texas 78714-9104;

(7) [~~(6)~~] regarding indemnification of the HMO as described in [~~the~~] Insurance Code §843.310 [~~Article 20A.18A(f)~~];

(8) [~~(7)~~] regarding prompt payment of claims as described in [~~the~~] Insurance Code Article 20A.09Z [~~20A.09(j)~~] and all applicable

statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J (Payment of Claims to Physicians and Providers) [~~Article 20A.18B (Prompt Payment of Physician and Providers)~~] and Chapter 21, Subchapter T [~~§§21.2801 - 21.2820~~] of this title (relating to Submission of Clean Claims) with respect to the payment to the physician or provider for covered services that are rendered to enrollees;

(9) [~~(8)~~] regarding capitation, if applicable, as described in [~~the~~] Insurance Code §843.315 and §843.316 [~~Article 20A.18A(e)~~];

(10) [~~(9)~~] regarding selection of a primary physician or provider, if applicable, as described in [~~the~~] Insurance Code §843.315; [~~Article 20A.18A(e); and~~]

(11) [~~(10)~~] entitling the physician or provider upon request to all information necessary to determine that the physician or provider is being compensated in accordance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including e-mail, computer disks, paper or access to an electronic database. Amendments, revisions or substitutions of any information provided pursuant to this paragraph must be made in accordance with subparagraph (D) of this paragraph. The HMO shall provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(A) This information must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider. At a minimum, the information must include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM codes and modifiers:

(I) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider [~~will be calculated and paid~~]; or

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

(ii) all applicable coding methodologies;

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

(iv) all applicable downcoding policies;

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

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

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

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

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

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

(E) Failure to comply with this paragraph constitutes a violation of Insurance Code Chapters 843 and [~~Chapter~~] 20A (Texas Health Maintenance Organization Act).

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

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

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

(I) the physician's or provider's practice management,

(II) billing activities,

(III) other business operations, or

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

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level,

type or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(H) A physician or provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider shall provide for reasonable advance notice to enrollees being treated by the physician or provider prior to the termination consistent with Insurance Code §843.309.

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

(12) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish x-rays and non-prefabricated orthotics covered by the evidence of coverage; and

(13) regarding electronic health care transactions as set forth in §21.3701 of this title (relating to Electronic Health Care Transactions) if the contract requires electronic submission of any information described by that section.

(b) [~~(11)~~] An HMO may require a contracting physician or provider to retain in the contracting physician or provider's records updated information concerning a patient's other health benefit plan coverage.

§11.902. Prohibited Actions.

(a) Pursuant to Insurance Code §843.320, a contract between an HMO and a physician may not require the physician to use a hospitalist for a hospitalized patient.

(b) Pursuant to Insurance Code §843.3045, an HMO may not refuse to contract with a nurse first assistant as defined by §301.1525, Occupations Code, to be included in the HMO's provider network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

(c) An HMO may not by contract or any other method require a physician to use the services of a nurse first assistant as defined by §301.1525, Occupations Code.

(d) Pursuant to Insurance Code §843.319 (Certain Required Contracts), an HMO may not deny a contract to a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider, satisfies the HMO's application procedures and meets the HMO's qualification and credentialing requirements for contracting.

(e) Pursuant to Insurance Code §843.312, an HMO may not refuse a request by a contracted physician and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced practice nurse as a provider in the HMO's network, provided the physician assistant or advanced practice nurse meets the quality of care standards for participation in the HMO's network.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

(a) Pursuant to Insurance Code Article 21.53K, an [~~An~~] HMO shall not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

(b) No contract between an HMO and a pharmacy or pharmacist shall prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, (Subtitle J, Occupations Code) [~~Article 4542a-1, Texas Civil Statutes~~] and rules promulgated thereunder.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER K. REQUIRED FORMS

28 TAC §11.1001

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain

a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1001. Required Forms.

The following forms are to be used in conjunction with the rules adopted under this chapter. Copies of these forms may be obtained by contacting the Company Licensing and Registration [~~Insurer Services~~] Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Each HMO or other person or entity shall use such form or forms as are required by this title and as are appropriate to its particular activities. The forms are listed as follows:

(1) Name Application Form Rev. 02/99 [~~11/97~~];

(2) Application for a Certificate of Authority to do business in the State of Texas, Rev. 02/99 [~~11/97~~];

(3) State of Texas Officers and Directors Page, Rev. 06/2000 [~~11/97~~];

(4) State of Texas Biographical Affidavit, Rev. 01/2002 [~~11/97~~];

(5) HMO Certification and Transmittal Form Rev. 02/99 [~~11/97~~];

(6) Reconciliation of Benefits to Schedule of Charges Form, Rev. 04/92 [~~4/92~~];

(7) Deposit Report Form, No. 120; and

(8) Withdrawal Form, No. 121.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406521
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION

28 TAC §§11.1301 - 11.1306

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring

availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1301. Plan of Operation.

This plan of operation, hereinafter referred to as the plan, shall become effective upon written approval of the Texas Department of Insurance, hereinafter referred to as the department, as provided by the Texas Health Maintenance Organization Act, Insurance Code Chapters [~~Chapter~~] 20A and 843, hereinafter referred to as the Act. As used in this subchapter, the committee shall be the solvency surveillance committee as provided for and defined in the Act, and the members shall be the members of the committee as provided for and defined in the Act.

§11.1302. Solvency Surveillance Committee.

(a) Members. The composition of the committee shall be in accordance with Insurance Code §843.436. [~~There shall be nine members of the committee appointed by the commissioner. A member is a Texas licensed HMO as defined in the Act or a public representative. Five of the members shall represent HMOs or their holding company system. The remaining four members shall be public representatives. The commissioner shall appoint the HMO members along with the officers or employees of the members who shall serve on the committee. The HMO members shall be appointed based on plan characteristics. Of the HMO members, one shall be a single service HMO as defined in the Act. The remaining HMO members shall be selected by the commissioner with due consideration of factors deemed appropriate including, but not limited to, the varying categories of premium income and geographical location. No two HMO members may be employees or officers of the same HMO or holding company system. Public representatives may not be officers, directors or employees of an HMO, HMO agents, or any other business entities regulated by the department; or persons required to register with the Texas Ethics Commission under Government Code, Chapter 305, or related to persons described in this subsection within the second degree of affinity or consanguinity.~~]

(1) The HMO members' terms shall last for three years unless otherwise appointed by the commissioner and shall be staggered with three appointments expiring each year. A member's term shall terminate if the member leaves the HMO [~~plan~~] whose characteristics were the basis for appointment. The HMO [~~plan~~] shall not automatically continue as a member.

(2) (No change.)

(3) A member shall serve until a successor is appointed unless such member's term is in conflict with the Act, or unless a member misses two or more consecutive meetings or engages in willful misconduct, in which case the commissioner may remove the member. The [~~If a member's term is in conflict with the Act, the~~] committee shall make recommendations to the commissioner and the department to fill vacancies. [~~this vacancy. The committee may at such other times make recommendations to the commissioner and the department regarding vacancies which may arise from time to time.~~] Members shall not receive any remuneration or emolument of office.

(4) (No change.)

(b) Voting. A majority of the members [~~present and voting~~] shall constitute a quorum for the transaction of business, and the acts of a majority of the members [~~voting in person~~] at a meeting at which a quorum is present shall be the acts of the committee. An [~~; except that an~~] affirmative vote of a majority of the total membership of the committee shall be required:

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

(5) to extend funding of expenses of supervision, conservation, rehabilitation, or liquidation [~~conservation~~] of an HMO as provided in Insurance Code §843.441 [~~beyond the statutory 150 days~~] unless special notice of the desire to take action on this item is part of the notice of the meeting, in which case the acts of a majority of the members voting in person at a meeting at which a quorum is present shall be the acts of the committee.

(c) Meetings. On a day determined by the members, the committee shall hold a regular annual meeting. At its annual meeting, the committee may schedule additional regular meetings to be held during the period between annual meetings. Meetings shall be held [~~meetings~~] at the department's offices [~~no less frequently than quarterly each year~~] unless the commissioner, chairman of the committee, or other officer acting on the chairman's behalf, designates [~~officers, upon 10 days' notice, shall designate~~] some other [~~date or~~] place. [~~Such notice can be oral or written. Notice of regular meetings shall be provided by the chairman or other officer acting on his or her behalf.~~] At each such meeting the committee may:

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

(5) consider any extension of funding for the expenses of supervision, conservation, rehabilitation, or liquidation [~~conservation~~] of an HMO as provided in Insurance Code §843.441 [~~beyond the statutory 150 days~~];

(6) review [~~latest~~] financial information relating to [~~statements of~~] each HMO. Committee members shall be provided with reports regarding the financial condition of Texas licensed HMOs and regarding the financial condition, administration, and status of HMOs in [~~rehabilitation, liquidation,~~] supervision, [~~or~~] conservation, rehabilitation, or liquidation at meetings. Committee members shall not reveal the condition of nor any information secured in the course of any meeting of the committee with regard to any corporation, form, or person examined by the committee;

(7) - (9) (No change.)

(10) review, consider, and act on the powers given the committee for a special or emergency meeting as outlined in subsection (d)(1) - (3) of this section; and

(11) (No change.)

(d) Special or emergency meetings. The committee shall hold a special or emergency meeting promptly after receiving notice from the commissioner of the need for such meeting. In addition, a special meeting of the committee may be held at the request of a majority of the membership, which shall be polled by the chairman at the request of any two members seeking a special meeting. [~~Such meeting may be held at the department's offices or by telephone conference call at the discretion of the commissioner. At least 48 hours' oral or written notice shall be given each member of such meeting by the commissioner; provided, however, if the period of notice is less than five days, such notice must be given orally by telephone conference to a majority of the full committee; provided, further, however, the committee may always act orally or in meeting by waiving the 48-hour notice.~~] At such meetings, the committee, if appropriate, shall perform the following functions.

(1) The committee shall receive and consider the report of the commissioner regarding HMO impairments or insolvencies within the meaning of [~~the~~] Insurance Code Articles 21.28 and 21.28-A. Such reports may include progress and developments on management of such impairments or insolvencies.

(2) In consultation with the commissioner, the committee shall consider what assessment, if any, shall be levied, decide whether any refund should be made to an HMO, and consider and decide whether any assessment for expenses of supervision, conservation, rehabilitation, or liquidation [~~conservation~~] shall be extended as provided in Insurance Code §843.441 [~~beyond 150 days~~]. Assessments shall conform to Insurance Code §843.441 [~~the Act, §36(c) and (h)~~]. Any HMO failing to pay an assessment after 30 days' written notice that payment is due, shall be reported to the commissioner, and the committee shall consider what other action, if any, shall be taken.

(3) - (4) (No change.)

(e) Notice. Notice of [~~Special~~] meetings of the committee shall be in accordance with Chapter 551 of the Government Code. [~~may be called by the chairman and shall be called upon request of any two members. Not less than five days' oral or written notice shall be given to each member of the time, place, and purpose of any such special meeting. Any member not present may consent in writing to any specific action taken by the committee, but this shall not permit members to act through other members by proxy. Any action approved by the required number of members at such meeting, including those members consenting in writing, shall be as valid a committee action as though authorized at a regular meeting of the committee. At such special meeting, the committee may consider and decide any matter deemed by it to be necessary for the proper administration of the committee.~~]

[~~(f) Emergency meetings. Emergency meetings of the committee may be called by the commissioner, by the chairman, or upon the request of any two members. Due to the urgent nature of emergency meetings, the five days' oral or written requirement for notice shall be waived provided the commissioner makes reasonable attempts to contact each committee member. At such emergency meeting, the committee may consider, decide, and act on any matter deemed by it to be necessary and urgent for the proper administration of the committee.~~]

(f) [~~(g)~~] Attendance at meeting. Committee meetings shall [~~not~~] be open to the public, but the committee may hold a closed meeting under the provisions of Subchapter D of Chapter 551, Government Code, in which [~~and~~] only committee members, the commissioner, and persons authorized by the commissioner shall be in attendance at such meeting.

§11.1303. Operations.

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

(c) Custodian of accounts.

(1) The committee [~~hereby~~] appoints the director of liquidation oversight [~~liquidator designated by the department~~] as the custodian of the administrative account and as its agent for collecting assessments from HMOs. In the name of the committee, the custodian shall maintain such funds in depositories as provided by [~~the~~] Insurance Code Article 21.28, §(2)(h). The committee may authorize the investment of some or all of these funds in other types of [~~type~~] investments.

(2) The director of liquidation oversight [~~liquidator~~] shall maintain suitable account records [~~to account for the funds under his custody~~] and shall furnish the committee at each regular meeting [~~thereof~~] a statement of the financial condition of the committee and a statement of income and disbursements since the last report. The director of liquidation oversight [~~liquidator~~] shall be entitled to reimbursement for [~~his~~] actual expenses in performing the custodian's [~~his~~] duties under this subsection and is authorized to hire a certified public accountant to audit the annual statement required by [~~the~~] Insurance Code Chapters [~~Article~~] 20A and 843.

(3) Disbursement of any of the funds of the committee specifically authorized by this plan or subsequently authorized by resolution of the committee may be made by the custodian upon receipt

of a statement or voucher describing the proposed expenditure that [which] has been approved in writing by an officer of the committee.

(d) Additional procedures. The committee shall[, from time to time, as it deems appropriate,] establish any additional procedures for handling any [asset or] assets of the committee as deemed appropriate.

§11.1304. Records and Reports.

(a) Written record. A written record of the proceedings of each committee meeting shall be made. The original of this record shall be retained by the commissioner with copies [being] furnished to each member[,] and to the department. The [Such] record shall be subject to the pertinent provisions of the law, including [those as to the] confidentiality laws [of the proceedings of the committee].

(b) (No change.)

§11.1305. Appeals.

(a) (No change.)

(b) Appeal to district court. Any HMO or HMO agent which is affected by any ruling or action of the commissioner may file a petition in the District Court of Travis County, Texas to have any [such] ruling or action reviewed by the court pursuant to [the] Insurance Code §§36.201 - 36.205 [Article 1.04, §(a)].

§11.1306. Conformity of Statute.

Sections 843.435 - 843.441 of the Texas Insurance Code are[, Article 20A.36, as written, and as may be amended, is] incorporated as a part of this plan.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406522
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

28 TAC §§11.1401 - 11.1404

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt

any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1401. Commissioner's Authority to Require Additional Information.

The commissioner may require additional information as needed to make any determination required by [~~the Texas~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843, or this chapter [~~these rules~~].

§11.1402. Notification to Providers.

(a) A health maintenance organization that provides coverage for health care services or medical care through one or more providers or physicians is required by the provisions of [~~the Texas~~] Insurance Code §843.305[~~, Article 20A.14(h),~~] to provide a 20 calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in providing health care services or medical care under the terms and conditions established by the health maintenance organization for the provision of such services and the designation of such providers and physicians. Section 843.305 [~~Article 20A.14(h)~~] may not be construed to:

(1) require that a health maintenance organization utilize a particular type of provider or physician in its operation;

(2) require that a health maintenance organization accept a provider or physician of a category or type that does not meet the practice standards and qualifications established by the health maintenance organization; or

(3) require that a health maintenance organization contract directly with such providers or physicians.

(b) An [~~In order to effectively notify providers or physicians of the opportunity to apply to provide services, after January 1, 1992, an~~] HMO which is covered by [~~the Texas~~] Insurance Code §843.305[~~, Article 20A.14(h),~~] must publish a notice of an application period to physicians and providers in the public notice section of at least one major newspaper with general circulation in each of its service areas. The notice must be published for five consecutive days during the period of January 2 through January 23 of each calendar year and must include[~~:~~] this caption in bold type: Notice to Physicians and Providers, the name and address of the HMO, what type of services the HMO provides, and the specific dates of the 20 day period during which physicians and providers may make application to be a participating physician or provider.

(c) [~~(b)~~] A health maintenance organization must notify a physician or provider of acceptance or non-acceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider.

(d) [~~(c)~~] A health maintenance organization must file a copy of the published notice with the HMO Division [~~unit~~], for information, within 15 days of publication. The filing must include the following:

(1) the name of the newspaper; and

(2) the beginning and ending date of the publication.

[~~(d) During the year 1992, HMOs must publish a notice meeting the requirements of this section within 60 days of the effective date of this section, and file a copy of the notice with the HMO unit in accordance with subsection (c) of this section and must comply with subsection (b) of this section.~~]

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

Health Maintenance Organizations shall include in their next available newsletter or other general mailing to all enrollees following the effective date of this section [~~rule~~], and shall include in information provided to new subscribers, the following notice:
Figure: 28 TAC §11.1403

§11.1404. Pharmacy Application and Recertification.

(a) An HMO [~~subject to the requirements of the Texas Insurance Code, Article 21.52B, as amended,~~] may establish reasonable application and recertification fees for each licensed pharmacy that [~~which~~] participates or applies to participate as a contract provider in an HMO delivery network.

(b) An application or recertification fee charged under this section shall be considered reasonable provided:

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

(4) no more than one fee per licensed pharmacy is charged by an HMO for processing an application or recertification for participation as a contracted [~~contract~~] provider under more than one group or individual contract or in more than one HMO delivery network; and

(5) no more than one fee per licensed pharmacy is charged by any HMO or insurer within the same insurance holding company system, as defined in [~~the~~] Insurance Code §843.002[~~, Article 21.49-1, §2~~], utilizing common networks.

(c) An HMO shall not require any pharmacy or pharmacist participating or applying to participate as a contracted [~~contract~~] provider in an HMO delivery network:

(1) - (2) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER P. PROHIBITED PRACTICES

28 TAC §11.1500

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080

provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1500. Discrimination Based on Health Status-Related Factors.

[~~(a)~~] An HMO may not require an enrollee in a group health plan to pay a premium or contribution that is different from [~~grater than~~] the premium or contribution for a similarly situated enrollee based on a health status-related factor. For purposes of this section, the term "similarly situated" has the meaning assigned to it in 45 CFR §146.121, relating to prohibiting discrimination against participants and beneficiaries based on a health factor.

[~~(b)~~] An HMO may not establish policies or procedures that are [~~charge different premiums or contributions~~] based on health status-related factors for the eligibility of any individual to enroll [~~enrollees~~] under a group [~~health~~] plan.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406524
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §§11.1600 - 11.1602, 11.1604 - 11.1607

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit

modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1600. Information to Prospective and Current [~~Group~~] Contract Holders and Enrollees.

(a) An HMO shall provide an accurate written description of health care plan terms and conditions[~~;~~] to allow any prospective [~~or current group~~] contract holder or [~~and prospective~~] enrollee [~~eligible for enrollment in a health care plan~~] or [~~a~~] current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. By agreement, the HMO may deliver the required description of health care plan terms required by this section electronically.

(b) The written or electronic plan description must be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category, and must include a clear, complete and accurate description of these items in the following order:

(1) (No change.)

(2) a toll-free number, unless exempted by statute or rule, and address [~~for the prospective or current group contract holder or prospective or current enrollee~~] for obtaining additional information, including provider information;

(3) - (10) (No change.)

(11) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, updated on at least a quarterly basis. The list shall include the information necessary to fully inform prospective or current enrollees about the network, including names and locations of physicians and providers, a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network, and a disclosure of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees. [~~If an HMO limits enrollees' access to a limited provider network, it shall provide the following information to prospective and current group contract holders and enrollees:~~]

(A) If an HMO limits enrollees' access to a limited provider network, it shall provide to prospective and current group contract holders and enrollees a notice in substantially the following form: "Choosing Your Physician--Now that you have chosen XYZ Health Plan, your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick and when you need preventive care

such as immunizations. Your PCP is also part of a "network" or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all [All] of your care [will be provided by or arranged for within the network to which your PCP belongs], so make sure that your PCP's network includes the specialists and hospitals that you prefer."

[(B) If an HMO opts to limit a female enrollee's designation of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or primary care provider belongs, a notice in substantially the following form: "ATTENTION FEMALE ENROLLEES: Your Choice of Physician or Provider Affects your Choice of OB/GYN--In selecting your Primary Care Physician or Primary Care Provider (PCP), remember that your PCP's network affects your choice of an OB/GYN. You have the right to designate an OB/GYN to whom you have access without first obtaining a referral from your PCP. However, if you choose to designate an OB/GYN, the OB/GYN you designate must belong to the same network as your PCP. This is another reason to make certain that your PCP's network includes the specialists, particularly the OB/GYN and hospitals that you prefer. You are not required to designate an OB/GYN; you may elect to receive your OB/GYN services from your PCP."]

(B) [(C)] If an HMO does not limit an enrollee's selection [designation] of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or [primary care] provider belongs, it shall provide to current or prospective enrollees a notice in compliance with Insurance Code Article 21.53D in substantially the following form: "ATTENTION FEMALE ENROLLEES: [Although your choice of Primary Care Physician or Primary Care Provider (PCP) in most cases limits your selection of specialists and hospitals to those specialists and hospitals that belong to your PCP's network, such is not the case in your choice of an OB/GYN.] You have the right to select [designate] an OB-GYN [OB/GYN] to whom you have access without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN [OB/GYN] to your PCP's network. You are not required to select [designate] an OB-GYN [OB/GYN]; you may elect to receive your OB-GYN [OB/GYN] services from your PCP."

(C) [(D)] An HMO shall clearly differentiate limited provider networks and open networks within its service area by providing [assigning different colors, symbols, or other distinguishing marks to each network. An HMO shall provide] a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. [Specialists shall be listed by city in alphabetical order by specialty.] An HMO shall include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area [shall be included], and shall indicate [include the name, the color, symbol or other distinguishing mark indicating] the limited provider network(s) to which the physician or provider belongs, and the page number where the physician or provider's name can be found.

(D) An HMO shall provide notice regarding payment of non-contracted physicians and providers that perform either emergency services or medically necessary covered services due to the unavailability of a participating physician or provider. Consistent with §11.1607(i) of this title (relating to Accessibility and Availability Requirements) and §11.506(10)(D) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement, and Group Certificate), the notice shall inform enrollees that the HMO will indemnify or otherwise hold them harmless for such services.

(E) An HMO that maintains an internet site shall include on its internet site the information as required in subparagraphs (A) - (D) of this paragraph.

(12) the service area.

(c) No HMO, or representatives thereof, may cause or knowingly permit the use or distribution of [prospective] enrollee information which is untrue or misleading.

(d) An HMO may utilize its handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under subsection (b) of this section.

(e) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (e.g., hospital or skilled nursing facility), the plan description must disclose that upon admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(f) An HMO that maintains an internet site shall list the information as required by this paragraph and Insurance Code §843.2015 on its internet site.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the [allows physicians or providers to require that enrollees present an identification (ID) card in order to receive services, that] HMO shall issue the [to an enrollee an] ID cards [card] within 30 calendar days of receiving notice of the enrollee's selection [designation] of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage which require presentation of the card.

(b) All ID cards an HMO issues shall comply with the requirements of §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO shall issue an ID card in compliance with §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, Issuance of Standard Identification Cards, and Previously Issued Identification Cards).

(d) All ID cards issued by an HMO shall comply with the requirements of Business and Commerce Code Section 35.58, which restricts the display of social security numbers on ID cards.

§11.1602. Access to Certain Information.

(a) (No change.)

(b) The HMO shall provide, at its own expense, an enrollee handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the language

of the major population of the HMO's enrolled population pursuant to [~~the~~] Insurance Code §843.205 [~~Article 20A.11A~~].

(c) (No change.)

§11.1604. Requirements for Certain Contracts between Primary HMOs and ANHCs and Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine, or a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network shall:

(1) (No change.)

(2) file with the Texas Department of Insurance, pursuant to §11.301(5) of this title (relating to Filing Requirements [~~Filings for Information~~]), a copy of the form of the written agreement with an ANHC or provider HMO that:

(A) requires that [~~the agreement cannot be terminated by~~] the ANHC or provider HMO cannot terminate the agreement without 90 days written notice;

(B) contains a hold-harmless provision that prohibits [~~providing that~~] the ANHC or provider HMO and its contracted physicians and providers [~~are prohibited~~] from billing for or attempting to collect from HMO members (except for authorized co-payments and deductibles) charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC or provider HMO;

(C) (No change.)

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) - (ii) (No change.)

(iii) the primary HMO may take [~~whatever action is deemed~~] necessary action to assure that all HMO systems and functions which are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all regulatory requirements of the Texas Department of Insurance;

(E) - (F) (No change.)

(G) requires the ANHC or provider HMO to provide the primary HMO on at least a monthly basis, in a usable form necessary for audit purposes, the data necessary for the HMO to comply with the Texas Department of Insurance, and Texas Health Care Council reporting requirements with respect to any services provided pursuant to the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) - (xi) (No change.)

(xii) documentation of any inquiry and/or [~~inquiries and~~] investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of such an inquiry and/or investigation; and

(xiii) (No change.)

(3) - (4) (No change.)

§11.1605. Pharmaceutical Services.

(a) Should an HMO provide prescription drug coverage, such coverage shall be subject to copayments for both generic drugs and name brand drugs. If the negotiated or usual or customary cost of the drug is less than the copayment, the enrollee shall pay the lower cost. The copayments may be the same, or if different, shall be applied as follows:

(1) if the prescription is for a generic drug, the enrollee shall pay no more than the generic copayment;

(2) if the prescription is for a name brand drug, the enrollee shall pay no more than the name brand copayment if:

(A) the prescription is written "Dispense as written"; or

(B) there is no generic equivalent for the prescribed drug;

(3) if the prescription is written "product selection permitted" and the enrollee elects to receive a name brand drug when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug.

(4) if the enrollee's prescription benefit requires the use of generic equivalent drugs ("required generic") and the enrollee receives a name brand drug when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug, even when the prescription is written "dispense as written."

(b) Pharmacy services, if offered, shall be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO shall offer such pharmacy services directly or through contracts.

(c) An HMO that provides coverage for prescription drugs under an individual or group health benefit plan shall comply with the requirements of Insurance Code Article 21.53M, and §21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drugs).

(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of Insurance Code Article 21.52L (Health Benefit Plan Coverage for Prescription Contraceptive Drugs and Devices and Related Services).

(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of Insurance Code Article 21.52J and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).

§11.1606. Organization of an HMO.

(a) The governing body as described in [~~the~~] Insurance Code §843.004 [~~Article 20A.07~~], shall have ultimate responsibility [~~be responsible~~] for the development, approval, implementation and enforcement of administrative, operational, personnel and patient care policies and[~~,~~] procedures [~~and~~] related to [~~documents for~~] the operation of the HMO.

(b) The HMO shall have [~~provide~~] a [~~full time~~] chief executive officer or operations officer who shall be accountable for the administration of the health plan, including: [~~and at least one full-time medical director; and if a limited service health care plan or single service health care plan, a full-time director, who is available with a service area.~~]

(1) developing corporate strategy;

(2) overseeing marketing programs;

(3) overseeing medical management functions; and

(4) ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

(c) The HMO shall have a clinical director who:

(1) shall be currently licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO. For example:

(A) a basic HMO shall have a physician;

(B) a dental HMO shall have a dentist or physician;

(C) a vision HMO shall have an optometrist or physician; and

(D) a limited services HMO shall have a physician.

(2) shall reside in the state of Texas;

(3) shall be available at all times to address complaints, clinical issues, utilization review and any quality of care issues on behalf of the HMO;

(4) shall demonstrate active involvement in all quality management activities; and

(5) shall be subject to the HMO's credentialing requirements, as appropriate.

(d) [~~(c)~~] The HMO may establish one or more service areas within Texas. Each defined service area must [~~meet the following~~]:

(1) demonstrate to the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties and zip codes, or any portions thereof, included in the service area;

(3) provide a complete physician and provider listing for all enrollees residing, living or working in the service area; and

(4) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HMO financial reporting.

[~~(d) The HMO shall ensure the service area maintains the following: ~~]

[~~(1) if a basic health care service plan, a medical director, and if a limited health care service plan or a single health care service plan, a director who: ~~]

[~~(A) shall be currently licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO; ~~]

[~~(B) shall reside in the service area; and ~~]

[~~(C) may serve in a part-time capacity and shall be available at all times to each service area. However, the medical director or a physician designee or single service director or designee meeting the criteria described in subparagraphs (A) and (B) of this paragraph, shall be available at all times to address complaints, clinical issues, utilization review and any quality of care inquiries on behalf of the HMO. ~~]

[~~(2) compliance with all requirements for quality improvement and utilization review functions as described in Subchapter T of this chapter (relating to Quality of Care). ~~]

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network which is adequate and complies with Insurance Code §843.082.

(b) There shall be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO shall make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that such limited provider network complies with the provisions of this section.

(e) An HMO shall make emergency care available and accessible 24 hours per day, seven days per week, without restrictions as to where the services are rendered.

(f) All covered services that are offered by the HMO shall be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) HMOs must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request and consistent with guidelines set out in paragraphs (1) - (3) of this subsection:

(1) Urgent care shall be available:

(A) within 24 hours for medical and dental conditions; and

(B) within 48 hours for behavioral health conditions.

(2) Routine care shall be available:

(A) within three weeks for medical conditions;

(B) within eight weeks for dental conditions; and

(C) within two weeks for behavioral health conditions.

(3) Preventive health services shall be available:

(A) within two months for a child;

(B) within three months for an adult; and

(C) within four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

[~~(a) An enrollee shall not be required to:~~]

(1) [~~travel in excess of~~] 30 miles for [~~from the site of eligibility to reach a~~] primary care [~~physician~~] and general hospital care [~~except as provided in subsections (b) and (c) of this section~~]; and

(2) [~~travel in excess of~~] 75 miles for [~~from the site of eligibility to secure contact with referral specialists,~~] specialty care. [~~hospitals, psychiatric hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or providers except as provided in subsections (b) and (c) of this section;~~]

[~~(3) for purposes of this subsection, "site of eligibility" refers to the location which makes the subscriber eligible for coverage~~].

(i) [~~(b)~~] If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage

radii specified in subsection (h) [(a)] (1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access [a] plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:

(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;

(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;

(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;

(4) the HMO's [general] plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified, which shall include an explanation of the HMO's plan to ensure that enrollees are indemnified or otherwise held harmless when non-participating physicians and providers provide services to enrollees due to the unavailability of the service from a physician or provider in the HMO's network or network facility;

(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the HMO delivery network to meet the medical needs of the enrollees covered under the HMO's [general] plan required under paragraph (4) of this subsection;

(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;

(7) [a general description of] the [day to day] procedures to be followed by the HMO to assure that primary care physicians, general hospitals, [referral] specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers and all other mandated health care services are made available and accessible to enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and

(8) any other information which is necessary to assess the HMO's plan.

(j) [(c)] The HMO may make [is not precluded from making] arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level which is available within the HMO service area such as, but not limited to, transplants, treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive such services, unless the HMO provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

[(d) The HMO shall require the HMO physicians and other providers of care who employ physician assistants, advanced practice nurses, dental hygienists and individuals other than physicians to assess the health care needs of HMO enrollees to have written policies which are implemented and enforced and describe the duties of all such providers in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.]

[(e) The HMO shall systematically and regularly verify that health care services furnished by physicians and providers of care such as dentists and physical therapists are available and accessible to enrollees without unreasonable periods of delay.]

[(f) The HMO shall develop and maintain a statistical reporting system which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of its services, and the availability and accessibility of it services.]

[(g) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network which is adequate and complies with the Insurance Code Article 20A.05(a)(1).]

(k) [(h)] The HMO shall not be required to expand services outside its service area to accommodate enrollees who live outside the service area, but work within the service area.

(l) [(i)] In accordance with Insurance Code Article 21.53F (Telemedicine), each [Each] evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or a telemedicine medical service.

[(j) Before providing telehealth services or telemedicine medical services to an enrollee, an HMO shall provide the enrollee with the option to select a physician or provider within the HMO delivery network to provide the covered health care services, or to elect to receive telehealth services or telemedicine medical services.]

[(k) In order to provide covered health care services to any enrollee by a telehealth service or a telemedicine medical service, an HMO shall satisfy the criteria specified under subsection (a) of this section.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

28 TAC §§11.1702 - 11.1704

The amendments are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K,

21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146.

§11.1702. Requirements for Issuance of Certificate of Authority to ANHC.

(a) Prior to obtaining a certificate of authority under [~~the~~] Insurance Code, Chapter 844 [~~Article 21.52F~~] (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under [~~the~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843; this chapter [~~title, Chapter 11~~]; and applicable insurance laws and regulations of this state; and

(2) (No change.)

(b) The commissioner shall grant a provisional certificate of authority to an applicant ANHC under [~~the~~] Insurance Code, Chapter 844 [~~Article 21.52F, §4(b)~~], if:

(1) the applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under [~~the~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843; this chapter [~~title, Chapter 11~~]; and applicable insurance laws and regulations of this state;

(2) the applicant ANHC demonstrates that it has applied for accreditation;

(3) - (4) (No change.)

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under [~~the~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843; this chapter [~~title, Chapter 11~~]; and applicable insurance laws and regulations of this state in order to maintain a certificate of authority.

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code, Chapters 843 and 844 [~~Articles 21.52F(2) and 20A.26(f)~~], including an ANHC that contracts to arrange for or provide only medical care as defined in Insurance Code §843.002 [~~, Article 20A.02(k)~~].

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

Any agent for an ANHC with a certificate of authority or a provisional certificate of authority shall be considered an HMO agent and shall

comply with the requirements of [~~the~~] Insurance Code Article 21.07-1 and Chapter 19 of this title (relating to Agent's Licensing) [~~, Article 20A.15 or Article 20A.15A~~], as applicable[~~, and §§11.401 - 11.409 of this title (relating to Licensure and Regulation of HMO Agents)~~].

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code, Chapter 844 [~~Article 21.52F~~], and this subchapter shall be subject to the same statutes and rules as an HMO and considered an HMO for purposes of regulation and regulatory enforcement.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID

28 TAC §§11.1801 - 11.1806

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.1801. Entities Covered.

(a) As used in this subchapter, a managed care organization is an entity holding a certificate of authority to operate as an HMO under Chapters [~~Chapter~~] 20A and 843 of the Texas Insurance Code or as an approved nonprofit health corporation under Chapter 844 [~~Article 21.52F~~] of the Texas Insurance Code.

(b) Any managed care organization or other entity providing the services specified in 42 United States Code §1396b(m)(2)(A) and participating in the State Medicaid Program (all hereinafter referred to as an [~~a~~] "MCO") must first comply with the requirements and solvency standards set forth in this subchapter, and must not be in a hazardous financial condition as defined in §843.406 [~~Article 20A.19~~] of the Texas Insurance Code, §11.810 of this title (relating to Hazardous Conditions for HMOs), or Chapter 8 of this title (relating to Early Warning System for Insurers in Hazardous Condition) where pertinent to managed care organizations. In addition, any MCO already subject to regulation of any kind, must be in compliance with any solvency standard and/or requirement pertinent to its regulation, as well as all applicable licensing laws and regulations.

[~~(c) Notwithstanding any other provision in this subchapter, if an MCO had a Medicaid contract in effect immediately prior to August 1, 1996 and if that MCO is subject to this subchapter, then that MCO must comply with the requirements in this subchapter within one year after becoming subject to this subchapter.~~]

§11.1802. Minimum Surplus or Net Worth.

(a) An [~~Subject to the reduction specified in §11.1804 of this title (relating to Guarantees) and the exception specified in §11.1801 of this title (relating to Entities Covered), an~~] MCO must possess the greater of:

(1) the statutory minimum capital and surplus (net worth) required of an MCO in accordance with the types of business that the MCO is authorized to write [~~$1.5 million for a basic service MCO, $1.0 million for a limited service MCO, and $500,000 for a single service MCO of admitted assets in excess of all liabilities plus sufficient capital of a nature acceptable to the department to cover 12 months of reasonably projected losses, with the 12 months beginning from the date of inception of the initial Medicaid contract executed with the MCO which is subject to this subchapter~~]; or

(2) a minimum surplus or net worth equal to no less than the regulatory action level of risk based capital (150% of its authorized control level risk based capital) in accordance with the formula adopted by the commissioner pertaining to the MCO subject to the following phase-in:

(A) at December 31, 2005, the minimum net worth shall be equal to no less than 100% of the authorized control level risk based capital,

(B) at December 31, 2006, the minimum net worth shall be equal to no less than 125% of the authorized control level risk based capital, and

(C) at December 31, 2007, the minimum net worth shall be equal to no less than 150% of the authorized control level risk based capital [~~a minimum net worth equal to $25 per existing enrollee plus the number of reasonably projected enrollees for the next 12 months, which projection may not be a negative number~~].

(b) If at any time the MCO discovers that it does not meet its minimum net worth requirement, the MCO shall immediately fund capital sufficient to cure the impairment. [~~In addition, an MCO must infuse capital in a form acceptable to the department at the end of every six months to fund any losses in excess of its originally projected losses or to maintain the $25 per enrollee requirement provided above.~~]

§11.1803. Statutory Deposits.

(a) [~~As used in this section, "uncovered health care expenses" means the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the MCO.~~]

[~~(b)~~] In addition to amounts already deposited in accordance with other statutory and regulatory provisions, and subject [~~Subject~~] to the reduction specified in §11.1804 of this title (relating to Guarantees), an MCO must have on] deposit with the Office of the Comptroller of Public Accounts of Texas [~~the greater of~~]:

(1) $400,000 [~~$500,000~~] if a basic service MCO;

(2) $275,000 [~~$375,000~~] if a limited service MCO; or

(3) $200,000 [~~$250,000~~] if a single service MCO. [~~; or~~]

[~~(2) an amount equal to uncovered health care expenses incurred for the previous calendar year. If an MCO has not existed for a full calendar year, then this amount must equal the reasonably projected uncovered health care expenses for the first 12 months of operation.~~]

(b) [~~(c)~~] This deposit may be used to protect the interests of the enrollees of the MCO, including but not limited to the payment of the costs delineated in §11.1805(a)(2)(C) of this title (relating to Performance and Fidelity Bonds) [~~or related to uncovered health care services~~]. Any deposit is subject to the procedures set forth in §11.802 of this title (relating to Statutory Deposit Requirements).

§11.1804. Guarantees.

(a) As used in this section, the phrase "certified audited financial statements" means financial statements audited by a CPA utilizing generally accepted auditing standards that [~~which~~] attest that the financial condition of the MCO is fairly represented in accordance with generally accepted accounting principles; and the phrase "section 1115 waiver expansion program" means the Medicaid program involving children of the ages 6-18 years in a socio-economic level of up to 133% over the federal poverty level and who are not eligible under the regular Medicaid program.

(b) If a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in this section, then the additional deposit amounts specified in §11.1803(a)(1) of this title (relating to Statutory Deposits) [~~requirements~~] shall be reduced to the following amounts [~~as follows~~]:
Figure: 28 TAC §11.1804(b)

(c) (No change.)

(d) If at any time a guarantee issued for the benefit of an MCO does not comply with every requirement of this section, then the reductions provided for in this section terminate and the amounts stated in §11.1803 [~~§11.1802(a)~~] of this title [~~(relating to Minimum Surplus or Net Worth) and §11.1803(b) of this title (relating to Statutory Deposits)~~] immediately apply to the MCO.

§11.1805. Performance and Fidelity Bonds.

(a) (No change.)

(b) In addition, an MCO must maintain the fidelity bonds required by and comply with [~~the~~] Insurance Code §843.402 [~~Article 20A.30~~].

§11.1806. Additional Information That May be Requested From [~~to be Submitted by~~] an MCO Participating in Medicaid.

(a) Whenever requested by the department [~~Within 30 days after the end of each reporting period~~], the MCO shall file a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be

modified or amended by the Texas [~~Department of~~] Health and Human Services Commission. When a request is received, the [~~The~~] MCO shall then file, on two separate occasions, an original Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. The first annual report shall reflect data completed through the 90th day after the end of the contract year, and shall be submitted within 120 days after the end of the contract year. The second annual report shall reflect data completed through the 270th day after the end of the contract year, and shall be submitted 300 days after the end of the contract year. The second (final) report shall be accompanied by a written opinion from a CPA attesting to the fact that the subject report presents fairly, in all material respects, the financial and statistical results of the contract's state Medicaid program operations for the period stated therein, in conformity with generally accepted accounting principles consistently applied throughout the reported period(s).

(b) For any new or modified request to the Texas Health and Human Services Commission for participation in the Medicaid managed care program, all financial projections, including enrollment projections, from the effective or renewal date of a Medicaid contract that are submitted to the Texas Health and Human Services Commission are also required to be submitted to the Texas Department of Insurance. The MCO shall submit the same financial projections, including a cash flow statement, submitted to the Texas [~~Department of~~] Health and Human Services Commission with the request to participate in the Medicaid program [~~for application (RFA)~~]. This information shall be submitted with the certificate of authority if the MCO is not already a licensed MCO. If the MCO is a licensed operation, then the financial projections must [~~should~~] be sent with the next financial statement due to the department.

(c) The MCO shall notify the department of any [~~Any~~] similar financial or statistical reports required by other contracting state agencies and shall submit copies of these reports, when requested by [~~also be submitted to~~] the department [~~in the same manner as described in subsections (a) and (b) of this section~~].

(d) Information submitted pursuant to this section shall be sent to the Texas Department of Insurance, Financial Analysis & Examinations [~~Monitoring Unit~~], Mail Code 303-1A, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER T. QUALITY OF CARE

28 TAC §11.1901, §11.1902

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the

commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.1901. Quality Improvement Structure for Basic and Limited Services HMOs.

(a) A basic or limited services [~~The~~] HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement.

(b) The [~~HMO~~] governing body is ultimately responsible for the QI [~~overall quality improvement~~] program. The [~~HMO~~] governing body shall:

(1) appoint a quality improvement committee (QIC) that shall include practicing physicians, individual providers and at least one enrollee from throughout the HMO's service area. For purposes of this section, the enrollee appointed to the committee may not be an employee of the HMO;

(2) approve the QI [~~quality improvement~~] program;

(3) approve an annual QI [~~quality improvement~~] plan;

(4) meet no less than annually to receive and review reports of the QIC [~~quality improvement committee~~] or group of committees and take action when appropriate; and

(5) review the annual written report on the QI [~~quality improvement~~] program.

(c) The QIC [~~quality improvement committee~~] shall [~~develop and~~] evaluate the overall effectiveness of the QI [~~quality improvement~~] program.

(1) The QIC [~~quality improvement committee~~] may delegate QI [~~quality improvement~~] activities to other committees that may, if applicable, include practicing physicians and[~~,~~] individual providers, and enrollees from [~~throughout~~] the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services [~~to be furnished by the HMO to its enrollees~~].

(B) All committees shall meet [~~and~~] regularly and report the findings of each meeting, including any recommendations, [~~and resolutions~~] in writing to [~~through~~] the QIC [~~qualify improvement committee for the HMO governing body~~].

(C) If the QIC [~~quality improvement committee~~] delegates any QI [~~quality improvement~~] activity to any subcommittee, then the QIC [~~quality improvement committee~~] must establish a method to oversee [~~of oversight of~~] each subcommittee.

(2) The QIC [~~quality improvement committee~~] shall use multidisciplinary teams, when indicated, to accomplish QI [~~quality improvement~~] program goals.

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs.

The QI [~~quality improvement~~] program for basic and limited services HMOs shall be continuous and comprehensive, addressing [~~including~~] both the quality of clinical care and the quality of services [~~service~~]. The HMO shall dedicate adequate resources, such as personnel and information systems, [~~analytic capabilities, and data resources~~] to the QI [~~quality improvement~~] program. [~~The HMO shall continuously update and monitor the quality improvement program.~~]

(1) Written description. The QI program [~~There~~] shall include [~~be~~] a written description of the QI [~~quality improvement~~] program that outlines program organizational structure, functional responsibilities, [~~responsibility~~] and meeting frequency [~~design~~].

(2) Work plan. The QI program [~~There~~] shall include [~~be~~] an annual QI [~~quality improvement~~] work plan [~~that includes a schedule of activities~~] designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan shall include [~~but not be limited to the following~~]:

(A) Objective and measurable goals; [~~Goals, objectives, and~~] planned [~~projects or~~] activities to accomplish the goals; [~~identified from the previous year, as well as for the current year;~~] time frames for implementation; responsible individuals; and evaluation methodology [~~coordination of functions~~].

[~~(B) Use of quality indicators, performance measurements, and quality improvement data collection to monitor quality improvement.~~]

[~~*(i)* Quality indicators must be objective, measurable, and include performance goals for each indicator.~~]

[~~*(ii)* Performance measures must be process or outcome measures.~~]

[~~*(iii)* Data collected must be appropriate to the goals and objectives of the activity.~~]

[~~(C) Ongoing or periodic assessment of both quality of clinical care and quality of service in planned projects, specifically:~~]

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services;

(iii) Clinical studies [~~, which shall specify methodologies to be used to accomplish them~~];

(iv) The adoption and periodic [~~annual~~] updating of clinical practice guidelines or clinical care standards [~~, compatible with~~

~~current principles of health care~~]; the QI [~~quality improvement~~] program shall assure the practice guidelines:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers [~~included in physician and provider manuals~~]; and

(III) include preventive health services.

(v) Enrollee, physician, and individual provider satisfaction;

(vi) The complaint and appeals process, complaint data, and identification and removal of communication barriers that [~~which~~] may impede enrollees, physicians, and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities; [~~:~~]

~~[(I) The HMO shall inform and educate physicians and providers about using the health management and outreach programs for the enrollees assigned to them.]~~

~~[(II) Outreach may be accomplished through, but not limited to, written educational materials, community-based programs and presentations, health promotion fairs, and monetary contributions to community-based organizations and health related initiatives of other programs.]~~

(viii) Claims payment processes;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements; [~~and~~]

(x) Utilization review processes; [~~.~~]

(xi) Credentialing;

(xii) Member services; and

(xiii) Pharmacy services, including drug utilization.

~~[(D) Ongoing or periodic analysis and evaluation of both quality of clinical care and quality of service planned projects specified in subparagraph (C) of this paragraph, which shall include:]~~

~~[(i) Evidence that results of evaluation are used to improve clinical care and services; and]~~

~~[(ii) A systematic method of tracking areas identified for improvement to assure that appropriate action is taken to effect the needed improvement.]~~

(3) Evaluation. The QI program [~~There~~] shall include [~~be~~] an annual written report on the QI [~~quality improvement~~] program, which includes completed activities, trending of clinical and service goals [~~indicators~~], analysis of program performance, and conclusions [~~, and demonstrated improvements in care and services~~].

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential [~~Credentialing is required for~~] all physicians and providers, including advanced practice nurses, and physician [~~physicians'~~] assistants, if they are listed in the provider directory. An HMO shall credential each physician [~~Physicians~~] or individual provider [~~providers~~] who is a member [~~are members~~] of a contracting group, such as an independent physician association or medical group [~~, shall be credentialed individually~~].

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) [~~(ii)~~] An HMO [~~Credentialing~~] is not required to credential [~~for~~]:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician [~~physicians'~~] assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows; [~~or~~]

(IV) pharmacists; or[~~.~~]

(V) opticians.

(iv) [~~(iii)~~] An HMO must complete the [~~The~~] initial credentialing process, including application, verification of information, and a site visit (if applicable), [~~must be completed~~] before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) [~~(iv)~~] An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to [~~the~~] Insurance Code §§843.306 - 843.309 [~~Article 20A.18A(b)~~].

(vii) [~~(v)~~] The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality [~~are identified~~]. Monitoring shall include [~~, but not be limited to~~]:

(I) Medicare and Medicaid sanctions; the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

~~[(vi) If the HMO delegates credentialing functions to other entities, it shall have a process for developing delegation criteria and for performing pre-delegation and annual audits, a delegation agreement, a monitoring plan, and a procedure for termination of the delegation agreement for non-performance. If the HMO delegates~~

~~credentialing functions to an entity accredited by the National Committee for Quality Assurance, the annual audit of that entity is not required; however, evidence of this accreditation shall be made available to the department for review. The HMO shall maintain documentation of pre-delegation and annual audits, executed delegation agreements, reports received from the delegated entities, current rosters or copies of signed contracts with physicians and providers who are affected by the delegation agreement, and ongoing monitoring and shall make this documentation available to the department for review. Credentialing files maintained by the other entities to whom the HMO has delegated credentialing functions shall be made available to the department for examination upon request. In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.]~~

(viii) [~~(vii)~~] The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients.

(ix) [~~(viii)~~] The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include[~~, but not be limited to,~~] the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following [~~shall be verified~~] from primary sources and shall include evidence of verification [~~shall be included~~] in the credentialing files:

(I) (No change.)

(II) Education and training, including evidence of graduation from an [~~the~~] appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association [~~Association's~~] MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary [~~Primary~~] source verification [~~may be obtained~~] from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use [~~source used must be~~] the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them [~~be verified~~] by any one of the following means:

(-a-) - (-d-) (No change.)

(-e-) entry in the American Medical Association Physician MasterFile [~~Master File~~].

(iii) The HMO shall verify [~~following shall be verified~~] within 180 calendar days prior to the date of the credentialing decision and shall include [~~also be included~~] in the physician's or individual provider's credentialing file the following:

(I) Past five-year [~~years of~~] history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain [~~may be obtained~~] from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain [~~be obtained~~] from one of the following:

(-a-) - (-f-) (No change.)

(-g-) entry in the American Medical Association Physician MasterFile [~~Master File~~].

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual primary care provider, obstetrician-gynecologist, primary care dentist, and high-volume [~~individual~~] behavioral health physician or individual provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume [~~individual~~] behavioral health physicians and individual providers. If physicians or individual providers are part of a group practice that [~~which~~] shares the same office, the HMO may perform one visit to the site [~~may be used~~] for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment [~~shall be made~~] available to the department for review. The HMO shall have a process to track the opening of new physician and individual provider offices. The HMO shall perform a site visit of each new office site of primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO [~~it~~] shall determine [~~be determined~~] whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing [~~, including professional liability coverage. The process shall also consider performance indicators for primary care and high-volume individual behavioral health care providers, including enrollee complaints and information from quality improvement activities~~].

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include [~~, but not be limited to,~~] the following processes:

(I) [~~(i)~~] Reverification of the following from the primary sources [~~and in accordance with the same verification time limit as for the initial credentialing process specified in subparagraph (C) of this paragraph~~]:

(-a-) [~~(I)~~] Licensure and information on sanctions or limitations on licensure;

(-b-) [~~(II)~~] Board certification:

(-1-) [~~(-a-)~~] if the physician or individual provider was due to be recertified; or

(-2-) [~~(-b-)~~] if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) [~~(III)~~] Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) [~~(-a-)~~] copy of the DEA or DPS certificate;

(-2-) [~~(-b-)~~] visual inspection of the original certificate;

(-3-) [~~(-c-)~~] confirmation with DEA or DPS;

(-4-) [~~(-d-)~~] entry in the National Technical Information Service database; or

(-5-) [~~(-e-)~~] entry in the American Medical Association Physician MasterFile [~~Master File~~].

(II) [~~(ii)~~] Review of updated [~~Updated~~] history of professional liability claims [~~, and sanction and restriction information from Medicare and Medicaid~~] in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, [~~Texas Mental Health and Mental Retardation~~] certification for community mental health centers from the Texas Department of Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies [~~policy~~] and procedures must state which national accrediting bodies it accepts;

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i)-(iv) [~~(E)(i)-(v)~~] of this paragraph.

(G) (No change.)

(5) Site visits for cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which [~~shall be conducted by appropriate personnel and~~] may include [~~, but not be limited to,~~] an evaluation of any facilities or services related [~~relating~~] to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI [~~quality improvement~~] program shall provide for a [~~an effective~~] peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(ii) a delegation agreement;

(iii) a monitoring plan; and

(iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not

required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

(i) documentation of pre-delegation and annual audits;

(ii) executed delegation agreements;

(iii) semi-annual reports received from the delegated entities;

(iv) evidence of evaluation of the reports;

(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and

(vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

28 TAC §§11.2101 - 11.2103

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers

and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2101. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. Community Health Maintenance Organization (CHMO)--An entity created under the authority of Section 534.101, Health and Safety Code, by one or more community centers as defined by Section 534.001, Health and Safety Code, and authorized by the Texas Department of Insurance to provide a limited health care service plan as defined in [~~Article 20A.02(l),~~] Insurance Code §843.002(18).

§11.2102. General Provisions.

(a) (No change.)

(b) Each CHMO shall provide coverage for work in progress and must clearly specify that the enrollee must agree to have the work completed by a participating provider in the HMO delivery network, as defined under [~~Article 20A.02(w)~~] Insurance Code §843.002(15), or as otherwise arranged by the limited service HMO.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Prior to obtaining a certificate of authority under Section 534.101, Health and Safety Code (concerning Health Maintenance Organizations Certificate of Authority), an applicant CHMO must comply with each requirement for the issuance of a certificate of authority imposed on a limited health care service plan under [~~the~~] Insurance Code Chapters [~~Chapter~~] 20A and 843; [~~Chapter 11 of~~] this chapter [~~title (relating to Health Maintenance Organizations)~~]; and applicable insurance laws and regulations of this state.

(b) A CHMO with a certificate of authority must comply with all the appropriate requirements that a limited health care service plan must comply with under [~~the~~] Insurance Code Chapters [~~, Chapter~~] 20A and 843; [~~Chapter 11 of~~] this chapter [~~title~~]; and applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO shall be subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) Nothing in this subchapter precludes one or more community centers from forming a nonprofit corporation under §162.001 [~~Section 5.01~~], Medical Practice Act , Chapters 151- 164, Occupations Code [~~(Article 4495b, Vernon's Texas Civil Statutes)~~], to provide services on a risk-sharing or capitated basis as permitted under [~~Article 21.52F~~] Insurance Code Chapter 844.

(d) This subchapter does not apply to an activity exempt from regulation under [~~Article 20A.26(f)~~] Insurance Code §§843.051, 843.053, 843.073, and 843.318.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER W. SINGLE SERVICE HMOS

28 TAC §§11.2200, 11.2201, 11.2203, 11.2204, 11.2207, 11.2208

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO

choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2200. Definitions.

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

(1) (No change.)

(2) CDT--The current dental terminology [~~users~~] manual developed and revised periodically by the ADA.

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

(6) Insurer--An insurance company, a group hospital service corporation operating under Chapter 842 [~~20~~] of the Texas Insurance Code, a fraternal benefit society operating under Chapter 885 [~~10~~] of the Code, or a stipulated premium insurance company operating under Chapter 884 [~~22~~] of the Code.

(7) (No change.)

(8) Point-of-service plan--A plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services other than emergency care or emergency dental care are provided by an insurer in conjunction with corresponding benefits arranged or provided by an HMO that provides dental benefits and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the HMO plan in accordance with specific provisions of Insurance Code §843.112[~~, Article 20A.38~~].

(9) (No change.)

§11.2201. General Provisions.

(a) Each single service HMO shall provide uniquely described services with any corresponding copayments for each covered service and benefit and shall provide a single health care service plan as defined under Insurance Code §843.002(26)[~~, Article 20A.02(y)~~]. Each single service HMO must comply with all requirements for a single health care service plan specified in this subchapter.

(b) Each single service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits and may specify recognized procedure codes or other information which is used for the purpose of maintaining a statistical reporting system, as required under §11.1606 of this title (relating to Organization of an HMO[~~and Service Area~~]).

(c) Each single service HMO evidence of coverage shall include a glossary of terminology [~~defining the terms~~], including [~~but not limited to,~~] such terms used in the evidence of coverage required by §11.501 of this title (relating to Forms Which Must be Approved Prior to Use [~~Evidence of Coverage~~]). Such glossary shall be included in the information to prospective and current group contract holders and enrollees, as required under Insurance Code §843.201[~~, Article 20A.11~~].

(d) (No change.)

§11.2203. Minimum Standards, Dental Care Services and Benefits.

(a) (No change.)

(b) Each single service HMO evidence of coverage providing coverage for dental care services shall provide benefits for covered dental treatment in progress and may, if clearly disclosed, require the enrollee to have such treatment completed by a participating provider in the Health Maintenance Organization Delivery Network, as defined under Insurance Code §843.002(15) [~~Article 20A.02(w)~~], or as otherwise arranged by the single service HMO.

(c) Each single service HMO evidence of coverage providing coverage for dental care services and benefits shall offer services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal [~~peridontal~~] disease. Such services may include an infection control (sterilization) fee. Single service HMOs providing coverage for dental care services shall offer coverage for the following primary and preventive services provided by a general dentist or hygienist, as applicable: office visit-during and after regularly scheduled hours; oral evaluations; x-rays; bitewings; panoramic film; dental prophylaxis (adult and child); topical fluoride treatment for children; dental sealants for children; amalgam fillings (one, two, three and four or more surface, primary and permanent-including polishing); anterior resin fillings (one, two, three and four or more surface or involving incisal angle, primary and permanent-including polishing); simple oral extractions; surgical incision and drainage of abscess-intraoral soft tissue; and palliative (emergency) treatment of dental pain.

(d) Each single service HMO evidence of coverage providing coverage for dental care services and benefits may include an infection control (sterilization) fee, and may provide secondary dental care services and benefits, including[~~, but not limited to,~~] posterior resin

restorations, one, two, three and four or more surface (to include polishing); crowns and crown recementation; composite resin crowns, anterior-primary; sedative fillings; core buildup, including any pins, and pin retention; pulp cap (direct and indirect); therapeutic pulpotomy; root canal therapy, anterior, bicuspid and molar; gingival curettage; osseous surgery; periodontal scaling and root planing; periodontal maintenance procedures; complete denture (maxillary and mandibular); partial denture (maxillary and mandibular); root removal-exposed roots; surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth; removal of impacted tooth (soft tissue and completely bony); tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus; alveoplasty; occlusal guard (bruxism appliance); or orthodontia.

(e) (No change.)

§11.2204. Minimum Standards, Vision Care Services and Benefits.

(a) Each single service HMO evidence of coverage providing vision care services and benefits shall provide the following as covered primary and preventive vision services: comprehensive eye examination to include medical history; visual acuities, with correction (distance and near), without correction (distance and near); cover test at 20 feet and at 16 inches; versions; external examination of the eye lids, cornea, conjunctiva, pupillary reaction (neurological integrity) and muscle function; binocular measurements for far and near; internal eye examination (ophthalmoscopy); autorefraction/refraction (far point and near point); tonometry (reasonable attempt or equivalent testing if contraindicated); retinoscopy; biomicroscopy; intraocular pressure-glaucoma test; slit lamp examination; and urgent care as defined in §11.2 [~~§11.2(46)~~] of this title (relating to Definitions).

(b) A single service HMO evidence of coverage providing vision care services and benefits may provide coverage for secondary vision care services which include[~~, but are not limited to,~~] contact lens examination; fitting; training; follow-up visits, or eye glasses.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a QI committee (QIC) that shall include practicing physicians, individual providers and at least one enrollee from throughout the HMO's service area. For purposes of this section, the enrollee appointed to the committee may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services .

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status, as applicable. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services, as applicable;

(iii) Clinical studies;

(iv) The adoption and use of current professionally-recognized clinical practice guidelines, or, in the absence of current professionally-recognized clinical practice guidelines for particular practice areas or conditions, those developed by the health plan that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services.

(v) Enrollee, physician, and individual provider satisfaction;

(vi) The complaint and appeal process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities:

(viii) Claims payment processes, as applicable;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;

(x) Utilization review processes, as applicable;

(xi) Credentialing;

(xii) Member services; and;

(xiii) Pharmacy services, including drug utilization.

(3) Evaluation. The QI program shall include an annual report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential all physicians and providers including advanced practice nurses and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician and individual provider who is a member of a contracting group, such as an independent practice association or medical group.

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) An HMO is not required to credential:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.

(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients.

(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the

state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:

(-a-) copy of the DEA or DPS certificate;

(-b-) visual inspection of the original certificate;

(-c-) confirmation with DEA or DPS;

(-d-) entry in the National Technical Information Service database; or

(-e-) entry in the American Medical Association Physician MasterFile.

(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:

(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:

(-a-) National Practitioner Data Bank;

(-b-) Cumulative Sanctions Report available over the internet;

(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General;

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians and individual providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the opening of new physician or individual provider offices. The HMO shall perform a site visit of each new office site of primary care physicians and individual providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:

(I) Reverification of the following from the primary sources:

(-a-) Licensure and information on sanctions or limitations on licensure;

(-b-) Board certification:

(-1-) if the physician or individual provider was due to be recertified; or

(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) entry in the National Technical Information Service database; or

(-5-) entry in the American Medical Association Physician MasterFile.

(II) Review of updated history of professional liability claims, and sanction and restriction information from Medicare and Medicaid in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from Texas Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts;

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO's procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i)-(iv) of this paragraph.

(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.

(5) Site Visits for Cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(ii) a delegation agreement;

(iii) a monitoring plan; and

(iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

(i) documentation of pre-delegation and annual audits;

(ii) executed delegation agreements;

(iii) semi-annual reports received from the delegated entities;

(iv) evidence of evaluation of the reports;

(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and

(vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

§11.2208. Single Health Care Services Accessibility and Availability.

(a) A single health care service HMO that chooses to offer to an enrolled population a particular service shall comply with §11.1607(a) and (e) - (j) of this title (relating to Accessibility and Availability Requirements). Any single health care service shall be offered directly by the HMO or by contract.

(b) A sufficient number of participating single health care physicians or dentists or other individual providers with appropriate hospital or inpatient facility admitting privileges shall be available and accessible 24 hours per day, seven days per week, within the HMO's service area, to ensure availability and accessibility of care, including inpatient admissions and care, as appropriate.

(c) A single health care service HMO offering a service requiring inpatient status for the management of a single health care condition shall provide for the appropriate inpatient facility according to the need by contracting with one or more general, or special hospitals; or home and community support services agencies for outpatient services.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406530
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER X. PROVIDER SPONSORED ORGANIZATIONS

28 TAC §§11.2303, 11.2311, 11.2314

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Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2303. Application for Certificate of Authority.

(a) (No change.)

(b) Prior to obtaining a certificate of authority under [~~the~~] Insurance Code, Chapter 20A, an applicant PSO must comply with each requirement for the issuance of a certificate of authority imposed on an HMO under [~~the~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843, 28 Texas Administrative Code Chapter 11 and other applicable insurance laws and regulations of this state except where preempted by federal law.

(c) An applicant for a certificate of authority for a PSO shall complete and file with the department the application form for a health maintenance organization adopted by reference under §11.1001 of this title (relating to Required Forms[~~Adopted by Reference~~]) and the Financial Plan required by §11.2304 of this title (relating to Financial Plan Requirement).

§11.2311. Dissolution; Liquidation; Rehabilitation.

Any dissolution, liquidation, rehabilitation, supervision or conservation of an entity licensed under this subchapter shall be handled as provided in Insurance Code Articles[, ~~Article~~] 21.28 and[,] 21.28-A and §§843.463 and 843.407 [~~20A.31~~].

§11.2314. Suspension or Revocation of Certificate of Authority.

The commissioner, after notice and opportunity for hearing, may suspend or revoke any certificate of authority issued to a PSO, if the commissioner finds that the PSO is insolvent or that any of the conditions described in Insurance Code §843.461[, ~~Article 20A.20~~] exist.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER Y. LIMITED SERVICE HMOS

28 TAC §§11.2402, 11.2405, 11.2406

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2402. General Provisions.

(a) Each limited service HMO shall provide uniquely-described services with any corresponding copayments for each covered service and benefit and shall provide a limited health care service plan as defined under Insurance Code §843.002 [~~Article 20A.02(l)~~]. Each

limited service HMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(b) Each limited service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits and may specify recognized procedure codes or other information [~~which is~~] used for [~~the purpose of~~] maintaining a statistical reporting system, as required under §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs [~~§11.1606 of this title (relating to Organization of an HMO and Service Area~~]).

(c) Each limited HMO evidence of coverage shall include a glossary of terminology [~~defining the terms~~], including [~~but not limited to,~~] such terms used in the evidence of coverage required by §11.501 of this title (relating to Forms Which Must be Approved Prior to Use [~~Evidence of Coverage~~]). Such glossary shall be included in the information to prospective and current group contract holders and enrollees, as required under Insurance Code §843.201 [~~Article 20A.11~~].

(d) (No change.)

§11.2405. Minimum Standards, Mental Health and Chemical Dependency Services and Benefits.

(a) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall cover, in accord with the limited service HMO's standards of medical necessity, court ordered mental health/chemical dependency treatment and may, if clearly disclosed, require the enrollee to have such treatment completed by a participating provider in the Health Maintenance Organization Delivery Network, as defined under Insurance Code §843.002 [~~Article 20A.02(w)~~], or as otherwise arranged by the limited service HMO.

(b) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall provide primary mental health/chemical dependency services and benefits, including[~~, but not limited to~~]:

(1) - (2) (No change.)

(3) Treatment of chemical dependency [~~that shall be provided~~] in accord with the levels of care and clinical criteria specified in §§3.8001, [~~28 TAC ((§3.8001~~] et seq. of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

(4) (No change.)

(c) (No change.)

§11.2406. Minimum Standards, Long Term Care Services and Benefits.

Each limited service HMO evidence of coverage providing long-term care services and benefits shall comply with Insurance Code Article 3.70-12 and §§3.3801, et seq. of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406532

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

28 TAC §§11.2501 - 11.2503

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the

commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2501. Definitions.

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context indicates otherwise.

(1) (No change.)

(2) Corresponding benefits--Benefits provided under a point-of-service (POS) rider or the indemnity portion of a point-of-service (POS) plan, as defined in Article [~~Articles~~] 3.64(a)(4) and §843.108 [~~20A.02(bb)~~] of the Code, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(3) - (13) (No change.)

§11.2502. Issuance of Point-of-service Riders.

An HMO may issue a POS rider plan only if the HMO meets all of the applicable requirements set forth in this section.

(1) Solvency of HMOs Issuing Point-of-service Rider Plans.

(A) For HMOs that have been licensed for at least one calendar year, the HMO shall maintain a net worth of at least the sum of:

(i) the greater of:

(I) the minimum net worth required by the Code for that HMO; or

(II) 100% of the authorized control level of risk-based capital as set forth in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); and

(ii) (No change.)

(B) - (E) (No change.)

(2) - (5) (No change.)

§11.2503. Coverage Relating to POS Rider Plans.

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

(d) An HMO that issues or offers to issue a POS rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of Chapters [~~Chapter~~] 20A and 843, and Articles 21.21, 21.21A [~~21.21-A~~], 21.21-1, 21.21-2, 21.21-5 and 21.21-6 of the Code.

(e) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406533
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER AA. DELEGATED ENTITIES

28 TAC §11.2601, §11.2602

The amendments and new sections are proposed pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §§843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the

commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed amendments and new sections affect regulation pursuant to the following statutes: Insurance Code, Chapters 843, 844 and 20A, Articles 1.15, 1.16, 1.19, 1.61 3.10, 21.21, 21.21-1, 21.21-2, 21.21-6, 21.52J, 21.52L, 21.53D (Obstetrical), 21.53F (Telemedicine), 21.53F (Children's Benefits), 21.53K, 21.53L, 21.53M, 21.58A, 21.58D, 26.08 and 26.71, and §822.203; Business and Commerce Code, §35.58; Occupations Code, §§162.001, 301.152, 301.1525 and 554.004; 42 U.S.C. §1396(b); and 42 CFR, Chapter 146

§11.2601. General Provisions.

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

(c) Applicability to Group Model HMO. This subchapter does not apply to a group model HMO, as defined by [~~Texas~~] Insurance Code §843.111 [~~Art. 20A.06A~~].

§11.2602. Definitions.

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

(1) Act--The HMO Act, [~~Texas~~] Insurance Code, Chapters [~~Chapter~~] 20A and 843.

(2) - (5) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406534
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Texas Department of Insurance proposes repeal of Subchapter L, §§11.1101 and 11.1102, concerning standard language for mandatory and other provisions; Subchapter U, §§11.2001- 11.2006, concerning services; and §11.1608 of Subchapter Q, concerning designation of obstetrician/gynecologist notice. Repeal of Subchapters L and U is necessary primarily to improve textual organization within Chapter 11 and increase regulatory efficiency. Some provisions of each subchapter are transferred to other subchapters to achieve placement of similar regulatory provisions in closer proximity to one another, and are published elsewhere in this issue of the *Texas Register*; others are deleted as unnecessary or to eliminate redundancy with substantially similar provisions in other subchapters. Repeal of §11.1608 of Subchapter Q is necessary because many of its notice provisions are included in proposed amended §11.1600(b)(11), published elsewhere in this issue of the *Texas Register*. Its repeal will eliminate unnecessary repetition of regulatory provisions addressing the same subject matter.

Kim Stokes, Senior Associate Commissioner for the Life, Health & Licensing Program, has determined that during the first five years that the proposed repeal is in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the sections. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Ms. Stokes also has determined that for each year of the first five years the repeal of the sections is in effect, the public benefit anticipated as a result of administration and enforcement of the repealed sections will be improved textual organization resulting in greater regulatory efficiency in administering regulations under Chapter 11. There is no anticipated economic cost to persons who are required to comply with the proposed repeal. There is no anticipated difference in cost of compliance between small and large businesses.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 13, 2006 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-1C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Kim Stokes, Senior Associate Commissioner for the Life, Health & Licensing Program , Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a public hearing must be submitted separately to the Office of Chief Clerk.

SUBCHAPTER L. STANDARD LANGUAGE FOR MANDATORY AND OTHER PROVISIONS

28 TAC §11.1101, §11.1102

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Insurance or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed repeal affects regulation pursuant to the following statutes: RuleStatute Insurance Code, Chapters 843 and 20A, Articles 20A.09Y, 20A.39, 21.53D, and 21.58D

§11.1101. Purpose.

§11.1102. Hold-Harmless Clause.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §11.1608

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Insurance or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed repeal affects regulation pursuant to the following statutes: RuleStatute Insurance Code, Chapters 843 and 20A, Articles 20A.09Y, 20A.39, 21.53D, and 21.58D

§11.1608. Designation of Obstetrician/Gynecologist Notice.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER U. SERVICES

28 TAC §§11.2001 - 11.2006

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Insurance or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed pursuant to the Insurance Code §§843.102, 843.151, and 36.001. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides the commissioner may adopt reasonable rules as necessary and proper to fully implement Insurance Code Chapters 843 and 20A, as well as the requirements of federal law and regulations. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed repeal affects regulation pursuant to the following statutes: RuleStatute Insurance Code, Chapters 843 and 20A, Articles 20A.09Y, 20A.39, 21.53D, and 21.58D

§11.2001. Ambulatory Health Care Services.

§11.2002. Emergency Care.

§11.2003. Inpatient Hospital and Medical Services.

§11.2004. Diagnostic and Therapeutic Services.

§11.2005. Optional Services.

§11.2006. Single Health Care Services.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406511
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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CHAPTER 21. TRADE PRACTICES
SUBCHAPTER X. CREDENTIALING OF PHYSICIANS, ADVANCED PRACTICE NURSES AND PHYSICIAN ASSISTANTS

28 TAC §21.3201

The Texas Department of Insurance proposes amendments to §21.3201, concerning the Texas Standardized Credential Application for physicians, advanced practice nurses and physician assistants. These amendments are necessary to implement Insurance Code Article 21.58D, as amended by Acts 2003, 78th Legislature in §11 of House Bill (HB) 1095. Since September 1, 2001, Article 21.58D has required public or private hospitals, health maintenance organizations (HMOs) and preferred provider organizations to use standardized forms developed by the department for the verification of credentials of a physician. Article 21.58D was amended to include advanced practice nurses and physician assistants in the group of professionals whose credentials must be verified, using a standardized form prescribed by the Department of Insurance (department), by public or private hospitals, HMOs and preferred provider organizations. To effect this implementation, this proposed amendment adds definitions for "advanced practice nurse" and "physician assistant" to §21.3201. References to "advanced practice nurse" and "physician assistant" are included where appropriate to make clear that the department's standardized form must be used to verify their credentials, and an effective date is specified.

Additionally, minor clarification changes are proposed. These include appropriate renumbering of subsections and paragraphs, and updating a reference to the chapter of the Insurance Code that addresses requirements for HMOs. The language in §21.3201(a) indicating that the department's form is incorporated by reference and the description of the form that appeared at §21.3201(c)(2) are unnecessary and this proposal deletes them.

Kim Stokes, Senior Associate Commissioner, Life, Health and Licensing Program, has determined that for each year of the first five years the proposed amendments will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Ms. Stokes has also determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of the proposed sections will be the efficiencies that result from the use of simplified standard credentialing forms and increased public confidence in services rendered by advanced practice nurses and physician assistants with whom hospitals, HMOs and preferred provider organizations contract. There will be some minor economic cost to persons required to comply with the amended rule. Advanced practice nurses and physician assistants will incur the costs associated with downloading and completing the credentialing form. However, this cost is a direct result of the enactment of HB 1095, and therefore not caused by the adoption of this rule amendment.

The department believes there will be no adverse effect on small and micro businesses. However, if there is an adverse impact, it would be the direct result of the enactment of HB 1095, and therefore not caused by the adoption of these rule amendments. Waiver or modification of the proposed amendments for small or micro businesses is not appropriate, because it would establish disparate standards for large and small businesses that are required to comply with these statutory requirements, and could thwart the purpose of the statute.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 13, 2004 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Bill Bingham, Deputy for Regulatory Matters, Life, Health and Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a public hearing should be submitted separately to the Office of the Chief Clerk.

The amendments are proposed under the Insurance Code Articles 20A.39 and 21.58D, and §36.001. Article 20A.39 provides the statutory basis for credentialing of physicians and providers, and Article 21.58D requires hospitals, HMOs and preferred provider organizations to use forms prescribed by the department when verifying the credentials of physicians, advanced practice nurses and physician assistants. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The following sections are affected by this proposal: Insurance Code Articles 20A.39 and 21.58D, and §36.001

§21.3201. Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants.

(a) Purpose and Applicability. The purpose of this section is to identify the [~~adopt a~~] standardized credentialing application form [~~as~~] required by the Insurance Code Article 21.58D. Hospitals, health maintenance organizations, preferred provider benefit plans, and preferred provider organizations are required to use this form for credentialing

and recredentialing of physicians, advanced practice nurses and physician assistants.

(b) Definitions. The following words and terms when used in this section shall have the following meanings:

(1) Advanced practice nurse--An advanced practice nurse as that term is defined by Occupations Code §301.152.

(2) [~~(1)~~] Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

(3) [~~(2)~~] Department--Texas Department of Insurance.

(4) [~~(3)~~] Health maintenance organization--A health maintenance organization as that term is defined by the Insurance Code §843.002(14) [~~Article 20A.02(n)~~].

(5) [~~(4)~~] Hospital--A licensed public or private institution as defined by Chapter 241, Health and Safety Code, and any hospital owned or operated by state government.

(6) [~~(5)~~] Physician--An individual licensed to practice medicine in this state.

(7) Physician assistant--A person who holds a license issued under Chapter 204, Occupations Code.

(8) [~~(6)~~] Preferred provider benefit plan--A plan issued by an insurer under the Insurance Code Article 3.70-3C.

(9) [~~(7)~~] Preferred provider organization--An organization contracting with an insurer issuing a preferred provider benefit plan under the Insurance Code Article 3.70-3C, for the purpose of providing a network of preferred providers.

(10) [~~(8)~~] Recredentialing--The periodic process by which:

(A) qualifications of physicians, advanced practice nurses and physician assistants are reassessed;

(B) performance indicators including utilization and quality indicators are evaluated; and

(C) continued eligibility to provide services is determined.

(c) Texas Standardized Credentialing Application.

[~~(1)~~] The [~~Department adopts and incorporates by reference the~~] Texas Standardized Credentialing Application shall be used [~~for required use~~] by all hospitals, health maintenance organizations, preferred provider benefit plan insurers, and preferred provider organizations for credentialing and recredentialing of physicians, advanced practice nurses and physician assistants.

[~~(2) The application consists of three sections. Section I requests personal, professional, and educational information. Section II consists of disclosure questions on sanctions, professional liability insurance, malpractice claims history, criminal/civil history, and ability to perform job. Section III consists of an Authorization, Acknowledgment, Attestation, and Release form.~~]

(d) Effective date. The application form is required for initial credentialing or recredentialing that occurs on or after August 1, 2002 for physicians. The application form is required for advanced practice nurses and physician assistants for initial credentialing and recredentialing that occurs on or after September 1, 2003.

(e) Availability. This form may be obtained on the Department's Web site at www.tdi.state.tx.us or from the Texas Department of Insurance, Quality Assurance Section, HMO Division, Mail Code 103-6A, P. O. Box 149104, Austin, Texas, 78714-9104; or by calling 1-800-599-SHOP (1476); in Austin, 305-7211. Reproduction of this form without any changes is allowed.

(f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406546
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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CHAPTER 26. SMALL EMPLOYER HEALTH INSURANCE REGULATIONS

The Texas Department of Insurance proposes amendments to §§26.4 - 26.11, 26.13, 26.15 - 26.16, 26.18 - 26.20, 26.22, 26.24, 26.26, 26.301 - 26.309, 26.311, 26.312, and new §26.14 and §26.27, concerning small and large employer health insurance regulations. This proposal is necessary to implement House Bills 1211, 1217, and 2969 and Senate Bill 881, enacted by the 76th Legislature (1999); House Bills 471, 949, 1440, 1676, and 2382 and Senate Bill 990, enacted by the 77th Legislature (2001); and House Bills 897 and 1446, and Senate Bills 10 and 541, enacted by the 78th Legislature (2003). The referenced bills amended provisions of Insurance Code, Chapter 26, to provide for the availability and affordability of health insurance for small and large employers; to conform Texas law with updates to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); and to clarify the scope and meaning of certain provisions in the rules. In conjunction with the proposed new sections, the department is proposing the repeal of existing §26.14 and §26.27, which is published elsewhere in this issue of the *Texas Register*.

Proposed §26.4 amends existing and adds new definitions of terms relating to small and large employer health coverage. Proposed §26.5 expands the scope of the chapter in compliance with HIPAA, and clarifies requirements relating to minimum group size. Proposed §26.6 revises procedures and deadlines and adds new procedures for filing certain certifications. Proposed §26.7 clarifies that health carriers may require proof of status as a small employer, provides examples of reasonable and appropriate supporting documentation, and redefines open enrollment periods in compliance with recent state legislation. Proposed §26.8 contains minor changes in compliance with HIPAA as well as new language explaining a health carrier's option to terminate coverage due to group size violations. Proposed §26.9 makes clarifying changes to language and the example relating to the application of preexisting conditions. Proposed §26.10 replaces the term "group size" with "the number of employees and dependents of a small employer." Proposed §26.11 revises procedures for filing proposed changes to rating methodology, amends the procedure for developing and retaining rate manuals in accordance with recent legislation, replaces the term "group

size" with "the number of employees and dependents of a small employer" in reference to limits on disparity in rate factors, and requires use of the same term for obtaining information relating to a small employer group. Proposed §26.13 updates references to changes in forms; revises the requirement regarding offers of standard benefit plans, including a requirement that small employers must affirm an offer of the plans; prohibits carriers from discriminating between small employer groups when obtaining information; changes the term "price quote" to "premium rate quote;" revises the requirement for eliciting information regarding whether a plan is subject to Chapter 26, Subchapters A - G, and this subchapter; and prohibits retaliation against an agent related to the agent's request that the carrier issue coverage to a small employer. Proposed §26.14 sets out requirements for offers of plans; revises continuation and conversion requirements to conform to new legislation; and contains minor technical changes in compliance with HIPAA. Proposed §26.14 contains some provisions from the §26.14 proposed for repeal. Proposed §26.15 allows nonrenewal of plans not in compliance with minimum group size requirements, and deletes requirements for conversion provisions. Proposed §26.16 adds a subsection clarifying that carriers are subject to all applicable withdrawal and discontinuation requirements. Proposed §26.18 revises requirements relating to the election to be a risk-assuming or reinsured carrier and clarifies requirements for renewal of that election or application at the end of the election period. Proposed §26.19 revises and clarifies requirements related to filing certifications, and revises format requirements for accident and health policy filings. Proposed §26.20 clarifies a carrier's obligation to complete certain forms and revises previous reporting requirements in light of new requirements to offer consumer choice health benefit plans instead of prototype policies. Proposed §26.22 clarifies that March 1 of each year is the deadline for Private Purchasing Cooperatives to file their statements of amounts collected and expenses incurred, and changes the reference to a form that must be filed. Proposed §26.24 reflects organizational changes within the department. Proposed §26.26 updates statutory references due to recodification. Proposed §26.27 provides notice as to how required forms may be obtained.

Proposed §26.301 expands the scope of this chapter in compliance with HIPAA as well as clarifying requirements relating to minimum group size and a carrier's option to terminate coverage due to violation of minimum group size requirements. Proposed §26.302 revises procedures and deadlines and adds new procedures for filing certain certifications. Proposed §26.303 makes minor amendments to comply with HIPAA and adds language allowing termination for noncompliance with minimum group size requirements. Proposed §26.304 clarifies that health carriers may require proof of status as a large employer and provides examples of reasonable and appropriate supporting documentation. Proposed §26.305 redefines open enrollment periods in compliance with recent state legislation. Proposed §26.306 clarifies that the 12 month limitation on preexisting condition provisions may not apply with regard to certain late enrollees and clarifies the example relating to the application of preexisting conditions. Proposed §26.307 revises the requirement for eliciting information regarding whether a plan is subject to Chapter 26, Subchapters A, C and H, and this subchapter, and prohibits retaliation against an agent related to the agent's request that the carrier issue coverage to a large employer. Proposed §26.308 allows nonrenewal of plans not in compliance with minimum group size requirements. Proposed §26.309 clarifies the notification requirements of health carriers withdrawing from the large employer market.

Throughout the sections, including §§26.9, 26.311 and 26.312, minor changes were made to correct form and grammar, make clarifications, correct citations and update examples and references to form numbers.

Kim Stokes, Senior Associate Commissioner for the Life, Health & Licensing Program, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Ms. Stokes has also determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of the proposed sections will be the increased affordability and availability of health benefit plans to small and large employers and their employees and dependents, if dependent coverage is offered to employees. The proposed sections will also promote fairer, more uniform marketing practices and provide for efficiencies for carriers, as well as provide for easier administration of and access to the forms. Except as specifically enumerated below, the probable economic cost to persons required to comply with the sections results from the enactment of House Bills 1211, 1217, and 2969 and Senate Bill 881 by the 76th Legislature (1999); House Bills 471, 949, 1440, 1676, and 2382 and Senate Bill 990 by the 77th Legislature (2001); and House Bills 897 and 1446, and Senate Bills 10 and 541 by the 78th Legislature (2003); as well as the federal HIPAA legislation and rules adopted thereunder, and not a result of the adoption, enforcement, or administration of the proposed amendments or new sections. Some carriers may incur additional costs as a result of reprinting forms, many of which will need to be reprinted due to other changes required by statute. To the extent that forms need to be reprinted for reasons related solely to changes in this rule, the department estimates the printing cost to be between $.01 and $.04 per page. The number of pages a carrier will need to print will depend on the carrier's marketing and business practices. To the extent that carriers need to file endorsements or forms with the department to conform to changes resulting solely from this rule, the department estimates that the cost to carriers will include a $100 filing fee and a printing cost of between $.01 and $.04 per page. The proposal revises reporting requirements in a manner which should result in cost savings to carriers. The proposal does require, as part of annual reporting, tendering copies of certain policies issued by small employer carriers. The department estimates that the cost to carriers of providing these copies will be between $.01 and $.04 per page, with the total cost depending on the length of a carrier's policies.

The proposal's cost to a health carrier is not dependent upon the size of the carrier, but rather is dependent upon the number of persons to whom the carrier markets and/or provides health coverage. Both small and micro-businesses and the largest businesses affected by these sections would incur the same cost per notice. The cost per hour of labor would not vary between the smallest and largest businesses, assuming that a small business and the largest business have to modify forms for approximately the same percentage of their applicants or insured groups. Therefore, it is the department's position that the adoption of these proposed sections will have no adverse economic effect on small or micro-businesses. Regardless of the fiscal effect, it is neither legal nor feasible to waive or modify

the requirements of this rule for small or micro-businesses because the proposed amendments are either required by statute or would result in unallowable differentiation of benefits between the applicants/enrollees of small and micro-carriers, compared to those benefits provided to the applicants/enrollees of large carriers.

To be considered, written comments on the proposal must be submitted not later than 5:00 p.m. on December 13, 2004 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be submitted simultaneously to Bill Bingham, Deputy for Regulatory Matters, Life, Health, & Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The department will consider the adoption of the proposed amendments and new sections in a public hearing under Docket Number 2607, scheduled for 9:30 a.m., on December 9, 2004, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

SUBCHAPTER A. SMALL EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT REGULATIONS

28 TAC §§26.4 - 26.11, 26.13 - 26.16, 26.18 - 26.20, 26.22, 26.24, 26.26, 26.27

The amendments and new sections are proposed under Insurance Code Article 26.04, HIPAA, and Insurance Code §36.001. The Insurance Code, Chapter 26, implements provisions regarding small and large employers which were necessary to comply with the federal requirements contained in HIPAA. Article 26.04 requires the commissioner to adopt rules as necessary to implement the Insurance Code, Chapter 26, and to meet the minimum requirements of federal law and regulations which, for small and large employer health carriers, are contained in HIPAA. Federal agencies have adopted regulations implementing HIPAA as follows: Department of the Treasury, 26 CFR Part 54; Department of Labor, 29 CFR Part 2590; and Department of Health and Human Services, 45 CFR Parts 144 and 146. As identified in the Introduction, portions of the Federal Regulations are included in these rules as necessary to meet the minimum requirements of federal law. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The following articles are affected by this proposal: Insurance Code, Chapter 26 and Chapter 843, Subchapter G; Articles 26.02, 20A.09(k), 3.70-3C,and 21.58A; and §843.002.

§26.4. Definitions.

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

(1) Actuary--A qualified actuary who is a member in good standing of the American Academy of Actuaries.

(2) Affiliation period--A period of time that under the terms of the coverage offered by an [a] HMO, must expire before the coverage becomes effective. During an affiliation period an [a] HMO is not required to provide health care services or benefits to the participant or beneficiary and a premium may not be charged to the participant or beneficiary.

(3) Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued under the Insurance Code, [~~Article 20A.15 or 20A.15A, or under the Insurance Code,~~] Chapter 21 [~~, Subchapter A~~].

(4) - (5) (No change.)

(6) Child--An unmarried natural child of the employee, including a newborn child; adopted child, including a child as to whom an insured is a party in a suit seeking [~~in which~~] the adoption of the child [~~by the insured is sought~~]; natural child or adopted child of the employee's spouse[~~, provided that the child resides with the employee~~].

(7) - (8) (No change.)

(9) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Article 3.80 or Article 20A.09N.

(10) [~~(9)~~] Creditable coverage--

(A) An individual's coverage is creditable for purposes of this chapter if the coverage is provided under:

(i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001et seq.);

(ii) a group health benefit plan provided by a health insurance carrier or an HMO;

(iii) an individual health insurance policy or evidence of coverage;

(iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s, Program for Distribution of Pediatric Vaccines);

(vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(vii) a medical care program of the Indian Health Service or of a tribal organization;

(viii) a state or political subdivision health benefits risk pool;

(ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(x) a public health plan as defined in this section;

(xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); and

(xii) short-term limited duration insurance as defined in this section.

(B) Creditable coverage does not include:

(i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit only insurance;

(vii) coverage for onsite medical clinics;

(viii) other coverage that is similar to the coverage described in this subsection under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;

(ix) if offered separately, coverage that provides limited scope dental or vision benefits;

(x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;

(xi) if offered separately, coverage for limited benefits specified by federal regulation;

(xii) if offered as independent, noncoordinated benefits, coverage for specified disease or illness;

(xiii) if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or

(xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

(11) [~~(10)~~] Department--The Texas Department of Insurance.

(12) [~~(11)~~] Dependent--A spouse; newborn child; child under the age of 25 [~~19~~] years; [~~child who is a full-time student under the age of 23 years and who is financially dependent on the parent;~~] child of any age who is medically certified as disabled and dependent on the parent; any person who must be covered under [~~the~~] Insurance Code[~~,~~]Article 3.51-6, §3D or §3E, or the Insurance Code[~~,~~] Article 3.70-2(L); and any other child included as an eligible dependent under an employer's benefit plan, including a child who is a full-time student described in Insurance Code Article 21.24-2 and §11.506(19) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate).

(13) [~~(12)~~] DNA--Deoxyribonucleic acid.

(14) [~~(13)~~] Effective date--The first day of coverage under a health benefit plan, or, if there is a waiting period, the first day of the waiting period.

(15) [~~(14)~~] Eligible employee--An employee who works on a full-time basis and who usually works at least 30 hours a week. The term also includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small or large employer, regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly. The term does not include:

(A) an employee who works on a part-time, temporary, seasonal or substitute basis; or

(B) an employee who is covered under:

(i) another health benefit plan;

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 United States Code, §§1001, et seq.);

(iii) the Medicaid program if the employee elects not to be covered;

(iv) another federal program, including the TRICARE [~~CHAMPUS~~] program or Medicare program, if the employee elects not to be covered; or

(v) a benefit plan established in another country if the employee elects not to be covered.

(16) Employee--Any individual employed by an employer.

(17) [~~(15)~~] Franchise insurance policy--An individual health benefit plan under which a number of individual policies are offered to a selected group of a small or large employer. The rates for such a policy may differ from the rate applicable to individually solicited policies of the same type and may differ from the rate applicable to individuals of essentially the same class.

(18) [~~(16)~~] Genetic information--Information derived from the results of a genetic test or from family history.

(19) [~~(17)~~] Genetic test--A laboratory test of an individual's DNA, RNA, proteins, or chromosomes to identify by analysis of the DNA, RNA, proteins, or chromosomes the genetic mutations or alterations in the DNA, RNA, proteins, or chromosomes that are associated with a predisposition for a clinically recognized disease or disorder. The term does not include:

(A) a routine physical examination or a routine test performed as a part of a physical examination;

(B) a chemical, blood or urine analysis;

(C) a test to determine drug use; or

(D) a test for the presence of the human immunodeficiency virus.

(20) [~~(18)~~] HMO--Any person governed by the Texas Health Maintenance Organization Act, Insurance Code, Chapters [~~Chapter~~] 20A and 843, including:

(A) a person defined as a health maintenance organization under [~~Section 2 of~~] the Texas Health Maintenance Organization Act;

(B) an approved nonprofit health corporation that is certified under §162.001 [~~Section 5.01(a), Medical Practice Act, Article 4495b~~], Texas Occupations Code [~~Civil Statutes~~], and that holds a certificate of authority issued by the commissioner under Insurance Code[~~,~~] Article 21.52F;

(C) a statewide rural health care system under Insurance Code, Chapter 845 that holds a certificate of authority issued by the commissioner under Insurance Code, Chapter 843 [~~Article 20C.05~~]; or

(D) a nonprofit corporation created and operated by a community center under Chapter 534, Subchapter C, Health and Safety Code.

(21) [~~(19)~~] Health benefit plan--A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include the following plans of coverage:

(A) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(B) credit-only insurance;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single-service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) insurance coverage arising out of a workers' compensation or similar insurance;

(L) automobile medical payment insurance coverage;

(M) jointly managed trusts authorized under 29 United States Code §§141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 United States Code §157;

(N) hospital indemnity or other fixed indemnity insurance;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) short-term limited duration insurance as defined in this section;

(Q) liability insurance, including general liability insurance and automobile liability insurance;

(R) coverage for onsite medical clinics; or

(S) coverage that provides other limited benefits specified by federal regulations; or

(T) other coverage that is:

(i) similar to the coverage described in subparagraphs (A) - (S) of this paragraph under which benefits for medical care are secondary or incidental to other insurance benefits; and

(ii) specified in federal regulations.

(22) [~~(20)~~] Health carrier--Any entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state including an insurance company, a group hospital service corporation under [~~the~~] Insurance Code, Chapter 842 [~~20~~], an HMO, and a stipulated premium company under [~~the~~] Insurance Code, Chapter 844 [~~22~~].

(23) [~~(21)~~] Health insurance coverage--Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

(24) [~~(22)~~] Health status related factor--Health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

(25) [~~(23)~~] Index rate--For each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(26) [~~(24)~~] Large employer--An employer who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two [~~eligible~~] employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner.

(27) [~~(25)~~] Large employer carrier--A health carrier, to the extent that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Insurance Code, Chapter 26, Subchapters A and H.

(28) [~~(26)~~] Large employer health benefit plan--A health benefit plan offered to a large employer.

(29) [~~(27)~~] Late enrollee--Any employee or dependent eligible for enrollment who requests enrollment in a small or large employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the small or large employer or after the expiration of an open enrollment period under Insurance Code[~~,~~] Article 26.21(h) or 26.83(f), who does not fall within the exceptions listed below, and who is accepted for enrollment and not excluded until the next open enrollment period. An employee or dependent eligible for and requesting enrollment cannot be excluded until the next open enrollment period and, when enrolled, is not a late enrollee, in the following special circumstances:

(A) the individual:

(i) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(ii) declines in writing, at the time of initial eligibility, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of the termination of employment, the reduction in the number of hours of employment, the termination of the other plan's coverage, the termination of contributions toward the premium made by the employer; or the death of a spouse, or divorce; and

(iv) requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates;

(B) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(C) a court has ordered coverage to be provided for a spouse under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued;

(D) a court has ordered coverage to be provided for a child under a covered employee's plan and the request for enrollment

is made not later than the 31st day after the date on which the employer receives the court order or notification of the court order;

(E) the individual is a child of a covered employee and has lost coverage under Chapter 62, Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396s, Program for Distribution of Pediatric Vaccines);

(F) [~~(E)~~] the individual has a change in family composition due to marriage, birth of a child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child;

(G) [~~(F)~~] an individual becomes a dependent due to marriage, birth of a newborn child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child; and

(H) [~~(G)~~] the individual described in subparagraphs (E), [~~and~~] (F) and (G) of this paragraph requests enrollment no later than the 31st day after the date of the marriage, birth, adoption of the child, loss of the child's coverage, or within 31 days of the date an insured becomes a party in a suit for the adoption of a child.

(30) [~~(28)~~] Limited scope dental or vision benefits--Dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital, medical, or surgical benefits contracts.

(31) [~~(29)~~] Medical care--Amounts paid for:

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to the medical care described in subparagraph (A) of this paragraph; or

(C) insurance covering medical care described in either subparagraphs (A) or (B) of this paragraph.

(32) [~~(30)~~] Medical condition--Any physical or mental condition including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. Genetic information in the absence of a diagnosis of the condition related to such information shall not constitute a medical condition.

(33) [~~(31)~~] New business premium rate--For each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(34) [~~(32)~~] New entrant--An eligible employee, or the dependent of an eligible employee, who becomes part of or eligible for a small or large employer group after the initial period for enrollment in a health benefit plan. After the initial enrollment period, this includes any employee or dependent who becomes eligible for coverage and who is not a late enrollee.

(35) [~~(33)~~] Participation criteria--Any criteria or rules established by a large employer to determine the employees who are eligible for enrollment, including continued enrollment, under the terms of a health benefit plan. Such criteria or rules may not be based on health status related factors.

(36) [~~(34)~~] Person--An individual, corporation, partnership, or other legal entity.

(37) [~~(35)~~] Point-of-service coverage (POS coverage)--Coverage provided under a POS plan as described [~~defined~~] in §21.2901 of this title (relating to Definitions) [~~Articles 3.64(a)(4), 20A02(bb), 26.09(a)(2) of the Code~~] and as permitted by Article 26.48, Insurance [~~of the~~] Code.

(38) [~~(36)~~] Plan [~~Policy~~] year--For purposes of the Insurance Code, Chapter 26, and this chapter, a 365-day period that begins on the plan or policy's effective date or a period of one full calendar year [~~calendar-year~~], under a health benefit plan providing coverage to small or large employers and their employees, as defined in the plan or policy. Small or large employer carriers must use the same definition of plan [~~policy~~] year in all small or large employer health benefit plans.

(39) [~~(37)~~] Postmark [~~Postmarked~~]--A date stamp by the US Postal Service or other delivery entity, including any electronic delivery available.

(40) [~~(38)~~] Preexisting condition provision--A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(41) [~~(39)~~] Premium--All amounts payable [~~paid~~] by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer carrier, including any fees or other contributions associated with a health benefit plan.

(42) Premium rate quote--A statement of the premium a small or large employer carrier offers and will accept to make coverage effective for a small or large employer.

(43) [~~(40)~~] Public health plan--Any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(44) [~~(41)~~] Rating period--A calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(45) [~~(42)~~] Reinsured carrier--A small employer carrier participating in the Texas Health Reinsurance System.

(46) [~~(43)~~] Renewal date--For each small or large employer's health benefit plan, the earlier of the date (if any) specified in such plan (contract) for renewal; the policy anniversary date; or the date on which the small or large employer's plan is changed. To determine the renewal date for employer association or multiple employer trust group health benefit plans, small or large employer carriers may use the date specified for renewal, or the policy anniversary date, of either the master contract or the contract or certificate of coverage of each small or large employer in the association or trust. Small or large employer carriers must use the same method of determining renewal dates for all small or large employer health benefit plans. A change in the premium rate is not considered a renewal if the change is due solely:

(A) to the addition or deletion of an employee or dependent if the deletion is due to a request by the employee, death or retirement of the employee or dependent, termination of employment of the employee, or because a dependent is no longer eligible; or

(B) to fraud or intentional misrepresentation of a material fact by a small employer or an eligible employee or dependent [~~is not considered a renewal date. For association or multiple employer trusts group health benefit plans, small or large employer carriers may use the date specified for renewal or the policy anniversary date, of either the master contract or the contract or certificate of coverage of each small or large employer in the association or trust, in determining the renewal date. Small or large employer carriers must use the same~~

~~method of determining renewal dates for all small or large employer health benefit plans~~].

(47) [~~(44)~~] Risk-assuming carrier--A small employer carrier that elects not to participate in the Texas Health Reinsurance System, as approved by the department.

(48) [~~(45)~~] Risk characteristic--The health status related factors, duration of coverage, or any similar characteristic, except genetic information, related to the health status or experience of a small employer group or of any member of a small employer group.

(49) [~~(46)~~] Risk load--The percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group. A small employer carrier may not use genetic information to alter or otherwise affect risk load.

(50) [~~(47)~~] Risk pool--The Texas Health Insurance Risk Pool established under Insurance Code[~~,~~] Article 3.77, or other similar arrangements in other states.

(51) [~~(48)~~] RNA--Ribonucleic acid.

(52) [~~(49)~~] Short-term limited duration insurance--Health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective.

(53) [~~(50)~~] Significant break in coverage--A period of 63 consecutive days during all of which the individual does not have any creditable coverage. Neither a waiting period nor an affiliation period is counted in determining a significant break in coverage.

(54) [~~(51)~~] Small employer--An employer that employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two [~~eligible~~] employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner. A small employer includes an independent school district that elects to participate in the small employer market as provided under Insurance Code[~~,~~] Article 26.036.

(55) [~~(52)~~] Small employer carrier--A health carrier, to the extent that health carrier is offering, delivering, issuing for delivery, or renewing, under Insurance Code Article 26.06(a), health benefit plans subject to Subchapters A - G of the Insurance Code, Chapter 26[~~, under Article 26.06(a)~~].

(56) [~~(53)~~] Small employer health benefit plan--A health benefit plan offered to a small employer [~~developed by the commissioner~~] under the Insurance Code, Chapter 26, Subchapter E [~~, or any other health benefit plan offered to a small employer under the Insurance Code, Article 26.42(c) or Article 26.48~~].

(57) [~~(54)~~] State-mandated health benefits--As defined in §21.3502 of this title (relating to Definitions) [~~Standard benefit plans--The basic coverage benefit plan and the catastrophic care benefit plan required to be offered by health carriers, excluding HMOs, under the Insurance Code, Chapter 26, Subchapter E. For HMOs, the standard benefit plan means the prototype small employer group health benefit plan that may be offered by an HMO, as provided under the Insurance Code, Chapter 26, Subchapter E~~].

(58) [~~(55)~~] Waiting period--A period of time[~~,~~] established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits. If an employee or dependent enrolls as a late enrollee, under special circumstances that except the employee or dependent from the definition of late enrollee, or during an open enrollment period, any period of eligibility before the effective date of such enrollment is not a waiting period.

§26.5. Applicability and Scope.

(a) Except as otherwise provided, Subchapter A of this chapter shall apply to any health benefit plan providing health care benefits covering two or more eligible employees of a small employer, whether provided on a group or individual franchise basis, regardless of whether the policy was issued in this state, if the plan meets one of the following conditions:

(1) a portion of the premium or benefits is paid by a small employer;

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of 26 United States Code §106 or §162; [~~or~~]

(3) the health benefit plan is a group policy issued to a small employer; or

(4) the health benefit plan is an employee welfare benefit plan under 29 CFR §2510.3-1(j).

(b) Except as provided by Insurance Code[~~,~~] Article 26.06(a), or subsection (a) of this section, this subchapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is remitted through a payroll deduction method.

(c) For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of [~~eligible~~] employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(d) An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed to small employers and their employees on or after July 1, 1997 shall comply with all provisions of the Insurance Code, Chapter 26, Subchapters A - G[~~, as amended by the 75th Legislature,~~] and with [~~amendments to~~] this subchapter.

(e) - (h) (No change.)

(i) If a small employer or the employees of a small employer are issued a health benefit plan under the provisions of [~~the~~] Insurance Code, Chapter 26, Subchapters A - G, and this subchapter, and the small employer subsequently employs more than 50 eligible employees or less than two eligible employees, the provisions of [~~the~~] Insurance Code, Chapter 26, and this subchapter shall continue to apply to that particular health plan subject to the provisions of §26.15 of this chapter [~~title~~] (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees or less than two eligible employees, but not later than the first renewal date occurring after the small employer has ceased to be a small employer qualifying for coverage under Insurance Code Article 26.06(a) and this subchapter, notify the employer that the protections provided under [~~the~~] Insurance Code, Chapter 26, Subchapters A - G, and this subchapter shall cease to apply to the employer, if such employer fails to renew its current health benefit plan;[~~,~~] fails to comply with the contribution, minimum group size (as set forth in subsection (a) of this section), or participation requirements of this subchapter;[~~,~~] or elects to enroll in a different health benefit plan. The notice requirement of this subsection does not apply to a health carrier electing,

pursuant to this subchapter, to issue coverage to a group consisting of one eligible employee.

(j) (No change.)

(k) A governmental entity's [~~entities'~~] health benefit plan (subject to Insurance Code[~~,~~] Articles 3.51-1, 3.51-2, [~~3.51-3,~~] 3.51-4, 3.51-5, [~~or~~] 3.51-5A, or Chapter 1578) that is provided through health insurance coverage and that otherwise meets the requirements of being a small employer is subject to the provisions of [~~Chapter 26,~~] Insurance Code, Chapter 26, Subchapters A - G and this subchapter. The portion of a non-federal governmental entity's health benefit plan that is self-insured may elect not to comply with §2721 of the Public Health Services Act as added by the Health Insurance Portability and Accountability Act of 1996.

§26.6. Status of Health Carriers as Small Employer Carriers and Geographic Service Area.

(a) No later than March 1 annually, [~~1998,~~] each health carrier providing health benefit plans in this state shall make a filing with the commissioner indicating whether the health carrier will or will not offer, renew, issue, or issue for delivery health benefit plans to small employers in this state as defined in the Insurance Code, Chapter 26, Subchapters A - G, and this subchapter. The required filing shall include the certification [~~form~~] provided in the current [~~at Figure 40 of §26.27(b) of this title (relating to Forms) (~~] Form Number 1212 CERT SEHC STATUS, [~~)~~] completed according to the carrier's status and shall at least provide a statement to the effect of one of the following:

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

(b) If a health carrier chooses to change its election or the date of implementing its election under subsection (a)(1), (2), or (4) of this section, the health carrier shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 1212 CERT SEHC STATUS [~~provided at Figure 40 of §26.27(b)(40) of this title (relating to Forms)~~].

(c) Upon election to become a small employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services adequately to small employers in each established geographic service area. Small employer carriers shall comply with the following:

(1) The carrier shall define [~~The~~] geographic service areas [~~shall be defined~~] in terms of counties or ZIP [~~zip~~] codes, to the extent possible[~~, and shall be submitted in conjunction with any filing of a small employer health benefit plan~~].

(2) If the service area cannot be defined by counties or ZIP [~~zip~~] code, the carrier shall submit a map which clearly shows the geographic service areas [~~is required to be submitted in conjunction with the filing of the small employer health benefit plan~~].

(3) - (4) (No change.)

(5) [~~Networks of~~] HMO small employer carriers shall establish networks [~~be established~~] in accordance with Insurance Code, Chapters [~~Chapter~~] 20A and 843, and Chapter 11 of this title (relating to Health Maintenance Organizations) [~~, Insurance Code~~].

(6) Small employer carriers shall, no later than the initial filing of a small employer health benefit plan, utilize Form Number 1212 CERT GEOG to submit this information [~~provided at Figure 44 of §26.27(b)(44) of this title (relating to Forms)~~], as required by §26.19(b) of this chapter [~~title~~] (relating to Filing Requirements).

(7) If a small employer carrier elects to alter its geographic service area, the small employer carrier shall notify the department of its intent at least 30 days prior to the date the health carrier intends to effect the change. The small employer carrier shall utilize Form Number 1212 CERT GEOG to submit this information.

(d) Health carriers providing coverage under any health benefit plans issued to small employers and/or their employees, whether on a group or franchise basis, shall be considered small employer carriers for purposes of such plans, and shall comply with all provisions of [~~the~~] Insurance Code, Chapter 26, Subchapters A - G, and this subchapter, as applicable.

(e) A health carrier that continues to provide coverage pursuant to subsection (a)(2) of this section shall not be eligible to participate in the reinsurance program established under [~~the~~] Insurance Code, Chapter 26, Subchapter F.

(f) This subsection does not exempt a health carrier from any other applicable legal requirements, such as those for withdrawal from the market under §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures).

§26.7. Requirement to Insure Entire Groups.

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

(c) A small employer carrier may require each small employer that applies for coverage, as part of the application process, to provide a complete list of employees, eligible employees and dependents of eligible employees as defined in [~~the~~] Insurance Code[~~,~~] Article 26.02. The small employer carrier may also require the small employer to provide reasonable and appropriate supporting documentation [~~(such as a W-2 Summary Wage and Tax Form)~~] to verify the information required under this subsection, as well as to confirm the applicant's status as a small employer. The small employer carrier shall make a [~~A~~] determination of eligibility [~~shall be made~~] within five business days of receipt of any requested documentation. A small employer carrier may not condition the issuance of coverage on an employer's production of a particular document, where the employer can otherwise provide the information required by this section. Following are examples of the types of supporting documentation which a small employer carrier may request, as reasonable and appropriate, from an employer as needed to fulfill the purposes of this subsection:

(1) a W-2 Summary Wage and Tax Form or other federal or state tax records;

(2) a loan agreement;

(3) an invoice;

(4) a business check;

(5) a sales tax license;

(6) articles of incorporation or other business entity filings with the Secretary of State;

(7) assumed name filings;

(8) professional licenses; and

(9) reports required by the Texas Workforce Commission.

(d) - (h) (No change.)

(i) Periods provided for enrollment in and application for any health benefit plan provided to a small employer group shall comply with the following:

(1) the initial enrollment period shall extend [~~extends~~] at least 31 consecutive days after the date the new entrant begins employment or, if the waiting period exceeds 31 days, at least 31 consecutive days after the date the new entrant completes the waiting period for coverage;

(2) the new entrant shall be [~~is~~] notified of his or her opportunity to enroll at least 31 days in advance of the last date enrollment is permitted;

(3) the new entrant's application for coverage shall be considered timely if he or she submits the application within the initial enrollment [~~a~~] period [~~of at least 31 days following the date of employment, or following the date the new entrant is eligible for coverage, is provided during which the new entrant's application for coverage may be submitted~~]. Submits, [~~Submitted~~] for purposes of this paragraph, means that the item(s) must be postmarked by the end of the specified time period. At the discretion of the small employer carrier, alternative methods of submission, such as facsimile transmission (fax) [~~fax~~], may be acceptable; and

(4) the small employer carrier shall provide an open enrollment period of at least 31 consecutive days [~~is provided~~] on an annual basis. [~~Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is a 30-day month, the enrollment period shall begin on the first day of the month and end on the first day of the following month. If the month is February, the period shall last through March 2nd.~~]

(j) - (n) (No change.)

§26.8. Guaranteed Issue; Contribution and Participation Requirements.

(a) (No change.)

(b) Health carriers may require small employers to answer questions designed to determine the level of contribution by the small employer, the number of employees and eligible employees of the small employer, and the percentage of participation of eligible employees of the small employer.

(c) (No change.)

(d) Coverage under a small employer health benefit plan is available if at least 75% of the eligible employees of a small employer elect to be covered, as provided in [~~the~~] Insurance Code[~~,~~] Article 26.21 [~~26.21(b)~~]. This 75% requirement shall not apply to a small employer that has only two eligible employees. A small employer that has only two eligible employees shall be subject to a 100% participation requirement.

(1) - (2) (No change.)

(e) - (f) (No change.)

(g) A health carrier shall treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due to a participation level of less than the qualifying participation level or group size.

(h) - (i) (No change.)

(j) If a small employer fails to meet, for a period of at least six consecutive months, the qualifying minimum group size requirement set forth in §26.5(a) of this chapter (relating to Applicability and Scope) for a small employer health benefit plan, the health carrier may terminate coverage under the plan no earlier than the first day of the next month following the end of the six-month consecutive period during which the small employer did not meet the qualifying minimum group size requirement, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum group size requirement and in accordance with Insurance Code Articles 26.23, 26.24, and 26.25 and §26.15 of this chapter (relating to Renewability of Coverage and Cancellation).

§26.9. Exclusions, Limitations, Waiting Periods, Affiliation Periods and Preexisting Conditions and Restrictive Riders.

(a) All health benefit plans that provide coverage for small employers and their employees as defined in [~~the~~] Insurance Code[~~,~~] Article 26.02(29) [~~26.02(28)~~] and §26.4 of this chapter [~~title~~] (relating to Definitions) shall comply with the following requirements.

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

(4) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party in a suit seeking [~~in which~~] the adoption of the child [~~by the insured is sought~~]. The adopted child of an insured may be enrolled, at the option of the insured, within either:

(A) - (B) (No change.)

(5) - (6) (No change.)

(7) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the time periods specified in paragraphs (3) or (4) of this subsection, respectively, and subsequently enrolls in another health benefit plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion or affiliation period with regard to the child. If a newborn or adopted child is not enrolled within the time periods specified in paragraphs (3) or (4) of this subsection, respectively, then in accordance with paragraph (8) of this subsection, the newborn or adopted child may be considered a late enrollee or excluded from coverage until the next open enrollment period.

(8) A small employer carrier shall choose one of the methods set forth in subparagraphs (A) or (B) of this paragraph for handling requests for enrollment as a late enrollee in any health benefit plan subject to this subchapter. The small employer carrier must use the same method in regards to all such health benefit plans.

(A) - (B) (No change.)

(C) The provisions of subparagraphs (A) and (B) of this paragraph do not apply to employees or dependents under the special circumstances listed as exceptions under the definition of late enrollee in §26.4 of this chapter [~~title (relating to Definitions)~~].

(D) (No change.)

(9) - (11) (No change.)

(12) A preexisting condition provision in a small employer health benefit plan shall not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the small employer health benefit plan, excluding any waiting period. For example, Individual A has coverage under an individual policy for six months beginning on May 1, 1997, through October 31, 1997, followed by a gap in coverage of 61 days until December 31, 1997. Individual A is covered under an individual health plan beginning on January 1, 1998 [~~1997~~], for six months through June 30, 1998 [~~1997~~], followed by a gap in coverage of 62 days until August 31, 1998 [~~1997~~]. Individual A's effective date of coverage under a small employer health benefit plan is September 1, 1998 [~~1997~~]. Individual A has 12 months of creditable coverage and would not be subject to a preexisting condition exclusion under the small employer health benefit plan.

(13) (No change.)

(14) A small employer may establish a waiting period that cannot exceed 90 days from the first day of employment during which a new employee is not eligible for coverage. Upon completion of

the waiting period and enrollment within the time frame allowed by §26.7(i) of this chapter [~~title~~] (relating to Requirement To Insure Entire Groups), coverage must be effective no later than the next premium due. Coverage may be effective at an earlier date as agreed upon by the small employer and the small employer carrier.

(15) A health maintenance organization may impose an affiliation period [~~factor~~], if the period is applied uniformly without regard to any health status related factor. The affiliation period shall not exceed two months for an enrollee, other than a late enrollee, and shall not exceed 90 days for a late enrollee. An affiliation period under a plan shall run concurrently with any applicable waiting period under the plan. An HMO shall not impose any preexisting condition limitation, except for an affiliation period.

(16) - (17) (No change.)

(b) To determine if preexisting conditions as defined in [~~the~~] Insurance Code[~~,~~] Article 26.02 [~~26.02(23)~~], exist, a small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage in the absence of a creditable coverage certification form.

§26.10. Establishment of Classes of Business.

(a) (No change.)

(b) A health carrier may not directly or indirectly use the number of employees and dependents of a small employer or, except as provided in Insurance Code Article 26.31(a), [~~group size or~~] the trade or occupation of the employees of a small employer or the industry or type of business of the small employer as criteria for establishing eligibility for a health benefit plan or for a class of business.

(c) (No change.)

§26.11. Restrictions Relating to Premium Rates.

(a) (No change.)

(b) A small employer carrier shall file with the department, at least 60 days prior to the proposed date of the change, any proposed change to [~~not modify~~] the rating method used in the rate manual for a class of business [~~until the change has been filed with the department for 60 days~~]. The small employer carrier shall ensure that the rating method used is actuarially sound and appropriate to assure compliance with [~~the~~] Insurance Code, Chapter 26, and this chapter, and that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. The commissioner may disapprove a change to the rating method that does not meet the [~~these~~] requirements of this chapter. At the expiration of 60 days from the filing of the form with the department the proposed change shall be deemed compliant unless prior thereto the commissioner has disapproved it by written order.

(1) [~~A small employer health carrier may modify the rating method for a class of business only with prior approval of the commissioner. A small employer health carrier requesting to change the rating method for a class of business shall make a filing with the commissioner at least 60 days prior to the proposed date of the change.~~] The filing shall contain at least the following information:

(A) - (E) (No change.)

(2) (No change.)

(c) Each rate manual developed pursuant to subsection (a) of this section shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(1) - (2) (No change.)

(3) The rate manual developed pursuant to subsection (a) of this section shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(4) (No change.)

(5) Each rate manual developed pursuant to subsection (a) of this section shall provide for premium rates to be developed in a two-step process. In the first step, the small employer carrier shall develop a base premium rate [~~shall be developed~~] for the small employer group without regard to any risk characteristics of the group. In the second step, the small employer carrier may adjust the resulting base premium rate [~~may be adjusted~~] by the [~~a~~] risk load of the group, subject to the provisions of [~~the~~] Insurance Code, Chapter 26, Subchapter D, to reflect the risk characteristics of the group.

(6) - (7) (No change.)

(8) The health carrier shall retain each [~~Each~~] rate manual developed pursuant to subsection (a) of this section [~~shall be maintained by the health carrier~~] for a period of six years. The health carrier shall maintain all updates [~~Updates~~] and changes [~~to the manual shall be maintained~~] with the manual.

(9) (No change.)

(d) If a small employer carrier uses the number of employees and dependents of a small employer [~~group size is used~~] as a case characteristic [~~by a small employer carrier~~], the highest rate factor associated with a [~~group size~~] classification based on the number of employees and dependents of a small employer shall not exceed the lowest rate factor associated with such a classification by more than 20%.

(e) - (f) (No change.)

(g) An HMO [~~HMOs shall follow the rating requirements set out in this section for the prototype benefit plans authorized by the Insurance Code, Article 26.42, and this chapter. HMOs~~] offering any state approved, federally qualified plan described in [~~the~~] Insurance Code[~~,~~] Article 26.48 and §26.14[~~,~~] of this chapter [~~title~~] (relating to Coverage) shall establish premium rates for those plans in accordance with formulae or schedules of charges filed with the department under the procedures set forth in [~~the~~] Insurance Code[~~,~~] Article 20A.09(b), and Chapter 11, Subchapter H of this title (relating to Schedule of Charges). An HMO shall follow the rating requirements set out in this section for any plan it offers that is not federally qualified.

(h) (No change.)

(i) When seeking to obtain information relating to a small employer group, including the risk characteristics of the small employer group, a small employer carrier shall comply with §26.13(i) of this chapter (relating to Rules Related to Fair Marketing).

§26.13. Rules Related to Fair Marketing.

(a) (No change.)

(b) To each small employer who inquires about purchasing a small employer health benefit plan, a [~~Each~~] small employer carrier shall offer the employer a choice of health benefit plans as required by §26.14 of this chapter (Relating to Coverage). The small employer

carrier may provide the offer directly to the small employer or deliver it through an agent, but in either case shall offer each required plan contemporaneously with the offer of any other small employer health benefit plan. The offer shall be in writing and shall include at least the following

(1) information describing how the small employer may enroll in the plan or plans;

(2) information set out in Insurance Code Article 26.40 and §26.12 of this chapter (relating to Disclosure); and

(3) [~~that has expressed an interest in purchasing a small employer health benefit plan shall be given~~] a written disclosure, as required by §21.3530 of this title (relating to Health Carrier Disclosure). [~~summary of the standard benefit plans. The summary shall be in a readable and understandable format and shall include a clear, complete and accurate description of these items in the following order: lifetime maximums; deductibles, coinsurance maximums and percentages payable; benefits provided; and limitations and exclusions and riders that must be offered. To assure that small employers are fully aware that the Basic Coverage Benefit Plan does not cover organ transplants, or hospice, small employer carriers, other than HMOs, electing not to utilize Figure 41, shall reference this difference in the summary which is prepared and shall appear in bold print. Small employer carriers other than HMOs may use Form Number 1212 SUMM at Figure 41 of §26.27(b)(41) of this title (relating to Forms) to meet the requirements of this subsection. HMOs shall use the disclosure format required by §11.1600 of this title (relating to Information to Prospective Group Contract Holders and Enrollees) to meet the requirements of this subsection~~].

(c) Upon request, a small employer carrier shall explain to a small employer each of the small employer health benefit plans it offers. [~~A small employer carrier shall offer the standard benefit plans to each small employer who inquires about purchasing a small employer health benefit plan and shall, upon request, explain each of the plans to the small employer. A small employer carrier, other than an HMO, shall offer and explain the basic coverage benefit plan and the catastrophic care benefit plan. An HMO shall offer and explain the small employer health benefit plans that the HMO has filed for use in the small employer market. The offer may be provided directly to the small employer or delivered through an agent. The offer shall be in writing and shall include at least the following information:~~]

[~~(1) information describing how the small employer may enroll in the plans; and~~]

[~~(2) information set out in the Insurance Code, Article 26.40, and §26.12 of this title (relating to Disclosure).~~]

(d) A small employer carrier shall obtain from each small employer to which it issues coverage, at or before the time of application, a written affirmation that the small employer carrier offered the small employer a consumer choice health benefit plan and a comparable policy or plan as provided by Insurance Code Articles 3.80, §8 and 20A.9N(k) and §21.3542(a) of this title (relating to Offer of State-Mandated Plan).

(e) [~~(d)~~] A small employer carrier shall:

(1) provide a premium rate [~~price~~] quote to a small employer (directly or through an authorized agent) within ten working days of receiving:

(A) a request for a premium rate quote; and

(B) such information as is necessary to provide the premium rate quote.

(2) not impose any conditions, other than those enumerated in paragraph (1) of this subsection, to its provision of a premium rate quote; and

(3) within five working days of receiving a request for a premium rate quote, [~~A small employer carrier shall~~] notify a small employer (directly or through an authorized agent) [~~within five working days of receiving a request for a price quote~~] of any additional information the small employer carrier needs, using the applicable rate manual and associated underwriting guidelines developed pursuant to §26.11 of this chapter (relating to Restrictions Relating to Premium Rates), [~~needed by the small employer carrier~~] to provide the premium rate quote.

(f) [~~(e)~~] A small employer carrier[~~, other than an HMO,~~] shall not apply more stringent or detailed requirements related to the application process, or otherwise discriminate in the offer of, any small employer health benefit [~~for the standard benefit plans, including the basic coverage benefit plan and the catastrophic coverage benefit~~] plan than are applied for other health benefit plans offered by the health carrier to small employers. [~~An HMO shall not apply more stringent or detailed requirements related to the application process for the prototype small employer group health benefit plan than are applied for other health benefit plans offered by the HMO to small employers.~~]

(g) [~~(f)~~] If a small employer carrier denies coverage under a health benefit plan to a small employer on any basis, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information).

(h) [~~(g)~~] A small employer carrier shall establish and maintain a means to provide information to small employers who request information on the availability of small employer health benefit plans in this state. The information provided to small employers shall [~~at least~~] include information about how to apply for coverage from the health carrier and may include the names and phone numbers of agents located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized agent or to otherwise apply for coverage.

(i) [~~(h)~~] The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of [~~the~~] Insurance Code, Chapter 26, Subchapters A - G.

(j) [~~(i)~~] A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(k) [~~(j)~~] Health carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of [~~the~~] Insurance Code, Chapter 26, Subchapters A - G, and this subchapter. Health carriers shall elicit the following information from applicants for such plans at the time of application:

(1) whether [~~or not~~] any portion of the premium will be paid by a small employer;

(2) whether [~~or not~~] the prospective policyholder, certificate holder, or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under §162 or §106 of the United States Internal Revenue Code of 1986 (26 United States Code §106 or §162); [~~or~~]

(3) whether the health benefit plan is an employee welfare benefit plan under 29 CFR §2510.3-1(j); or

(4) [~~(3)~~] whether [~~or not~~] the applicant is a small employer.

(l) [~~(k)~~] If a health carrier fails to comply with subsection (k) [~~(j)~~] of this section, the health carrier shall be deemed to be on notice of any information that could reasonably have been attained if the health carrier had complied with subsection (k) [~~(i)~~] of this section.

(m) A small employer carrier may not discriminate between small employer groups when obtaining information relating to a small employer, including information related to the risk characteristics of the small employer group or other aspects of the application or application process.

(n) A small employer carrier may not terminate, fail to renew, limit its contract or agreement of representation with, or take any other negative action against an agent for any reason related to the agent's request that the carrier issue a health benefit plan to a small employer.

§26.14. Coverage.

(a) Every small employer carrier other than an HMO shall, as a condition of transacting business in this state with small employers, offer plans in compliance with Insurance Code Articles 26.42 and 3.80, and Chapter 21, Subchapter AA of this title (relating to Consumer Choice Health Benefit Plans).

(b) An HMO small employer carrier, shall, as a condition of transacting business in this state with small employers, offer plans in compliance with Insurance Code Articles 26.42, 26.48 and 20A.09N, and Chapter 21, Subchapter AA of this title.

(c) All small employer health benefit plans shall provide for continuation and may provide an option for conversion which complies with Insurance Code Articles 3.51-6, Sec. 1(d)(3) and 20A.09(k) and rules adopted thereunder. A state approved health benefit plan that complies with the requirements of Title XIII, Public Health Service Act (42 U.S.C. §§300e, et seq. shall provide coverage for continuation which complies with the requirements of Insurance Code Article 20A.09(k) and must offer conversion in compliance with 42 C.F.R. §417.124(e) and applicable federal law.

(d) Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees shall comply with Insurance Code Article 26.43, be written in plain language, and meet the requirements of Chapter 3, Subchapter G of this title (relating to Plain Language Requirements). Requirements for use of plain language are not applicable to a health benefit plan group master policy or a policy application or enrollment form for a health benefit plan group master policy.

(e) Every small employer carrier providing health benefit plans to small employers is required to offer dependent coverage to each eligible employee. Dependent coverage may be paid for by the employer, the employee, or both.

(f) Every small employer carrier providing a health benefit plan to a small employer shall comply, as applicable, with Insurance Code Articles 3.51-14, 3.51-5A, and 3.50-3, Section 4C.

§26.15. Renewability of Coverage and Cancellation.

(a) Except as provided by [~~the~~] Insurance Code[~~,~~] Article 26.24, a small employer carrier shall renew any small employer health benefit plan for any covered small employer at the option of the small employer, unless:

(1) (No change.)

(2) the small employer has committed fraud or intentional misrepresentation of a material fact. On or after September 1, 1995, an intentional misrepresentation of a material fact shall not include any misrepresentation related to health status;[~~.~~]

(3) the small employer has not complied with a material provision of the health benefit plan relating to premium contribution, group size, or participation requirements;

(4) - (5) (No change.)

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or intentional misrepresentation of a material fact by that individual and with respect to an eligible employee or dependent who is a subscriber or enrollee in an HMO, for the reasons specified in §11.506 [~~§11.506(4)(A)~~] of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion [~~and Non-group~~] Agreement and Group Certificate). The coverage is also subject to any policy or contractual provisions relating to incontestability or time limits on certain defenses. On or after September 1, 1995, an intentional misrepresentation of a material fact shall not include any misrepresentation related to health status.

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

(e) Other [~~Standard benefit plans and other~~] small employer health benefit plans, provided through individual policies, shall be guaranteed renewable for life or until maximum benefits have been paid, or may be guaranteed renewable with the only reasons for termination being those set out in [~~the~~] Insurance Code[~~,~~] Articles 26.23 and 26.24, and this subchapter[~~, provided that such plans shall include a conversion provision which provides comparable benefits to those required under Chapter 3, Subchapter F of this title (relating to Group Health Insurance Mandatory Conversion Privilege)~~]. All other health benefit plans issued to small employers shall be renewed at the option of the small employer, but may provide for termination in accordance with [~~the~~] Insurance Code, Chapter 26, and this subchapter.

§26.16. Refusal to Renew and Application to Reenter Small Employer Market.

(a) - (d) (No change.)

(e) A small employer carrier may elect to discontinue a particular type of small employer coverage[~~, other than the basic and catastrophic plans,~~] only if the small employer carrier:

(1) [~~provides notice to each employer of the discontinuation~~] before the 90th day preceding the date of the discontinuation of the coverage:[~~;~~]

(A) provides notice of the discontinuation to each employer and the department; and

(B) [~~(2)~~] offers to each employer the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation; and

(2) [~~(3)~~] acts uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

(f) This section does not exempt a health carrier from any other legal requirements, such as those contained in Insurance Code Article 21.49-2C, §26.14(a) of this chapter (relating to Coverage) and §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures), or requirements for discontinuation of certain plans under this chapter.

§26.18. Election and Application to be Risk-Assuming or Reinsured Carrier.

(a) Each small employer carrier shall file with the commissioner, no later than with the first filing of a small employer health

benefit plan, notification of whether the carrier elects to operate as a risk-assuming or reinsured carrier. A small employer carrier's operation as a risk-assuming carrier is subject to approval by the commissioner, and each small employer carrier electing to operate as a risk-assuming carrier shall file an application with the commissioner contemporaneously with its election to operate as a risk-assuming carrier. A small employer carrier [The required filing] shall use [the form provided at Figure 42 of §26.27(b)(42) of this title (relating to Forms) (]Form Number 1212 RISK[)] for these purposes [this purpose].

(b) A small employer carrier seeking to change its status as a risk-assuming or reinsured carrier shall file an application with the commissioner. The required filing shall include a completed certification form [provided at Figure 42 of §26.27(b)(42) of this title (relating to Forms) (]Form Number 1212 RISK[)] and shall provide information demonstrating good cause why the carrier should be allowed to change its status.

(c) A small employer carrier's election is effective until the fifth anniversary of the election, and a small employer carrier seeking to maintain its status after that date: [carrier applying to become a risk-assuming carrier shall file an application with the commissioner. A completed certification form provided at Figure 42 of §26.27(b)(42) of this title (relating to Forms) (Form Number 1212 RISK) shall accompany each application.]

(1) as a reinsured carrier must file with the commissioner, at least 90 days prior to the fifth anniversary of its election, Form Number 1212 RISK to renew that election;

(2) as a risk-assuming carrier must file with the commissioner, at least 90 days prior to the fifth anniversary of its election, Form Number 1212 RISK to reapply for the commissioner's approval of that election.

§26.19. Filing Requirements.

(a) Each small employer [health] carrier shall file each form, including, but not limited to, each policy, contract, certificate, agreement, evidence of coverage, endorsement, amendment, enrollment form, and application that will be used to provide a health benefit plan in the small employer market, with the department in accordance with [the] Insurance Code[,] Article 3.42, and Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings [Filing of Policy Forms, Riders, Amendments, and Endorsements for Life, Accident and Health Insurance and Annuities]), or [the] Insurance Code[,] Article 20A.09, and §11.301 [§11.301(4)] of this title (relating to Filing Requirements) or §11.302 [§11.302(6)] of this title (relating to Service Area Expansion or Reduction Application [Requests]), as applicable, except as provided in subsection (b) of this section. A small employer [health] carrier desiring to use existing forms to provide a health benefit plan in the small employer market shall file a certification stating which previously approved forms the health carrier intends to use in that market provided such forms have been amended to comply with applicable laws. [The form provided at Figure 43 of §26.27(b)(43) of this title (relating to Forms) (]Form Number 1212 CERT ANN LIST-OTHER/SEHBPshall [) may] be used for this purpose. [The previously approved forms should be listed in Provision E of that form.] The certification shall be forwarded to the department as soon as reasonably possible after January 1, 1994, and for newly elected small employer carriers no later than with the first filing of a small employer health benefit plan.

(b) Each small employer carrier shall submit a [The following certification forms providing information relating to prototype policy forms, marketing in the small employer market and/or other markets, and] geographic service area certification form, provided in Form Number 1212 CERT GEOG, prior to offering any small employer health benefit plan and subsequent to such filing only if the small employer carrier changes the elections it made in the certification [areas shall accompany each health benefit plan form filing submitted for use in the small employer market]. The certification form

[(1) A geographic service area certification provided at Figure 44 of §26.27(b)(44) of this title (relating to Forms) (Form Number 1212 CERT GEOG) shall be submitted by each health carrier providing health benefit plans to small employers and] shall define the geographic service areas within which the small employer carrier will operate as a small employer carrier.

(1) [(A)] Each small employer carrier shall submit this [This] certification form no later than with the initial filing of [must accompany] a small employer health benefit plan [carrier's initial filing submitted for use in the small employer market].

(2) [(B)] If a [After the initial filings of health benefit plans intended for use in the] small employer carrier elects to alter its [market have been approved, this certification form will only be due annually, no later than March 1 of each calendar year; however, if the] geographic service areas, the small employer carrier shall notify the department of its intent at least [change at any time, a new certification form defining the new service areas will be due no later than] 30 days prior to the date the small employer carrier intends to effect the change. The small employer carrier shall utilize Form Number 1212 CERT GEOG to submit this information. This subsection does not exempt a health carrier from any other legal requirements, such as those for withdrawal from the market under §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures).

[(2) A prototype certification form provided at Figure 45 of §26.27(b)(45) of this title (relating to Forms) (Form Number 1212 CERT PROTOTYPES/MRKT shall accompany each policy form filing and/or certification filing. A small employer carrier other than an HMO shall complete the certification form indicating:]

[(A) which of the prototype policy forms will be used;]

[(B) alternate forms which will be used, where permitted, and their Flesch score. If a small employer health carrier, other than an HMO, utilizes the prototype forms and only uses variations permitted in the prescribed and/or adopted forms, the certification with the description of the variations will suffice and policy forms will not be required to be submitted for review and approval. Approval of the use of the prototype forms based on the certification and the description of the variations will be communicated via an approval letter;]

[(C) define the market in which the form will be used, such as, for use only in the small employer market or in all employer markets or other markets;]

[(D) the type of group filing, if applicable;]

[(E) the small employer carrier's required participation amount; election to issue or not issue medically underwritten plans, the required employer contribution amount; election or non-election of a grace period and the number of days; termination for failure of employer to maintain participation requirements; election of Policy Year definition, Prescription Drug Benefit Rider or Prescription Drug Card Program, preexisting condition limitation provision including the time period for the preexisting limitation; late enrollee election; election or non-election of reduction in benefits for failure to pre-certify and the reduction amount; form numbers, approval dates and description of any riders that will be offered with the standard benefit plans; and description of additional percentages payable, deductibles and coinsurance amounts the small employer carrier will offer and description of

PPO service area, if applicable, utilizing Figure 30 of §26.27(b)(30) of this title (relating to Forms) (Form Number 1212 PPO).]

[(3) A prototype certification form provided at Figure 46 of §26.27(b)(46) of this title (relating to Forms) (Form Number 1212 HMO-CERT) with elections for HMO small employer plans shall accompany the contract form filing for HMOs. The HMO small employer carrier shall complete the certification form for variable provisions of the prototype form.]

(c) Each small employer [health] carrier, other than an HMO, shall use a policy shell format for any group or individual health benefit plan form used to provide a health benefit plan in the small employer market. To expedite the review and approval process, all group and individual health benefit plan form filings (excluding HMO filings which are covered in subsection (d) of this section) shall be submitted as follows:

(1) - (2) (No change.)

(3) as applicable under Chapter 3, Subchapter A of this title, the toll-free number and complaint notice page, as required by Chapter 1, Subchapter E of this title (relating to Notice of Toll-Free Telephone Numbers and Procedures for Obtaining Information and Filing Complaints [Policyholder Complaint Procedure]);

(4) - (6) (No change.)

[(7) for the standard benefit forms, which include the Basic Coverage Benefit Plan and the Catastrophic Care Benefit Plan, an insert of the required benefits section that includes the schedule of benefits, definitions, benefits provided, alternate cost containment and preferred provider [provisions, if any, exclusions and limitations, continuation/conversion provisions, coordination of benefits, and riders;]

(7) [(8)] for small employer health benefit plans [that are not one of the standard benefit forms], an insert page for the benefits section of the health benefit plan, including, but not limited to, schedule of benefits, definitions, benefits provided, [alternate cost containment and preferred provider provisions, if any,] exclusions and limitations, continuation provisions [continuation/conversion provisions], and if applicable, alternate cost containment, preferred provider, conversion and coordination of benefits provisions, and riders;

(8) [(9)] insert pages for any amendments, applications, enrollment forms, or other form filings which comprise part of the contract;

[(10) insert pages for any additional forms required under Chapter 3, Subchapter F of this title (relating to Group Health Insurance Mandatory Conversion Privilege);]

(9) [(11)] insert pages for any required outline of coverage for individual products;

(10) [(12)] any additional form filings and documentation as outlined in Chapter 3, Subchapter A of this title and Chapter 3, Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies);

(11) [(13)] the certifications required under this section and any other rating information required under §26.10 of this chapter [title] (relating to Establishment of Classes of Business) and §26.11 of this chapter [title] (relating to Restrictions Relating to Premium Rates); and

(12) [(14)] the rate schedule applicable to any individual health benefit plan, as required by Chapter 3, Subchapter A of this title [(relating to Requirements for Filing of Policy Forms Riders, Amendments, and Endorsements for Life, Accident, and Health Insurance and Annuities)].

(d) (No change.)

§26.20. Reporting Requirements.

(a) Small employer health carriers offering a small employer health benefit plan shall file annually, not later than March 1 of each year, an actuarial certification [provided at Figure 47 of §26.27(b)(47) of this title (relating to Forms) (] Form Number 1212 CERT ACTUARIAL, [)] stating that the underwriting and rating methods of the small employer carrier:

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

[(b) Not later than March 1 of each calendar year, Each health carrier shall file a certification provided at Figure 43 of §26.27(b)(43) of this title (relating to Forms) (Form Number 1212 CERT ANN LIST-OTHER/SEHBP) with the commissioner, stating whether the health carrier is offering any health benefit plan to small employers that is subject to the Insurance Code, Article 26.06(a). The certification shall:]

[(1) list each other health insurance coverage (including the form number, approval date, and a very brief description of the type of coverage) that the health carrier is offering, delivering, issuing for delivery, or renewing to or through small employers in this state; and is not subject to this chapter because it is listed as excluded from the definition of a health benefit plan under the Insurance Code, Article 26.02, and §26.4 of this title (relating to Definitions);]

[(2) include a statement that the health carrier is not offering or marketing to small employers as a health benefit plan the coverage listed under the Insurance Code, Article 26.07(b), and paragraph (1) of this subsection, and the health carrier is complying with the provisions of the Insurance Code, Chapter 26, Subchapters A-G, and this subchapter to the extent it is applicable to the health carrier;]

[(3) list each health benefit plan along with riders (including the form number and approval date) previously filed with the department (or filed through the certification process) which the health carrier is no longer marketing to small employers in the state. If the health carrier no longer wishes to offer the plan, a formal withdrawal of the plan shall be filed and can be accomplished by marking the appropriate blank on the certification provided at Figure 43 of §26.27(b)(43) of this title (relating to Forms) (Form Number 1212 CERT ANN LIST-OTHER/SEHBP); and]

[(4) list each health benefit plan and rider (including the form number and approval date) previously filed with the department which the health carrier plans to continue marketing to small employers in the state.]

(b) [(c)] Not later than March 1 of each calendar year, a small employer carrier shall complete and file with the commissioner Form Number 1212 CERT DATA [provided at Figure 48 of §26.27(b)(48) of this title (relating to Forms),] This annual filing shall include the following information related to health benefit plans issued by the small employer carrier to small employers in this state:

(1) the number of small employers that were issued and the number of lives that were covered under health benefit plans in the previous calendar year (separated, if applicable, as to newly issued plans and renewals);

(2) the number of small employers that were issued and the number of lives that were covered under consumer choice health benefit plans, plans offering all state-mandated health benefits [the preventive and primary care benefit plan, the in-hospital benefit plan, the standard health benefit plan, basic coverage benefit plan, catastrophic care benefit plan, optional catastrophic care medical savings account plan], HMO consumer choice health benefit plans and HMO plans including

all state-mandated health benefits [~~preventive and primary care benefit plan, HMO group standard benefit plan and HMO small employer group health benefit plan~~] in the previous calendar year (as applicable, separated as to newly issued plans and renewals and by groups based on the following covered-employee size ranges: 2 - 9, 10 - 20, 21 - 35, and 36 - 50 [~~to class of business~~]);

(3) the number of small employers that were issued and the number of lives that were covered for each of the carrier's three (if applicable) most frequently issued consumer choice health benefit plans [~~under a prescription drug rider with the preventive and primary care benefit plan, a preventive and primary care benefit rider with the in-hospital benefit plan, an alcohol and drug abuse rider with the basic coverage and catastrophic benefit plans, a mental health benefit rider with the basic coverage and catastrophic care benefit plans, a prescription drug rider with the basic coverage and catastrophic care benefit plans, and a preventive care rider with the basic coverage benefit plan~~] (as applicable, separately listed as to newly issued plans and renewals and including copies of the consumer choice health benefits plans[~~, type of rider and type of benefit plan~~]);

(4) the number of small employer health benefit plans in force and the number of lives covered under those plans. This information should be broken down by the zip code of the small employers' principal place of business in the state of Texas;

(5) the number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(6) the number of small employer health benefit plans that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the health carrier in the previous calendar year;

(7) the number of small employer health benefit plans that were issued to small employers that were uninsured for at least the two months prior to issue; [~~and~~]

(8) the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers in the previous calendar year. For purposes of this subsection, gross premiums shall be the total amount of monies collected by the health carrier for health benefit plans during the applicable calendar year or the applicable calendar quarter. Gross premiums shall include premiums collected for individual and group health benefit plans issued to small employers or their employees. Gross premiums shall also include premiums collected under certificates issued or delivered to employees (in this state) of small employers, regardless of where the policy is issued or delivered;

(9) if applicable, information regarding any small employer health benefit plans assumed from another small employer carrier; and

(10) the number of small employers and the number of lives that were covered under plans issued to small employer health coalitions in the previous calendar year (as applicable, separated as to newly issued plans and renewals).

§26.22. Private Purchasing Cooperatives.

(a) (No change.)

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the purchasing cooperative shall file notification of the receipt of the certificate and a copy of the cooperative's organizational documents with the commissioner by filing the required notification and documents with the Life/Health Division [~~Group~~], Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(c) The board of directors shall file annually with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding years. The annual filing shall be made, no later than March 1 of each year, on Form Number 1212 CERT COOP [~~provided at Figure 49 of §26.27(b)(49) of this title (relating to Forms)~~] and shall be mailed to the Life/Health Division [~~Group~~], Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) (No change.)

§26.24. Procedure for Obtaining the Approval of Commissioner and Filing with the Commissioner.

(a) Whenever the approval of the commissioner is required by this chapter for a small employer carrier other than an HMO, the initial approval shall be granted or denied by the deputy commissioner for the Life/Health Division [~~Group~~]. The initial decision is expressly delegated by this section to the deputy commissioner for the Life/Health Division [~~Group~~]. Whenever the approval of the commissioner is required by this chapter for HMO small employer plans, the initial approval shall be granted or denied by the deputy commissioner for the HMO Division [~~HMO/URA Group~~]. The applicant for the approval may appeal the initial decision to the commissioner.

(b) Whenever a filing of a policy, contract, or form is required by §26.19 of this title (relating to Filing Requirements) for a small employer carrier other than an HMO, any approval, withdrawal, or disapproval of the filing shall initially be made by the deputy commissioner for the Life/Health Division [~~Group~~]. Whenever a filing of a contract, evidence of coverage, or form is required by §26.19 of this title [~~(relating to Filing Requirements)~~] for HMO small employer plans, any approval, withdrawal, or disapproval of the filing shall initially be made by the deputy commissioner for the HMO Division [~~HMO/URA Group~~]. Notice of any adverse action shall be given to the applicant not later than the fifth day before the action is proposed to be taken. The applicant may appeal an adverse decision to the commissioner.

(c) Whenever a report is required to be filed by this chapter, that filing shall be made to the Deputy Commissioner, Life/Health Division [~~Group~~], Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§26.26. Administrative Violations and Penalties.

If, after notice and opportunity for hearing, the commissioner determines that a health carrier or a small employer carrier has violated or is violating any provision of [~~the~~] Insurance Code, Chapter 26, Subchapters A - G, or this subchapter, the commissioner may impose sanctions under [~~the~~] Insurance Code §§82.001, et seq., and §§84.001, et seq. [~~, Article 1.10, 1.10E~~], and/or issue a cease and desist order under [~~the~~] Insurance Code §§83.001, et seq [~~, Article 1.10A~~].

§26.27. Forms.

The forms relating to Chapter 26, Insurance Code, for small and large employers referenced in this chapter can be obtained from the Texas Department of Insurance, Life/Health & HMO Intake Section, Life/Health Division, MC 106-1E, P. O. Box 149104, Austin, Texas 78714-9104, or at the department's website, www.tdi.state.tx.us.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406536

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT REGULATION

28 TAC §§26.301 - 26.309, 26.311, 26.312

The amendments are proposed under Insurance Code Article 26.04, HIPAA, and Insurance Code §36.001. The Insurance Code, Chapter 26, implements provisions regarding small and large employers which were necessary to comply with the federal requirements contained in HIPAA. Article 26.04 requires the commissioner to adopt rules as necessary to implement the Insurance Code, Chapter 26, and to meet the minimum requirements of federal law and regulations which, for small and large employer health carriers, are contained in HIPAA. Federal agencies have adopted regulations implementing HIPAA as follows: Department of the Treasury, 26 CFR Part 54; Department of Labor, 29 CFR Part 2590; and Department of Health and Human Services, 45 CFR Parts 144 and 146. As identified in the Introduction, portions of the Federal Regulations are included in these rules as necessary to meet the minimum requirements of federal law. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The following articles are affected by this proposal: Insurance Code, Chapter 26 and Chapter 843, Subchapter G; Articles 26.02, 20A.09(k), 3.70-3C,and 21.58A; and §843.002

§26.301. Applicability and Scope.

(a) Except as otherwise provided, this subchapter shall apply to any health benefit plan providing health care benefits covering 51 or more eligible employees of a large employer, whether provided on a group or individual franchise basis, regardless of whether the policy was issued in this state, if it provides coverage to any citizen or inhabitant of this state and if the plan meets one of the following conditions:

(1) (No change.)

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of 26 United States Code §106 or §162; [~~or~~]

(3) the health benefit plan is a group policy issued to a large employer; or

(4) the health benefit plan is an employee welfare benefit plan under 29 CFR 2510.3-1(i).

(b) (No change.)

(c) An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed to large employers and their employees on or after July 1, 1997, shall comply with all provisions of the Insurance Code, Chapter 26, Subchapters A and H[~~, as adopted by the 75th Legislature,~~] and with this subchapter.

(d) (No change.)

(e) If a large employer or the employees of a large employer are issued a health benefit plan under the provisions of the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter, and the large employer subsequently employs less than 51 eligible employees, the provisions of the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter shall continue to apply to that particular health plan if the employer elects to renew the large employer health benefit plan subject to the provisions of §26.308 of this chapter [~~title~~] (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has less than 51 eligible employees, but not later than the first renewal date occurring after the employer ceases to be a large employer, notify the employer of the following:

(1) (No change.)

(2) If the employer does not renew the large employer health benefit plan, the employer will be subject to the requirements of the Insurance Code, Chapter 26, Subchapters A - G concerning small employers, and Subchapter A of this chapter (relating to Small Employer Health Insurance Portability and Availability Regulations), including guaranteed issue, rating protections, and participation/contribution/minimum group size [~~participation/contribution~~] requirements.

(3) (No change.)

(4) If the employer fails to comply with the qualifying [~~minimum percentage~~] participation, [~~or~~] contribution, or group size requirements, of §26.303 of this chapter (relating to Coverage Requirements), the health carrier may terminate coverage under the plan, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the qualifying participation, contribution, or minimum group size requirement and in accordance with Insurance Code Articles 26.86, 26.87, 26.88 and §26.303 of this chapter [~~the coverage will terminate~~].

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

§26.302. Status of Health Carriers as Large Employer Carriers and Geographic Service Area.

(a) Not later than March 1 annually, [~~1998,~~] each health carrier providing health benefit plans in this state shall make a filing with the commissioner indicating whether the health carrier will or will not offer, renew, issue, or issue for delivery health benefit plans to large employers in this state as defined in the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter. The required filing shall include the certification form [~~provided at Figure 50 of §26.27(b)(50) of this title (relating to Forms)~~ (] Form Number 1212 CERT LEHC STATUS,(~~)~~) completed according to the carrier's status, and shall at least provide a statement to the effect of one of the following:

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

(b) If a health carrier chooses to change its election or the date of implementing its election under subsection (a)(1), (2), or (4) of this section, the health carrier shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 1212 CERT LEHC STATUS [~~provided at Figure 50 of §26.27(b)(50) of this title (relating to Forms)~~].

(c) Upon election to become a large employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services adequately to large employers in each established geographic service area. Large employer carriers shall comply with the following:

(1) The health carrier shall define and submit the geographic service areas [~~shall be defined~~] in terms of counties or ZIP [~~zip~~] codes, to the extent possible[~~, and shall be submitted in conjunction with any filing of a large employer health benefit plan~~].

(2) If the health carrier cannot define the service area [~~cannot be defined~~] by counties or ZIP [~~zip~~] code, the health carrier shall submit a map which clearly shows the geographic service areas [~~is required to be submitted in conjunction with any filing of the large employer health benefit plan~~].

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

(6) Large employer carriers shall, no later than the initial filing of a large employer health benefit plan, utilize Form Number 1212 LEHC GEOG [~~provided in Figure 51 of §26.27(b)(51) of this title (relating to Forms)~~] to submit this information.

(d) If a large employer carrier elects to alter its geographic service area, the large employer carrier shall notify the department of its intent at least 30 days prior to the date the health carrier intends to effect the change. The large employer carrier shall utilize Form Number 1212 LEHC GEOG to submit this information.

(e) This section does not exempt a large employer carrier from any other legal requirements, such as those for withdrawal from the market under §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures).

§26.303. Coverage Requirements.

(a) A large employer carrier may refuse to provide coverage to a large employer in accordance with the carrier's underwriting standards and criteria. However, on issuance to a large employer, each large employer carrier shall provide coverage to the eligible employees meeting the participation criteria established by the large employer without regard to an individual's health status related factors. The participation criteria may not be based on health status related factors. A large employer's participation criteria may not require an employee to maintain an actively at work status, unless the actively at work status is wholly unrelated to health status related factors, such as time off for a sabbatical leave or vacation.

(b) The large employer carrier shall accept or reject the entire group of individuals who meet the participation criteria established by the employer and who choose coverage and may exclude only those eligible employees or dependents, if applicable, who have declined coverage. The carrier may charge premiums in accordance with Insurance Code[~~,~~] Article 26.89 to the group of employees or dependents, if applicable, who meet the participation criteria established by the employer and who do not decline coverage.

(c) A large employer carrier shall secure a written waiver for each eligible employee who meets the participation criteria and each dependent, if dependent coverage is offered to enrollees under a large employer health benefit plan, who declines an offer of coverage under a health benefit plan provided to a large employer. If a large employer elects to offer coverage through more than one large employer carrier, waivers are only required to be signed if the eligible individual is declining all large employer health benefit plans offered. The large employer carriers may enter into an agreement designating which large employer carrier will receive and retain the waiver. Waivers shall be maintained by the large employer carrier for a period of six years. The waiver must ensure that the employee was not induced or pressured into declining coverage because of the employee's health status related factors. The waiver shall be signed by the employee (on behalf of such employee or the dependent, if applicable, of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. Receipt by the large employer carrier of a facsimile transmission of the waiver is permissible, provided that the transmission includes a representation from the large employer that the employer will maintain the original waiver on file for a period of six years from the date of the facsimile transmission. The waiver form shall:

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

(d) A large employer carrier may not provide coverage to a large employer or the employees of a large employer if the carrier or an agent for the carrier knows that the large employer has induced or pressured an eligible employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.

(e) An agent shall notify a large employer carrier, prior to submitting an application for coverage with the health carrier on behalf of a large employer or employee of a large employer, of any circumstances that would indicate that the large employer has induced or pressured an eligible employee who meets the large employer's participation criteria or a dependent of the employee to decline coverage due to the individual's health status related factors.

(f) A large employer carrier may require a large employer to meet minimum premium contribution requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in this state. A health carrier shall treat all similarly situated large employer groups in a consistent and uniform manner when terminating health benefit plans due to failure of the large employer to meet a contribution requirement. If a large employer fails to meet a contribution requirement for a large employer health benefit plan, the health carrier may terminate coverage as provided under the plan in accordance with the terms and conditions of the plan requiring such contribution and in accordance with [~~the~~] Insurance Code[~~,~~] Articles 26.86, 26.87, and 26.88 and §26.308 [~~§26.309~~] of this chapter [~~title~~] (relating to Renewability of Coverage and Cancellation).

(g) (No change.)

(h) A large employer carrier may require a large employer to meet minimum participation requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in this state. The minimum participation requirements may determine the percentage of individuals that must be enrolled in the plan in accordance with participation criteria established by the employer. These minimum participation requirements must be stated in the contract and must be applied uniformly to each large employer offered or issued coverage by the large employer carrier in this state. A large employer health carrier shall accept or reject the entire group of eligible employees meeting the participation criteria and minimum participation requirements that choose to participate and exclude only those employees and dependents, if applicable, that have declined coverage.

(i) In determining whether an employer has the required percentage of participation of eligible employees who meet the large employer's participation criteria, if the percentage of eligible employees is not a whole number, the result of applying the percentage to the number of eligible employees shall be rounded down to the nearest whole number. For example: if a large employer health carrier [~~an employer~~] uses a minimum participation requirement of 75% of the eligible employees meeting the large employer's participation criteria, 75% of 55 employees is 41.25, so 41.25 would be rounded down to 41; therefore, 75% participation by a 55 employee group will be achieved if 41 of the eligible employees meeting the large employer's participation criteria participate.

(j) If a large employer fails to meet the qualifying minimum participation requirement for a large employer health benefit plan, for a period of at least six consecutive months, the large employer health carrier may terminate coverage under the plan upon the first renewal date following the end of the six-month consecutive period during which the qualifying minimum participation requirement was not met, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum participation requirement and in accordance with [~~the~~] Insurance Code[~~,~~] Articles 26.86, 26.87, 26.88 and §26.308 [~~§26.309~~] of this chapter [~~title (relating to Renewability and Cancellation)~~]. A large employer health carrier shall treat all similarly situated large employer groups in a consistent and uniform manner when terminating health benefit plans due to a participation level of less than the qualifying participation level.

(k) A large employer must continue to meet the qualifying minimum group size requirement of §26.5(a) of this chapter (relating to Applicability and Scope) to be entitled to elect to renew coverage pursuant to §26.301(e) of this chapter (relating to Applicability and Scope). If a large employer fails to meet, for a period of at least six consecutive months, the minimum group size requirement of §26.5(a) of this chapter, the health carrier may terminate coverage under the plan upon the first renewal date following the later of the end of the six-month consecutive period during which the large employer did not meet the qualifying minimum group size requirement, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the minimum group size requirement of §26.5(a) of this chapter, and in accordance with the Insurance Code Articles 26.86, 26.87, 26.88 and §26.308 of this chapter.

§26.304. Requirement to Insure Entire Groups.

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

(c) A large employer carrier may require each large employer that applies for coverage, as part of the application process, to provide a complete list of employees, eligible employees, and if dependent coverage is offered to enrollees under a large employer health benefit plan, a complete list of dependents of eligible employees as defined in [~~the~~] Insurance Code[~~,~~] Article 26.02. The large employer carrier may also require the large employer to provide reasonable and appropriate supporting documentation [~~(such as a W-2 Summary Wage and Tax Form)~~] to verify the information required under this subsection, as well as to confirm the applicant's status as a large employer. The large employer carrier shall make a [~~A~~] determination of eligibility [~~shall be made~~] within five business days of receipt of any requested documentation. A large employer carrier may not condition the issuance of coverage on an employer's production of a particular document, where the employer can otherwise provide the information required by this section. Following are examples of the types of supporting documentation which a large employer carrier may request, as reasonable and appropriate, from an employer as needed to fulfill the purposes of this subsection.

(1) a W-2 Summary Wage and Tax Form or other federal or state tax records;

(2) a loan agreement;

(3) an invoice;

(4) a business check;

(5) a sales tax license;

(6) articles of incorporation or other business entity filings with the Secretary of State;

(7) assumed name filings;

(8) professional licenses; and

(9) reports required by the Texas Workforce Commission.

(d) A large employer carrier shall not deny two individuals that are married the status of eligible employee solely on the basis that the two individuals are married. The large employer carrier shall provide a reasonable opportunity for the individuals to submit evidence as provided in subsection (c) of this section to establish each individual's status as an eligible employee.

(1) The two individuals will not be eligible for coverage as a dependent. Each must be covered as an employee.

(2) A child of either of the two individuals may only be covered under the same large [~~small~~] employer health benefit plan as a dependent by one of the two individuals.

(e) - (h) (No change.)

§26.305. Enrollment.

(a) Periods provided for enrollment in and application for any health benefit plan provided to a large employer group shall comply with the following:

(1) the initial enrollment period for the employees meeting the large employer's participation criteria shall extend [~~must be~~] at least 31 consecutive days after the employee's initial date of employment, or if the waiting period exceeds 31 days, at least 31 consecutive days after the date the new entrant completes the waiting period for coverage;

(2) (No change.)

(3) a new entrant's application for coverage shall be timely if he or she submits the application within a period of at least 31 consecutive days following the initial date of employment, or following the date the new entrant is eligible for coverage[~~, shall be provided during which the new entrant's application for coverage may be submitted~~]. For purposes of this paragraph, "submits" [~~submitted~~] means that the item(s) must be postmarked by the end of the specified time period. At the discretion of the large employer carrier, alternative methods of submission such as facsimile transmission (fax) [~~fax~~], may be acceptable; and

(4) the large employer carrier shall provide an annual open enrollment period of at least 31 consecutive days [~~shall be provided on an annual basis. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is a 30-day month, the enrollment period shall begin on the first day of the month and end on the first day of the following month. If the month is February, the period shall last through March 2nd~~].

(b) If dependent coverage is offered to enrollees under a large employer health benefit plan, the initial enrollment period for the dependents must be at least 31 consecutive days, with a 31 consecutive day annual open enrollment period.

(c) A new employee who meets the participation criteria of a covered large employer may not be denied coverage if the application for coverage is received by the large employer carrier not later than the 31st day after the later of:

(1) (No change.)

(2) the date on which the waiting period established under Insurance Code[~~,~~] Article 26.83(h) expires.

(d) (No change.)

(e) A large employer carrier may not exclude any eligible employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

(f) - (n) (No change.)

§26.306. Exclusions, Limitations, Waiting Periods, Affiliation Periods and Preexisting Conditions and Restrictive Riders.

(a) A large employer carrier may not exclude any eligible employee who meets the participation criteria or an eligible dependent, if dependent coverage is offered to enrollees under a large employer health benefit plan (including a late enrollee, who would otherwise be covered under a large employer's health benefit plan), except to the extent permitted under [~~the~~] Insurance Code[~~,~~] Articles 26.83 and 26.90.

(b) A preexisting condition provision in a large employer health benefit plan may not apply to expenses incurred on or after the expiration of the 12 months following the initial effective date of coverage of the enrollee or late enrollee, except as authorized by subsection (h)(2) of this section.

(c) - (e) (No change.)

(f) A preexisting condition provision in a large employer health benefit plan shall not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the large employer health benefit plan, excluding any waiting period. For example, Individual A has coverage under an individual policy for 6 months beginning on May 1, 1997, through October 31, 1997, followed by a gap in coverage of 61 days until December 31, 1997. Individual A is covered under an individual health plan beginning on January 1, 1998 [~~1997~~], for 6 months through June 30, 1998 [~~1997~~], followed by a gap in coverage of 62 days until August 31, 1998 [~~1997~~]. The effective date of Individual A's coverage under a large employer health benefit plan is September 1, 1998 [~~1997~~]. Individual A has 12 months of creditable coverage and would not be subject to a preexisting condition exclusion under the large employer health benefit plan.

(g) (No change.)

(h) A large employer carrier shall choose one of the methods set forth in paragraphs (1) or (2) of this subsection for handling requests for enrollment from a late applicant in any health benefit plan subject to this subchapter. The large employer carrier must use the same method in regards to all such health benefit plans.

(1) The employee or dependent may be excluded from coverage and any application for coverage rejected until the next annual open enrollment period and, upon enrollment, may be subject to a 12-month preexisting condition provision, or, in the case of an HMO, may be subject to a 60-day affiliation provision, as such provisions are described by [~~the~~] Insurance Code[~~,~~] Article 26.90.

(2) (No change.)

(3) The provisions of paragraphs (1) and (2) of this subsection [~~subparagraphs (A) and (B)~~] do not apply to employees or dependents under the special circumstances listed as exceptions under the definition of late enrollee in §26.4 of this chapter [~~title~~] (relating to Definitions).

(4) (No change.)

(i) (No change.)

(j) A large employer may establish a waiting period applicable to all new entrants under the health benefit plan during which a new employee is not eligible for coverage. The large employer shall determine the duration of the waiting period. A large employer carrier shall not apply a waiting period, elimination period, or other similar limitation of coverage (other than an exclusion for preexisting [~~pre-existing~~] medical conditions or impose an affiliation period consistent with [~~the~~] Insurance Code[~~,~~] Articles 26.83 and 26.90), with respect to a new entrant, that is longer than the waiting period established by the large employer. Upon completion of the waiting period and enrollment within the time frame allowed by §26.305(a) of this chapter [~~title~~] (relating to Enrollment), coverage must be effective no later than the next premium due date. Coverage may be effective at an earlier date as agreed upon by the large employer and the large employer carrier.

(k) (No change.)

(l) To determine if preexisting conditions as defined in [~~the~~] Insurance Code[~~,~~] Article 26.02(23) exist, a large employer carrier shall ascertain the source of previous or existing coverage of each eligible employee meeting the participation criteria and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the large employer carrier. The large employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage in the absence of a creditable coverage certification form.

§26.307. Fair Marketing.

(a) - (d) (No change.)

(e) Health carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter. Health carriers shall elicit the following information from applicants for such plans at the time of application:

(1) whether [~~or not~~] any portion of the premium will be paid by a large employer;

(2) whether [~~or not~~] the prospective policyholder, certificate holder, or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under §162 or §106 of the United States Internal Revenue Code of 1986 (26 United States Code §106 or §162); [~~or~~]

(3) whether the health plan is an employee welfare benefit plan under 29 CFR §2510.3-1(i); or

(4) [~~(3)~~] whether [~~or not~~] the applicant is a large employer.

(f) If a health carrier fails to comply with subsection (e) [~~(f)~~] of this section, the health carrier shall be deemed to be on notice of any information that could reasonably have been attained if the health carrier had complied with subsection (e) [~~(f)~~] of this section.

(g) A large employer carrier may not terminate, fail to renew, limit its contract or agreement of representation with, or take any other negative action against an agent for any reason related to the agent's request that the carrier issue a health benefit plan to a large employer.

§26.308. Renewability of Coverage and Cancellation.

(a) Except as provided by [~~the~~] Insurance Code[~~,~~] Article 26.87, a large employer carrier shall renew any large employer health benefit plan for any covered large employer at the option of the large employer, unless:

(1) - (2) (No change.)

(3) the large employer has not complied with a material provision of the health benefit plan relating to premium contribution, group size, or minimum participation requirements;

(4) - (5) (No change.)

(b) A large employer carrier may refuse to renew the coverage of an eligible employee or dependent, if applicable, for fraud or intentional misrepresentation of a material fact by that individual and with respect to an eligible employee or dependent who is a subscriber or enrollee in an HMO, for the reasons specified in §11.506(3) [~~§11.506(4)(A)~~] of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion [~~Non-group~~] Agreement and Group Certificate). The coverage is also subject to any policy or contractual provisions relating to incontestability or time limits on certain defenses.

§26.309. Refusal to Renew and Application to Reenter Large Employer Market.

(a) A large employer carrier may elect to refuse to renew all large employer health benefit plans delivered or issued for delivery by the large employer carrier in this state or in a geographic service area approved under [~~the~~] Insurance Code[~~,~~] Article 26.85(d). The large employer carrier shall notify the commissioner of the election not later than the 180th day before the date coverage under the first large employer health benefit plan terminates under [~~the~~] Insurance Code[~~,~~] Article 26.87(a) and shall comply with the notification requirements set forth in §26.302(c) and (d)(2) of this chapter (relating to Status of Health Carriers as Large Employer Carriers and Geographic Service Area). This subsection does not exempt a health carrier from any other legal requirements, such as those for withdrawal from the market under §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures).

(b) - (d) (No change.)

(e) A large employer carrier may elect to discontinue a particular type of large employer coverage, only if the large employer carrier:

(1) [~~provides notice to each employer of the discontinuation~~] before the 90th day preceding the date of the discontinuation of the coverage: [~~;~~]

(A) provides notice of the discontinuation to each employer and the department; and

(B) [~~(2)~~] offers to each employer the option to purchase other large employer coverage offered by the large employer carrier at the time of the discontinuation; and

(2) [~~(3)~~] acts uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

§26.311. Administrative Violations and Penalties.

If, after notice and opportunity for hearing, the commissioner determines that a health carrier or a large employer carrier has violated or is violating any provision of the Insurance Code, Chapter 26, Subchapters A and H, or this subchapter, the commissioner may impose sanctions under [~~the~~] Insurance Code §§82.001, et seq., and §§84.001, et seq. [~~, Article 1.10, 1.10E~~], and/or issue a cease and desist order under [~~the~~] Insurance Code §§83.001, et seq [~~, Article 1.10A~~].

§26.312. Point-of-service Coverage.

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

(1) - (5) (No change.)

(6) Point-of-service (POS) plan--As defined in Insurance Code Article 26.09(a)(2) [~~of the Code~~].

(b) - (f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406537
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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CHAPTER 26. SMALL EMPLOYER HEALTH INSURANCE REGULATIONS

SUBCHAPTER A. SMALL EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT REGULATIONS

28 TAC §§26.14, §26.27

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Insurance or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Department of Insurance proposes repeal of §§26.14 and 26.27 concerning small and large employer health insurance regulations. The repeal of the sections is necessary so that Chapter 26 of the department's rules will conform to current statutory requirements. Contemporaneously with this proposed repeal, proposed new §§26.14 and 26.27 and amendments to §§26.4 - 26.11, 26.13, 26.15, 26.16, 26.18 - 26.20, 26.22, 26.24, 26.26, 26.301 - 26.309 and 26.311 - 26.312 are published elsewhere in this issue of the *Texas Register*.

Kim Stokes, Senior Associate Commissioner for the Life, Health and Licensing Program, has determined that during the first five years that the proposed repeal is in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the sections. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Ms. Stokes has also determined that for each year of the first five years the repeal of the sections is in effect, the public benefit anticipated as a result of administration and enforcement of the repealed sections will be that Chapter 26 of the department's rules will be up to date and conform to current statutory requirements. There is no anticipated economic cost to persons who are required to comply with the proposed repeal. There is no anticipated difference in cost of compliance between small and large businesses.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 13, 2004 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-1C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Bill Bingham, Deputy for Regulatory Matters, Life, Health and Licensing Program, Mail Code 107-2A,

Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a public hearing must be submitted separately to the Office of Chief Clerk.

Repeal of §§26.14 and 26.27 is proposed pursuant to Insurance Code Chapter 1153, and §36.001. Chapter 1153 gives the Commissioner of Insurance authority to set presumptive premium rates by rule for credit life and accident and health policies. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The proposed repeal affects regulation pursuant to the following statutes: RuleStatute §§26.14 and 26.27 Insurance Code, Chapter 1153.

§26.14. Coverage.

§26.27. Forms.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406509
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-6327

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 37. FINANCIAL ASSURANCE

SUBCHAPTER W. FINANCIAL ASSURANCE FOR DRY CLEANING FACILITIES

30 TAC §§37.9201, 37.9205, 37.9210, 37.9215, 37.9220

The Texas Commission on Environmental Quality (commission) proposes new §§37.9201, 37.9205, 37.9210, 37.9215, and 37.9220.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE PROPOSED RULES

The purpose of the proposed rules is to implement House Bill (HB) 1366, 78th Legislature, 2003. HB 1366 amends the Texas Health and Safety Code (THSC) by adding a new Chapter 374. HB 1366 requires rules to be adopted that are necessary to administer and enforce the new chapter. Specifically, these proposed rules set forth procedures for administering and enforcing THSC, §374.105, which requires owners of certain dry cleaning facilities to furnish a bond or other financial assurance to the commission.

A new 30 TAC Chapter 337, Dry Cleaner Environmental Response, is also proposed in this issue of the *Texas Register* to correspond with the proposed changes in this chapter.

SECTION BY SECTION DISCUSSION

The commission proposes new Subchapter W, Financial Assurance for Dry Cleaning Facilities, to establish the procedures to administer and enforce HB 1366.

Proposed new §37.9201, Applicability, states that the subchapter applies to an owner of a dry cleaning facility required to provide evidence of financial assurance under proposed new Chapter 337 and establishes requirements and mechanisms for demonstrating financial assurance for corrective action.

Proposed new §37.9205, Submission of Documents, states that an owner required to provide financial assurance shall submit an originally signed financial assurance mechanism for corrective action with the affidavit of nonparticipation in fund benefits. The signed financial assurance mechanism must be in effect at the time of submission.

Proposed new §37.9210, Financial Assurance Requirements for Corrective Action, sets forth the financial assurance requirements for corrective action at dry cleaning facilities. An owner of a dry cleaning facility shall establish financial assurance for the corrective action of the facility that meets the requirements of the proposed rule, in addition to the requirements specified under Subchapters A, C, and D of this chapter. In addition, an owner may use a fully funded trust, a surety bond guaranteeing payment, an irrevocable standby letter of credit, and insurance as specified in Subchapter C of this chapter to demonstrate financial assurance for corrective action.

Proposed new §37.9215, Continuous Financial Assurance Required, states that the owner of a facility required to provide financial assurance for corrective action shall provide continuous financial assurance until the executive director provides written consent to termination. Upon written request by the owner, the executive director shall provide written consent to termination of a financial assurance mechanism when an owner substitutes and receives approval from the executive director for alternate financial assurance as specified in this chapter or on the second anniversary of the date the facility closes for use as a dry cleaning facility, if the executive director has certified that corrective action is not required at the facility.

Proposed new §37.9220, Drawing on the Financial Assurance Mechanisms, states that the executive director may call on the financial assurance mechanism(s) when an owner who is required to comply with this chapter has failed to perform corrective action, when required; failed to provide an alternate financial assurance mechanism, when required; or failed to provide continuous financial assurance coverage.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENT

Jeff Horvath, Analyst, Strategic Planning and Grants Management Section, determined that for the first five-year period the proposed new rules are in effect, no significant fiscal implications are anticipated for the agency and no fiscal implications are anticipated for other units of state or local government.

The purpose of the proposed rules is to implement HB 1366, codified as THSC, Chapter 374. The proposed rules require owners of certain dry cleaning facilities to provide financial assurance for corrective action. Under the proposed rules, owners of dry cleaning facilities that have filed the affidavit of nonparticipation (exercising the option to not participate in the benefits of the Dry Cleaning Facility Release Fund) and who began operation on or after September 1, 2003, must furnish to the commission a bond

or other financial assurance authorized by the commission in the amount of $500,000. An option not to participate in fund benefits must have been filed with the commission before January 1, 2004. A facility may be designated as nonparticipating if the owner demonstrates, at the owner's expense, that the owner has never used perchloroethylene and will never use perchloroethylene. An owner would have to comply with the financial assurance requirements only if the owner chooses to be designated as nonparticipating and otherwise meets the statutory requirements.

At this time there are potentially two facilities that would be affected under the proposed financial assurance rules. Costs to the agency to ensure that the facilities comply with the proposed financial assurance requirements are not expected to be significant.

PUBLIC BENEFITS AND COSTS

Mr. Horvath also determined that for each year of the first five years the proposed new rules are in effect, the public benefit anticipated from the changes seen in the proposed rules will be compliance with state law and the protection of the state's groundwater and surface water from potential and actual contamination from certain dry cleaning facilities.

Fiscal implications are expected for businesses and individuals that choose to be designated as nonparticipating and otherwise meet the statutory requirements. Owners of nonparticipating dry cleaning facilities will have to pay for financial assurance for corrective action. However, these facilities will also be exempt from the per-gallon fee on dry cleaning solvents except perchloroethylene. They would also lose the financial benefit of participating in the Dry Cleaning Facility Release Fund, which would cover any corrective action costs at the site.

Currently, there are approximately two facilities that would be affected by the proposed rules. In order to meet the financial assurance requirements, the owners may use a fully funded trust, a surety bond guaranteeing payment, an irrevocable letter of credit, or insurance. Guaranteed surety bond payments or insurance premiums are estimated to cost approximately $10,000 each year for $500,000 worth of coverage, but may be higher or lower, depending upon the coverage requirements of the carrier.

SMALL BUSINESS AND MICRO-BUSINESS ASSESSMENT

No adverse fiscal implications are anticipated for dry cleaning facilities that are small or micro- businesses unless they were designated as a nonparticipatory dry cleaning facility and are a new business as of September 1, 2003. These owners would then be required to obtain financial assurance for corrective action in the amount of $500,000. Guaranteed surety bond payments or insurance premiums are estimated to cost $10,000 each year and may be higher or lower, depending upon the coverage requirements of the carrier.

The following is an analysis of the cost per employee for any small or micro-businesses affected by the proposed rules. Small and micro-business are defined as having fewer than 100 or 20 employees respectively. Owners of dry cleaning facilities with 100 or fewer employees could incur additional costs for obtaining financial assurance of up to $10,000 to comply with the proposed rules or $100 per employee. A micro-business with 20 or less employees would incur estimated additional costs of $500 per employee. The projected costs for affected facilities are the same for small businesses as for larger businesses.

LOCAL EMPLOYMENT IMPACT STATEMENT

The commission reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five years that the proposed rules are in effect.

DRAFT REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the proposed rules in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that this rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. While the specific intent of a major environmental rule is to protect the environment or reduce the risks to human health from environmental exposure, the specific intent of the proposed rules is to provide the framework within which the agency will administer the requirement in THSC, §374.105 for owners of certain dry cleaning facilities to furnish a bond or other financial assurance. Thus, the specific intent of the proposed rules is not to protect the environment nor reduce the risks to human health from environmental exposure. Additionally, the proposed rules do not adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

Furthermore, even if the proposed rules did meet the definition of a major environmental rule, Texas Government Code, §2001.0225 only applies to a major environmental rule if the result of the rule is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. These proposed rules do not meet any of the four applicability requirements and thus are not subject to the regulatory analysis provisions of §2001.0225 even if they did meet the definition of a major environmental law. Specifically, the proposed rules are required by state law, are not proposed solely under the general powers of the agency, and do not exceed a requirement of state law, federal law, or a delegation agreement or contract between the state and an agency or representative of the federal government.

The commission invites public comment on this draft regulatory impact analysis determination.

TAKINGS IMPACT ASSESSMENT

The commission further evaluated these proposed rules and performed an assessment of whether these proposed rules constitute a takings under Texas Government Code, Chapter 2007. The specific purpose of these proposed rules is to implement HB 1366, specifically the requirement in THSC, §374.105 for owners of certain dry cleaning facilities to furnish a bond or other financial assurance to the commission. The proposed rules significantly advance this stated purpose by providing the framework within which the agency will administer this financial assurance requirement.

Promulgation and enforcement of the proposed rules would be neither a statutory nor a constitutional taking of private real property by the commission. Specifically, the proposed rules do not affect a landowner's rights in private real property because this

rulemaking does not burden (constitutionally) nor restrict or limit the owner's rights to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the proposed rules.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the proposed rulemaking and found that the rules are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2), relating to Actions and Rules Subject to the Coastal Management Program, nor will they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the proposed rules are not subject to the Texas Coastal Management Program.

ANNOUNCEMENT OF HEARING

The commission will hold a public hearing on this proposal in Austin on December 6, 2004, at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes before the hearing and will answer questions before and after the hearing.

Persons with disabilities who have special communication or other accommodation needs who are planning to attend the hearing should contact the Office of Environmental Policy, Analysis, and Assessment at (512) 239-4900. Requests should be made as far in advance as possible.

SUBMITTAL OF COMMENTS

Comments may be submitted to Lola Brown, Office of Environmental Policy, Analysis, and Assessment, MC 205, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Comments must be received by 5:00 p.m., December 13, 2004, and should reference Rule Project Number 2003-047-337-WS. Copies of the proposed rules can be obtained from the commission's Web site at *http://www.tnrcc.state.tx.us/oprd/rules/propadop.html*. For further information, please contact Michael Bame, Policy and Regulations Division, (512) 239-5658.

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under Texas Water Code (TWC), §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§37.9201. Applicability.

This subchapter applies to an owner of a dry cleaning facility required to provide evidence of financial assurance under §337.60 of this title (relating to Nonparticipating Dry Cleaning Facility Financial Assurance). This subchapter establishes requirements and mechanisms for demonstrating financial assurance for corrective action.

§37.9205. Submission of Documents.

An owner of a dry cleaning facility required by this subchapter to provide financial assurance shall submit an originally signed financial assurance mechanism for corrective action with the affidavit of nonparticipation in fund benefits. The signed financial assurance mechanism must be in effect at the time of submission.

§37.9210. Financial Assurance Requirements for Corrective Action.

(a) An owner of a dry cleaning facility subject to this subchapter shall establish financial assurance for the corrective action of the facility that meets the requirements of this subchapter, in addition to the requirements specified under Subchapters A, C, and D of this chapter (relating to General Financial Assurance Requirements; Financial Assurance Mechanisms for Closure, Post Closure, and Corrective Action; and Wording of the Mechanisms for Closure, Post Closure, and Corrective Action).

(b) An owner of a dry cleaning facility subject to this subchapter may use a fully funded trust, a surety bond guaranteeing payment, an irrevocable standby letter of credit, and insurance as specified in Subchapter C of this chapter to demonstrate financial assurance for corrective action.

§37.9215. Continuous Financial Assurance Required.

The owner of a dry cleaning facility required by this subchapter to provide financial assurance for corrective action shall provide continuous financial assurance until the executive director provides written consent to termination. Upon written request by the owner, the executive director shall provide written consent to termination of a financial assurance mechanism when:

(1) an owner substitutes and receives approval from the executive director for alternate financial assurance as specified in this chapter; or

(2) on the second anniversary of the date the facility closes for use as a dry cleaning facility, if the executive director has certified that corrective action is not required at the facility.

§37.9220. Drawing on the Financial Assurance Mechanisms.

The executive director may call on the financial assurance mechanism(s) when an owner of a dry cleaning facility required to comply with this chapter has:

(1) failed to perform corrective action, when required;

(2) failed to provide an alternate financial assurance mechanism, when required; or

(3) failed to provide continuous financial assurance coverage.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406449
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 239-0348

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CHAPTER 337. DRY CLEANER ENVIRONMENTAL RESPONSE

The Texas Commission on Environmental Quality (commission or agency) proposes new §§337.1 - 337.4, 337.10 - 337.15, 337.20 - 337.22, 337.30 - 337.32, 337.40, 337.41, 337.50, 337.51, 337.60 - 337.63, 337.70 - 337.72, and 337.80.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE PROPOSED RULES

The purpose of the proposed rules is to implement House Bill (HB) 1366, 78th Legislature, 2003. HB 1366 amends the Texas Health and Safety Code (THSC) by adding a new Chapter 374. HB 1366 requires rules to be adopted that are necessary to administer and enforce the new chapter, including rules that establish: 1) performance standards for dry cleaning facilities; 2) requirements for the removal of dry cleaning solvents and waste from dry cleaning facilities; 3) criteria to be used in setting priorities for the expenditure of money from the dry cleaning fund; and 4) criteria under which the agency may determine the level at which corrective action is considered complete.

Corresponding changes to 30 TAC Chapter 37, Financial Assurance, are also proposed in this issue of the *Texas Register*.

SECTION BY SECTION DISCUSSION

The commission proposes a new Chapter 337, Dry Cleaner Environmental Response, to establish the procedures to administer and enforce HB 1366.

Proposed new §337.1, Purposes, provides the purposes of the chapter including regulating and remediating certain dry cleaning facilities as prescribed by THSC, Chapter 374; establishing minimum standards and procedures to reasonably protect and maintain the quality of the state's groundwater and surface water resources from contamination that could result from any release from a dry cleaning facility; providing for the use of risk-based corrective action; and providing for the protection of human health and safety and the environment of the state.

Proposed new §337.2, Applicability, describes who the chapter applies to, which includes all dry cleaning facilities, dry cleaning drop stations, and distributors. Proposed §337.2 also lists the entities that the chapter does not apply to.

Proposed new §337.3, Definitions, defines the following new terms: application for ranking; distributor; dry cleaning machine; dry cleaning waste; dry cleaning wastewater; empty; gross annual receipts; in service; non-participating non-perchloroethylene user registration certificate; operating dry cleaning drop station; operating dry cleaning facility; participating non-perchloroethylene user registration certificate; permanently removed from service; secondary containment; and temporarily removed from service.

Proposed new §337.4, General Prohibitions and Requirements, sets forth the following prohibitions and requirements: new dry cleaning facilities must meet the performance standards; a distributor is prohibited from selling, delivering, or otherwise distributing any dry cleaning solvent to a dry cleaning facility unless the dry cleaning facility has a valid, current registration certificate; the distributor must obtain and record the registration number from the dry cleaning facility's current registration certificate; a distributor cannot sell, deliver, or otherwise distribute the dry cleaning solvent perchloroethylene to a dry cleaning facility with a nonparticipating non-perchloroethylene user registration certificate or a participating non-perchloroethylene user registration certificate; a person is prohibited from purchasing dry cleaning solvent from a distributor that does not have a valid, current distributor registration certificate issued by the executive director; a person is prohibited from purchasing the dry cleaning solvent perchloroethylene for a dry cleaning facility with a nonparticipating non-perchloroethylene user registration certificate or a participating non-perchloroethylene user registration certificate; and a distributor is prohibited from selling, delivering, or otherwise distributing any dry cleaning solvent to a dry cleaning drop station.

Proposed new §337.10, Registration for Dry Cleaning Facilities and Drop Stations, sets forth the registration requirements of dry cleaning facilities and dry cleaning drop stations. All operating dry cleaning facilities and dry cleaning drop stations must be registered with the agency.

Proposed new §337.11, Dry Cleaner Registration Certificates, sets forth the procedures related to registration certificates for dry cleaning facilities and dry cleaning drop stations, including obtaining, renewing, and displaying a certificate, as well as the process for revocation or denial of a certificate. Dry cleaner registration certificates are necessary to receive delivery of dry cleaning solvents.

Proposed new §337.12, Registration for Distributors, sets forth the requirements for the registration of distributors. Distributors in operation on or after September 1, 2003, must register with the agency.

Proposed new §337.13, Distributor Registration Certificate, sets forth the procedures related to registration certificates for distributors, including obtaining and displaying a certificate, as well as the process for revocation or denial of a certificate. The certificate is necessary for the delivery of dry cleaning solvents.

Proposed new §337.14, Registration Fees, sets forth the procedures and requirements for owners of operating dry cleaning facilities and dry cleaning drop stations to pay the registration fees required by THSC, §374.102. The owner of the facility or drop station on or after September 1 of each state fiscal year (FY) is responsible for the registration fees owed for the state FY beginning on September 1. However, if a person acquires a dry cleaning facility or dry cleaning drop station that does not have a current registration certificate, the facility or drop station would have to be registered and the fee paid before a current registration certificate would be issued. This proposed section also requires owners to pay penalties and interest on late payments.

Proposed new §337.15, Solvent Fees, sets forth the procedures and requirements for payment and collection of the dry cleaning solvent fees required by THSC, §374.103. This section includes reporting requirements for distributors, specifications on payment of collected fees to the agency, and provisions governing late payments.

Proposed new §337.20, Performance Standards, sets forth the performance standards that apply to dry cleaning facilities and dry cleaning drop stations, including the dates by which owners must be in compliance. In §337.20(c), compliance with 30 TAC Chapter 335, Subchapter C, is required for storage, treatment, and disposal of hazardous dry cleaning wastes. In §337.20(d), dry cleaning process water is prohibited from discharge to sanitary sewers and septic systems and from discharge to the waters of the state. If this process water is not misted or evaporated in an appropriate device plumbed directly to, or immediately adjacent to, the dry cleaning machine, the owner of a dry cleaning facility must be able to account for the disposal of this process water in accordance with applicable hazardous or nonhazardous waste rules. In cases where this dry cleaning process water (often called "separator water") is disposed of by other methods,

the owner of a dry cleaning facility must create a log indicating the amount of water collected, who disposed of it, and the date and means of disposal. Section 337.20(e) requires compliance with the emission standards for hazardous air pollutants, as specified by HB 1366, and also specifies existing air permitting requirements for dry cleaners. All dry cleaners must have a new source review authorization. To satisfy this requirement, a person may claim the permit by rule (30 TAC §106.411). This permit by rule may be used to authorize dry cleaning equipment, including misters and evaporators, if the requirements of 30 TAC §106.4 are met. Generally, most dry cleaners will be able to claim the permit by rule. However, if emissions exceed those specified in §106.4, a new source review permit under 30 TAC Chapter 116 must be obtained. In §337.20(f), secondary containment is required for all dry cleaning facilities using chlorinated dry cleaning solvents and all other dry cleaning facilities when replacing or installing a dry cleaning machine on or after September 1, 2005. The secondary containment is required for both dry cleaning machines and storage areas. Secondary containment for facilities that do not utilize chlorinated solvents is required because other solvents may pose a greater danger to the environment than is presently understood, the dry cleaning machines made today usually include secondary containment, and such containment is already required by many local government fire codes. Section 337.20(g) sets forth requirements governing the delivery of solvents to the dry cleaning facility.

Proposed new §337.21, Removal of Dry Cleaning Solvents and Wastes, sets forth the requirement for the removal of solvents and waste from dry cleaning facilities as well as the removal of solvents and wastes from dry cleaning machines that are temporarily or permanently removed from service.

Proposed new §337.22, Variances and Alternative Procedures, sets forth the procedures for obtaining a variance from the requirements of the dry cleaning rules in this chapter, as well as recordkeeping requirements related to a variance that is granted.

Proposed new §337.30, Prioritization of Sites, sets forth the provisions relating to the prioritization of dry cleaning sites that require corrective action. A site will only be eligible for prioritization if it has been ranked with the dry cleaning facility ranking system.

Proposed new §337.31, Ranking of Sites, sets forth the procedures for the ranking of dry cleaning facilities. The ranking system is a methodology designed to determine a numerical score for a facility based on various factors that may impact human health or the environment. This section includes the information required to be contained in the application for ranking package as well as who may apply for a site to be ranked under THSC, §374.154(b). If multiple parties are involved with a site, the commission encourages the parties to work together to submit a single application to the agency. It should be noted that under THSC, §374.154(b), only owners of current and former facilities and real property may apply for a site to be ranked. Therefore, for the owner of a drop station to apply for such a site to be ranked, the owner would have to be the real property owner (and meet additional criteria in THSC, §374.154(b)) or would have to have owned the facility at the site.

Proposed new §337.32, Denial and Removal of Sites from Ranking, sets forth the criteria for the executive director to deny or remove a site from ranking.

Proposed new §337.40, General Requirements, sets forth the general requirements for meeting the deductible such as the eligible costs incurred by an applicant must be reasonable and appropriate.

Proposed new §337.41, Evidence of Eligible Costs, describes what evidence is required to be submitted with the application for ranking package to show that the deductible has been met; states that the executive director may require the applicant to provide additional information or return the application if the information is not sufficient to review the application; and gives examples of the types of costs that will not be considered eligible costs applicable to the deductible.

Proposed new §337.50, Corrective Action, states that corrective action will be conducted under 30 TAC Chapter 350 or other guidance established by the executive director; corrective action at a site may be postponed or suspended indefinitely in order to make money available for corrective action at a site with a higher priority; and postponement or suspension of corrective action does not mean that the cleanup standards under Chapter 350 have been met.

Proposed new §337.51, Eligibility for Corrective Action, describes the prerequisites for an owner or other person to be eligible to have corrective actions costs paid by the Dry Cleaning Facility Release Fund. The exemption from certain claims in THSC, §374.207 is conditioned on the owner or other person being eligible to have corrective action costs paid by the fund.

Proposed new §337.60, Nonparticipating Dry Cleaning Facility Financial Assurance, states that the owner of a dry cleaning facility that has submitted to the executive director the affidavit of nonparticipation for a facility that begins operation on or after September 1, 2003 and before January 1, 2004, shall provide financial assurance for corrective action in the amount of $500,000 per nonparticipating facility. The affidavit and financial assurance must be submitted to the executive director before January 1, 2004. This proposed section does not apply to a carbon dioxide facility.

Proposed new §337.61, Participating Non-Perchloroethylene User Registration Certificate, states that to obtain this certificate: 1) the owner must swear in an affidavit approved by the executive director that the owner has never used or allowed the use of perchloroethylene at any dry cleaning facility in the state; and 2) perchloroethylene must never have been used at the facility in question.

Proposed new §337.62, Nonparticipating Non-Perchloroethylene Facilities, sets forth requirements that apply to such a facility, including disclosure requirements for any sale of the facility.

Proposed new §337.63, Owner Affiliation, states that for the purposes of this subchapter, the term "owner" includes various entities or persons affiliated with the owner. The purpose of this section is to avoid the situation where, for example, owners may reorganize into a new company or transfer a facility to a relative to qualify as an owner that has never used perchloroethylene at any facility in the state. By doing such a reorganization or transfer, the owner would avoid solvent fees for a facility but the facility may still qualify for fund benefits if it has a participating non-perchloroethylene user registration certificate.

Proposed new §337.70, General Provisions, sets forth the requirements for the maintenance of records, records retention, and penalties for records violations.

Proposed new §337.71, Distributors, states that distributors shall maintain books, financial records, documents, and other evidence for sales of dry cleaning solvents and the fees collected and paid to the agency as required by this chapter. The records must include copies of all invoices for dry cleaning solvent sales and purchases showing the facility registration numbers, name, type, and quantity of the dry cleaning solvent purchased and sold, the name and address of the seller and purchaser, and the date of the sale or purchase.

Proposed new §337.72, Dry Cleaning Facilities, describes what records dry cleaning facilities must retain such as invoices of dry cleaning solvent purchases showing the name, type, and quantity of the dry cleaning solvent purchased, the name and address of the seller, and the date of the purchase; waste disposal records; and secondary containment logs.

Proposed new §337.80, Audits and Investigations, states that the executive director may conduct audits or investigations concerning payments, fees, or information submitted to the agency and persons shall cooperate with such audits and investigations.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENT

Jeff Horvath, Analyst, Strategic Planning and Grants Management Section, determined that for the first five-year period the proposed new rules are in effect, significant fiscal implications are anticipated for the commission. In addition, fiscal implications are anticipated for owners and operators of dry cleaning facilities, dry cleaning drop stations, distributors of dry cleaning solvent, and consumers who purchase the services of dry cleaning facilities.

The proposed new rules implement HB 1366, codified as Texas Health and Safety Code, Chapter 374. The bill established a dry cleaning regulation and remediation program at the commission. The new program does not apply to governmental entities or political subdivisions. The bill requires the commission to adopt rules to administer and enforce the new program including the development of performance standards for dry cleaning facilities and criteria for setting priorities for the expenditure of funds from the newly established Dry Cleaning Facility Release Fund in the General Revenue Fund. In addition, the commission is required to develop corrective action completion criteria for the remediation of contaminated sites.

The new rules are proposed in order to regulate and remediate certain dry cleaning facilities as prescribed by THSC, Chapter 374; establish minimum standards and procedures to reasonably protect and maintain the quality of the state's groundwater and surface water resources from contamination that could result from any release from a dry cleaning facility; provide for the use of risk-based corrective action; and provide for the protection of human health and safety and the environment of the state.

The proposed new rules apply to all dry cleaning facilities (except for certain types or categories of businesses such as hotels, motels, formal wear and costume rental businesses, and others), dry cleaning drop stations, and distributors of dry cleaning solvent. Currently, there are an estimated 2,165 dry cleaning facilities, 1,648 dry cleaning drop stations, and 21 distributors of dry cleaning solvents doing business in the state.

Under the legislation, each owner of an operating dry cleaning facility is required to register annually with the commission and to pay the required fees. No registration fee would be required for carbon dioxide facilities. A registration fee of $250 per year is required for facilities with $100,000 or less in gross annual receipts, for nonparticipating facilities, or for dry cleaning drop stations (locations where no cleaning occurs on site) that are not owned by a dry cleaning facility. The registration fee is $1,000 per year for drop stations that are owned by a dry cleaning facility, and $2,500 per year for participating dry cleaning plants that have gross annual receipts in excess of $100,000. A fee of $15 per gallon is imposed on the purchase of the dry cleaning solvent perchloroethylene and a fee of $5.00 per gallon is imposed on the purchase of other dry cleaning solvents. Owners that submit affidavits to the commission stating that they have never used perchloroethylene would be exempt from both of the per-gallon fees. Owners that opt not to participate in the remediation benefits provided by the Dry Cleaning Facility Release Fund would be exempt from the per-gallon fee on other dry cleaning solvents but not from the per-gallon fee on perchloroethylene. However, facility owners that have opted out of the Dry Cleaning Facility Release Fund cannot use perchloroethylene at the opted-out facility. Fee revenue is deposited into the Dry Cleaning Facility Release Fund. The fund is statutorily dedicated for use by the commission to administer the program and to remediate contaminated sites.

It is estimated that the commission will receive between $5.5 million and $6.1 million in fee revenue in FY 2004 and between $7.9 million and $10.1 million in fee revenue each year thereafter for the rest of the five-year period covered by the fiscal note. For FYs 2004 and 2005, the commission is limited by statute to spend 15% of the money credited to the fund in the same FY for administrative and start-up expenses. The commission is limited to 10% of the amount of money credited to the fund in the same FY for the same expenses after FY 2005.

To implement the program, the commission will be responsible for the following new activities and responsibilities: 1) registering dry cleaning facilities, dry cleaning drop stations, and dry cleaning solvent distributors; 2) billing registered dry cleaning facilities and dry cleaning drop stations; 3) processing registration and solvent fees; 4) processing applications for the ranking and prioritization of sites for corrective action; 5) the acquisition of contracts for corrective action; 6) oversight of corrective action contractors; 7) contract management including processing work orders, invoices, and payments to contractors; 8) facility inspection and enforcement activity; 9) financial audits of dry cleaners and distributors; and 10) processing and issuing special registration certificates for participating and nonparticipating non-perchloroethylene dry cleaning facilities.

The legislature appropriated the commission approximately $6 million in FY 2004 and $8.5 million in FY 2005 to implement and operate the program. The legislature did not appropriate additional full-time employees for the program.

At this time, the commission's administrative costs are approximately $330,000 for this FY and are expected to increase to as much as $700,000 each year. After administrative expenses, the remaining funds in the account will be used for corrective action activities at contaminated dry cleaning sites. Based upon information received from other states, remediation costs are estimated to average $500,000 per site, but could be much higher. The commission is prohibited by statute from spending more than $5 million at any one contaminated site for corrective action.

PUBLIC BENEFITS AND COSTS

Mr. Horvath also determined that for each year of the first five years the proposed new rules are in effect, the public benefit anticipated from the changes seen in the proposed rules will be compliance with state law and the protection of the state's groundwater and surface water from potential and actual contamination from certain dry cleaning facilities.

Costs are anticipated to businesses and individuals as a result of the implementation of the proposed new rules.

There are an estimated 2,165 dry cleaning facilities, 1,648 dry cleaning drop stations, and 21 distributors of dry cleaning solvents doing business in the state at this time. Each owner of an operating dry cleaning facility is required by statute to register annually with the commission and to pay the required fees. No registration fee would be required for carbon dioxide facilities.

In addition to the registration fees, owners of dry cleaning facilities or dry cleaning drop stations will also be required to pay fees for the purchase of dry cleaning solvents, unless they are exempt. Distributors of dry cleaning solvents will be required to register with the commission, collect the solvent fees, and remit the solvent fees to the commission on a quarterly basis. Solvent distributors will likely incur additional recordkeeping costs, though these costs are not anticipated to be significant.

The proposed rules would establish performance standards for dry cleaning facilities and dry cleaning drop stations. Owners of dry cleaning facilities using chlorinated solvents in operation before January 1, 2004 with gross annual receipts that exceed $200,000 (as indicated on the most current registration form filed with the commission) would be required to comply with the secondary containment and direct-coupled delivery requirements no later than January 1, 2006. Facilities with $200,000 or less in gross annual receipts would have until January 1, 2007. Additional performance standards required upon the effective date of the rule include: requirements for the proper storage and disposal of wastes; compliance with federal air emission standards; and the prevention of dry cleaning solvent discharges to a sanitary sewer, septic tank, or waters of the state. Facilities that do not use chlorinated solvents and replace or install a petroleum-based dry cleaning machine on or after September 1, 2005 would also be required to install dikes or other secondary containment structures around the unit and around each storage area for dry cleaning solvent, dry cleaning waste, or dry cleaning wastewater.

Costs are anticipated for dry cleaning facilities that must retrofit their equipment to meet the standards.

Most, if not all, new dry cleaning machines come with containment pans (secondary containment) as an integral part of the machine. Consequently, the cost of the containment pan on a new machine is rolled into the overall cost of the machine. Costs to retrofit an older machine with a secondary containment pan will vary with the size of the machine, but for the most common machine size, the containment pan costs approximately $2,500, with roughly an equal cost for installation, for a total of $5,000. It is not known how many facilities will have to retrofit their machines.

Distributors of dry cleaning solvents are also affected by performance standards that require all chlorinated solvents to be delivered to dry cleaning facilities by direct-coupled delivery systems. The costs for this equipment are expected to be minimal, as distributors either sell (parts may cost between $20 and $30) or give the equipment to their customers who lack it.

For those contaminated dry cleaning sites that do not pose an immediate threat to human health or the environment, the commission will rank the site for corrective action based upon information contained in an application submitted by the dry cleaning facility owner. Dry cleaning facility owners or others that submit applications for ranking the facility are required to pay a $5,000 deductible, which would go towards any corrective action costs. However, as part of the application for ranking as proposed in the rules, owners or operators must submit a soil or groundwater analysis, certain hydrogeologic information, and a field survey and a records survey of nearby water wells and surface water, along with other information. Costs to obtain this information or other information required for the application would count towards the required $5,000 deductible. Those sites that are determined by the commission to pose an immediate threat to human health or the environment would receive emergency action. Corrective action costs are estimated to average $500,000 per site, but could cost much more.

Contaminated dry cleaning sites would be eligible for corrective action managed by the commission and paid for out of the Dry Cleaning Facility Release Fund, unless the facility opts not to participate in the fund benefits. Owners of nonparticipating dry cleaning facilities must file with the commission and demonstrate, at their expense, that they have never used or allowed the use of perchloroethylene at any dry cleaning facility in the state. An option not to participate must have been filed with the commission before January 1, 2004. Approximately 381 nonparticipating non-perchloroethylene user affidavits have been filed with the commission at this time.

The statute requires certain dry cleaning facilities to provide financial assurance for corrective action. Under the proposed rules, owners of dry cleaning facilities that have filed the affidavit of non-participation (exercising the option to not participate in the benefits of the Dry Cleaning Facility Release Fund) and that began operation on or after September 1, 2003, must furnish to the commission a bond or other financial assurance authorized by the commission in the amount of $500,000. An option not to participate in fund benefits must have been filed with the commission before January 1, 2004, leaving a window of four months for any facilities to be affected by the financial assurance requirements.

Owners of nonparticipating dry cleaning facilities will have to pay for financial assurance for corrective action. However, these facilities will also be exempt from the per-gallon fee on dry cleaning solvents except perchloroethylene. These facilities would also lose the financial benefit of participating in the Dry Cleaning Facility Release Fund, which would cover corrective action costs at the site.

Currently, there are potentially two dry cleaning facilities that would be affected by the proposed financial assurance requirements. In order to meet the financial assurance requirements, the owner may use a fully funded trust, a surety bond guaranteeing payment, an irrevocable letter of credit, or insurance. A surety bond or annual insurance premiums are estimated to cost approximately $10,000 each year for $500,000 worth of coverage, but may be higher or lower depending upon the coverage requirements of the carrier.

It is assumed that owners and operators of dry cleaning facilities and solvent distributors will pass any increase in their operating expenses on to consumers. It is, therefore, estimated that consumers will likely pay more for dry cleaning, but how much more will depend upon the specific circumstances at the facility,

i.e., the type of facility, how much in solvent fees are paid, and how much the facility spends to comply with the proposed performance standards. Given an average invoice amount of $10 to $25, and assuming that the dry cleaner passes the entire cost on to the customer, it is estimated that consumers may see an increase in their bills of 2% to 2.5% or an additional $.20 to $.63 added to the average bill.

For those contaminated dry cleaning sites, increases in costs for the registration and solvent fees would be offset by the significant savings to the owner/operator in potential remediation costs. Remediation costs are estimated to average $500,000 per site, but could cost several million dollars or more.

SMALL BUSINESS AND MICRO-BUSINESS ASSESSMENT

Adverse fiscal implications are anticipated for dry cleaning facilities, dry cleaning drop stations, and solvent distributors that are small or micro-businesses. Of the 2,111 dry cleaning facilities currently registered with the commission, over 60% report gross receipts of less than $200,000. It is, therefore, estimated that most of the dry cleaning facilities in the state are small or micro-businesses. There are an estimated 21 distributors of dry cleaning solvents in the state, but it is not known how many of them are small or micro-businesses. The distributors will have additional recordkeeping costs under the proposed rules, though these are not considered significant.

Under the proposed new rules, owners of dry cleaning facilities with gross annual receipts of $200,000 or less will have an extra year (January 1, 2007 instead of January 1, 2006) to meet requirements of the proposed secondary containment and direct-coupled delivery performance standards established in the legislation. These costs will be in addition to the registration and solvent fees established in the legislation. The legislation also requires owners of dry cleaning facilities to pay a $5,000 deductible if they choose to apply for a ranking for corrective action. However, there will be cost benefits to those owners of dry cleaning facilities that participate in the program and have contaminated sites in that if they apply for a ranking, they will be eligible to have their remediation costs paid out of the Dry Cleaning Facility Release Fund. Remediation costs could be substantial, ranging in the millions of dollars.

Under the legislation, a dry cleaning facility that is a small or micro-business may see cost increases of $2,500 per year in registration fees and $2,250 each year in solvent fees (it is estimated that a facility on average would use 150 gallons per year of perchloroethylene ($15 per 150 gallons = $2,250). Some small or micro-businesses also may incur a one-time cost of $5,000 to retrofit an existing dry cleaning machine to meet the secondary containment requirements. These costs would total an estimated $10,000 for one year and approximately $5,000 each year thereafter.

The following is an analysis of the cost per employee for small or micro-businesses affected by the proposed rules. Small and micro-business are defined as having fewer than 100 or 20 employees respectively. Owners of dry cleaning facilities with 100 or fewer employees could incur additional costs of between $5,000 and $10,000 to comply with the existing legislation and the proposed rules or between $50 and $100 per employee. A micro-business with 20 or less employees would incur estimated additional costs of between $250 and $500 per employee. The projected costs for affected dry cleaning facilities is the same for small businesses as for larger businesses.

LOCAL EMPLOYMENT IMPACT STATEMENT

The commission reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five years that the proposed rules are in effect.

DRAFT REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the proposed rules in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that this rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. Although the intent of the proposed rules is to protect the environment or reduce risks to human health from environmental exposure, the proposed rules would not adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

Furthermore, even if the proposed rules did meet the definition of a major environmental rule, Texas Government Code, §2001.0225 only applies to a major environmental rule if the result of the rule is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. These proposed rules do not meet any of the four applicability requirements and thus are not subject to the regulatory analysis provisions of §2001.0225 even if they did meet the definition of a major environmental law. Specifically, the proposed rules are required by state law, are not proposed solely under the general powers of the agency, and do not exceed a requirement of state law, federal law, or a delegation agreement or contract between the state and an agency or representative of the federal government.

The commission invites public comment on this draft regulatory impact analysis determination.

TAKINGS IMPACT ASSESSMENT

The commission evaluated the proposed rules and performed an assessment of whether Texas Government Code, Chapter 2007 is applicable. The commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to these proposed rules because this is an action that is taken in response to a real and substantial threat to public health and safety; that is designed to significantly advance the health and safety purpose; and does not impose a greater burden than is necessary to achieve the health and safety purpose. Thus, this action is exempt under Texas Government Code, §2007.003(b)(13).

The proposed rules implement HB 1366, which created an environmental regulation and remediation program for dry cleaning facilities. Under the legislation, certain dry cleaners pay registration and solvent fees into a fund that is then used by the agency to investigate and cleanup eligible contaminated dry cleaning sites. Additionally, the legislation and proposed rules contain performance standards and waste handling requirements to alleviate the possibility of future contamination from dry cleaning facilities. Such contamination is a real and substantial threat to public health and safety. The proposed rules significantly advance a health and safety purpose by providing the framework within

which the agency will collect the funds for corrective action and use those funds to address health and safety concerns at sites around the state. Furthermore, the proposed rules significantly advance a health and safety purpose by specifying performance standards and waste handling requirements to alleviate future health and safety issues resulting from dry cleaning facilities. The proposed rules are narrowly tailored to apply to only certain dry cleaning facilities, dry cleaning drop stations, and distributors and do not impose a greater burden than is necessary to achieve the health and safety purpose as previously stated.

Nevertheless, the commission further evaluated these proposed rules and performed an assessment of whether these proposed rules constitute a takings under Texas Government Code, Chapter 2007. The specific purpose of this rulemaking is to implement HB 1366 by setting forth: 1) procedures governing registration, certificates, and the collection of fees; 2) performance standards; 3) requirements for the removal of dry cleaning solvents and waste; 4) procedures relating to the prioritization and ranking of sites; 5) criteria for corrective action; 6) provisions relating to non-perchloroethylene users and facilities; 7) requirements for recordkeeping; and 8) provisions concerning audits and investigations.

Promulgation and enforcement of the proposed rules would be neither a statutory nor a constitutional taking of private real property by the commission. Specifically, the proposed rules do not affect a landowner's rights in private real property because this rulemaking does not burden (constitutionally) nor restrict or limit the owner's rights to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the proposed rules. The proposed rules implement HB 1366 by providing the framework within which the agency will regulate and remediate dry cleaning facilities and dry cleaning drop stations. There are no burdens imposed on private real property from these proposed rules and the benefits to society are the proposed rules' specific procedures and requirements for a program that addresses dry cleaning contamination and seeks to prevent future contamination.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the proposed rulemaking and found that the proposal is a rulemaking identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2), relating to Actions and Rules Subject to the Texas Coastal Management Program (CMP), or will affect an action and/or authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6).

The commission prepared a consistency determination for the proposed rules under 31 TAC §505.22 and found that the proposed rulemaking is consistent with the applicable CMP goals and policies. The CMP goal applicable to the proposed rulemaking is the goal to protect, preserve, restore, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas. The CMP policy applicable to the proposed rulemaking is governing emissions of air pollutants to protect and enhance air quality in the coastal area so as to protect coastal natural resource areas and promote the public health, safety, and welfare. Promulgation and enforcement of these rules will not violate (exceed) any standards identified in the applicable CMP goals and policies. The proposed rules would establish performance standards for dry cleaning facilities; requirements for the removal of dry cleaning solvents and waste from dry cleaning facilities; criteria to be used in setting priorities for the expenditure of money from the Dry Cleaning Facility Release Fund; and criteria under which the executive director may determine the level at which corrective action is considered complete.

The commission seeks public comment on the consistency of the proposed rules with the CMP.

ANNOUNCEMENT OF HEARING

The commission will hold a public hearing on this proposal in Austin on December 6, 2004, at 10:00 a.m. in Building E, Room 201S, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes before the hearing and will answer questions before and after the hearing.

Persons with disabilities who have special communication or other accommodation needs who are planning to attend the hearing should contact the Office of Environmental Policy, Analysis, and Assessment at (512) 239-4900. Requests should be made as far in advance as possible.

SUBMITTAL OF COMMENTS

Comments may be submitted to Lola Brown, Office of Environmental Policy, Analysis, and Assessment, MC 205, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-4808. Comments must be received by 5:00 p.m., December 13, 2004, and should reference Rule Project Number 2003-047-337-WS. Copies of the proposed rules can be obtained from the commission's Web site at *http://www.tnrcc.state.tx.us/oprd/rules/propadop.html*. For further information, please contact Michael Bame, Policy and Regulations Division, at (512) 239-5658.

SUBCHAPTER A. GENERAL PROVISIONS

30 TAC §§337.1 - 337.4

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under Texas Water Code (TWC), §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.1. Purposes.

The purposes of this chapter are to:

(1) regulate and remediate certain dry cleaning facilities as prescribed by Texas Health and Safety Code, Chapter 374;

(2) establish minimum standards and procedures to reasonably protect and maintain the quality of the state's groundwater and surface water resources from contamination that could result from any release from a dry cleaning facility;

(3) provide for the use of risk-based corrective action; and

(4) provide for the protection of human health and safety and the environment of the state.

§337.2. Applicability.

(a) This chapter applies to all dry cleaning facilities, dry cleaning drop stations, and distributors.

(b) This chapter and Texas Health and Safety Code, Chapter 374 do not apply to the following types or categories of businesses:

(1) hotels, motels, and similar establishments that meet the definition of a "hotel" in Texas Tax Code, §156.001, unless the business is also a dry cleaning facility or a dry cleaning drop station that accepts garments or other fabrics from retail customers;

(2) formal wear and costume rental businesses, including tuxedo and bridal wear rental, as included in the North American Industry Classification System (NAICS) title "Formal Wear and Costume Rental," code 532220, unless the business is also a dry cleaning facility or a dry cleaning drop station that accepts garments or other fabrics from retail customers;

(3) linen supply establishments and industrial launderers, including uniform supply, as included in the NAICS titles "Linen Supply," code 812331, and "Industrial Launderers," code 812332, unless the business is also a dry cleaning facility or a dry cleaning drop station that accepts garments or other fabrics from retail customers;

(4) businesses that clean uniforms provided by the business for the sole use of the employees of the business using equipment located on the premises of the business, unless the business is also a dry cleaning facility or dry cleaning drop station that accepts garments or other fabrics from retail customers;

(5) mobile dry cleaning drop stations, meaning any vehicle that is used, in whole or in part, to operate or provide a route service or pickup and delivery service between a retail customer and a dry cleaning facility or dry cleaning drop station;

(6) transporting agents or services that haul garments between dry cleaning facilities and dry cleaning drop stations and that do not operate, in whole or in part, to provide a route service or pickup and delivery service between a retail customer and a dry cleaning facility or dry cleaning drop station; and

(7) governmental bodies as set forth in Texas Health and Safety Code, §374.003.

(c) For the purposes of this chapter, the terms "dry cleaning facility" and "dry cleaning drop station" do not include the types or categories of businesses set forth in subsection (b) of this section.

§337.3. Definitions.

Definitions set forth in Texas Health and Safety Code, Chapter 374 and §3.2 of this title (relating to Definitions) that are not specifically included in this section also apply. The following words and terms, when used in this chapter, have the following meanings.

(1) Application for ranking--The form approved by the executive director for an applicant to provide information pertaining to a dry cleaning facility and which is used, in part, for the prioritization of sites for corrective action.

(2) Distributor--A person that:

(A) maintains or uses, permanently or temporarily, directly or indirectly, or through an agent, by whatever name called, an office, place of distribution, sales or sample room, warehouse or storage place, or other place of business that is used, in whole or part, for selling, distributing, or delivering dry cleaning solvent;

(B) has any representative, agent, salesperson, canvasser, or solicitor who operates in Texas under the authority of the distributor to sell, deliver, or take orders for dry cleaning solvent;

(C) uses independent contractors in direct sales, distribution, or delivery of dry cleaning solvent in Texas;

(D) allows a franchisee or licensee to operate under its trade name if the franchisee or licensee is required to collect Texas fees on dry cleaning solvent;

(E) conducts business in Texas through employees, agents, or independent contractors for the purpose of selling, distributing, or delivering dry cleaning solvent; or

(F) otherwise distributes dry cleaning solvent to dry cleaning facilities or dry cleaning drop stations doing business in Texas.

(3) Dry cleaning machine--The equipment used for the purpose of cleaning garments or other fabrics using a process that involves any use of dry cleaning solvents.

(4) Dry cleaning waste--The waste, including dry cleaning wastewater, that is generated at a dry cleaning facility and that contains dry cleaning solvents.

(5) Dry cleaning wastewater--The separator water and all other water that is generated during the dry cleaning process and that contains dry cleaning solvents.

(6) Empty--The status of a dry cleaning machine in which all solvents have been removed as completely as possible by the use of commonly employed and accepted industry procedures.

(7) Gross annual receipts--The sum of all payments or compensation, including payments or compensation from laundry and other revenue generating activities, received by a dry cleaning facility or drop station, less any returns, discounts, or allowances. The calculation of gross annual receipts must not be reduced for cost of goods sold, general and administrative expenses, depreciation and amortization, or other operating expenses. Gross annual receipts do not include any taxes imposed on the services provided by any municipality, state, or other governmental unit and collected by the dry cleaning facility or drop station for such governmental unit.

(8) In service--The status of a dry cleaning machine that it is being used for cleaning garments or other fabrics with a process that involves any use of dry cleaning solvents.

(9) Nonparticipating non-perchloroethylene user registration certificate--A registration certificate issued by the executive director to a facility designated as a nonparticipating facility in accordance with Texas Health and Safety Code, §374.104.

(10) Operating dry cleaning drop station--A dry cleaning drop station that has accepted clothes for dry cleaning anytime during the state fiscal year.

(11) Operating dry cleaning facility--A dry cleaning facility in which there is at least one operating dry cleaning machine in service anytime during the state fiscal year.

(12) Participating non-perchloroethylene user registration certificate--A registration certificate issued by the executive director to an owner designated as a nonuser of perchloroethylene in accordance with Texas Health and Safety Code, §374.103(b)(1).

(13) Permanently removed from service--The status of a dry cleaning machine when its use is terminated by proper removal from the dry cleaning facility in accordance with this chapter.

(14) Secondary containment--A containment method by which a continuous barrier is installed around and under the primary storage vessel (e.g., tank or piping) in a manner designed to prevent a release from migrating beyond the secondary barrier before the release can be detected.

(15) Temporarily removed from service--The status of a dry cleaning machine that is not being used for cleaning garments or other fabrics for a time period not to exceed one year and that has not been permanently removed from service.

§337.4. General Prohibitions and Requirements.

(a) New dry cleaning facilities must meet the performance standards in §337.20 of this title (relating to Performance Standards).

(b) A distributor is prohibited from selling, delivering, or otherwise distributing any dry cleaning solvent to a dry cleaning facility unless the dry cleaning facility has a valid, current registration certificate issued by the executive director. Prior to sale, delivery, or other distribution of the dry cleaning solvent, the distributor must obtain and record the registration number and registration expiration date of the dry cleaning facility's registration certificate.

(c) A distributor shall not sell, deliver, or otherwise distribute the dry cleaning solvent perchloroethylene to a dry cleaning facility with a nonparticipating non-perchloroethylene user registration certificate or a participating non-perchloroethylene user registration certificate.

(d) A person is prohibited from purchasing dry cleaning solvent from a distributor that does not have a valid, current distributor registration certificate issued by the executive director.

(e) A distributor is prohibited from selling or otherwise distributing dry cleaning solvent to a dry cleaning facility unless the distributor has a valid, current distributor registration certificate issued by the executive director.

(f) A person is prohibited from purchasing the dry cleaning solvent perchloroethylene for a dry cleaning facility with a nonparticipating non-perchloroethylene user registration certificate or a participating non-perchloroethylene user registration certificate.

(g) A distributor is prohibited from selling, delivering, or otherwise distributing any dry cleaning solvent to a dry cleaning drop station.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406450
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 239-0348

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SUBCHAPTER B. REGISTRATION, CERTIFICATES, AND FEES

30 TAC §§337.10 - 337.15

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.10. Registration for Dry Cleaning Facilities and Drop Stations.

(a) Registration.

(1) All operating dry cleaning facilities and dry cleaning drop stations must be registered with the agency in accordance with this section.

(2) Any person that owns a new dry cleaning facility or dry cleaning drop station that is placed into service after September 1, 2003, shall register the dry cleaning facility or dry cleaning drop station with the agency in accordance with subsection (c) of this section and receive a registration certificate before operations begin.

(3) The owner of a dry cleaning facility or dry cleaning drop station is responsible for compliance with the registration requirements of this section. An owner may designate a legally authorized representative to complete and submit the required registration information. However, the owner remains responsible for compliance with the provisions of this section by such representative.

(4) All dry cleaning facilities and dry cleaning drop stations are subject to the fee and payment requirements of §337.14 and §337.15 of this title (relating to Registration Fees; and Solvent Fees, respectively). The failure by an owner to properly or timely register any dry cleaning facility or dry cleaning drop station does not exempt the owner from such fee and payment requirements.

(b) Changes or additional information.

(1) The owner of a dry cleaning facility or dry cleaning drop station shall provide written notice to the executive director of any changes or additional information concerning such facilities. Types of changes or additional information subject to this requirement include the following:

(A) change in owner or change in owner information (e.g., legally authorized representative, mailing address, or telephone number);

(B) change in dry cleaning facility or dry cleaning drop station information (e.g., establishment name, legally authorized representative, establishment address, or telephone number);

(C) change in the operational status of any dry cleaning unit (e.g., in service, temporarily out of service, removed from service);

(D) change in the type of cleaning solvents used;

(E) installation of additional dry cleaning units or ancillary equipment at an existing facility;

(F) addition of, or a change in the type of, secondary containment (for dry cleaning units or storage areas) and/or ancillary equipment;

(G) addition of, or a change in the type of, closed direct-coupled delivery system for the dry cleaning unit; and

(H) change in the location of records for the dry cleaning facility or dry cleaning drop station.

(2) Notice of any change or additional information must be submitted on the appropriate agency form that has been completed in accordance with this section. The agency's registration numbers for the dry cleaning facility/drop station must be included in the appropriate space on the form.

(3) Notice of any change or additional information must be submitted to the executive director within 30 days from the date of the occurrence of the change or addition.

(c) Required form for providing dry cleaning facility or dry cleaning drop station registration information.

(1) Dry cleaning facility owners and dry cleaning drop station owners shall provide the required information on the current agency registration form.

(2) The dry cleaning facility owner or dry cleaning drop station owner is responsible for ensuring that the registration form is fully complete and accurate. The form must be dated and signed by the owner or a legally authorized representative of the owner, and must be submitted to the agency in accordance with the time frames established in this chapter.

(3) Dry cleaning facility or dry cleaning drop station owners shall complete and submit a separate registration form for each facility or drop station.

(4) If additional information, drawings, or other documents are submitted with new or revised registration data, specific facility identification information (including the facility registration number) must be conspicuously indicated on each document, and all such documents must be attached to and submitted with the form.

(5) When any of the required dry cleaning facility or dry cleaning drop station registration information submitted to the executive director is determined to be incomplete or inaccurate (including illegible or unclear information), the executive director may require the owner to submit additional information. An owner shall submit any such required additional information within 30 days of receipt of such request.

§337.11. Dry Cleaner Registration Certificates.

(a) Completion of the registration form. Upon the executive director's determination that a submitted registration form has been completed in accordance with this chapter and that all fees, penalties, and interest owed to the agency have been paid, a registration certificate will be issued for the dry cleaning facility or dry cleaning drop station, as applicable. This certificate is necessary to receive the delivery of dry cleaning solvents under §337.4(b) of this title (relating to General Prohibitions and Requirements).

(b) Incomplete or inaccurate registration form or nonpayment. The executive director will not issue a registration certificate if the registration form is determined by the executive director to be incomplete or inaccurate (including forms with illegible or unclear information) or if any fees, penalties, or interest is owed to the agency. In order for a registration form to be complete and accurate, the registration form must contain all requested information with clear, legible, and true responses.

(c) Issuance of a registration certificate. The agency's issuance of a registration certificate for a dry cleaning facility or dry cleaning drop station does not constitute agency certification or affirmation of the compliance status of the location in question with this chapter, Chapter 37 of this title (relating to Financial Assurance), the Texas Water Code, or the Texas Health and Safety Code; and this issuance does not preclude the agency from investigating these locations and pursuing enforcement actions when apparent violations are discovered.

(d) Certificate availability.

(1) The owner of a dry cleaning facility or dry cleaning drop station shall make available to a person delivering dry cleaning solvent a valid, current agency registration certificate for that establishment before the delivery of dry cleaning solvent can be made or accepted.

(2) The owner of the dry cleaning facility or drop station shall immediately display, upon request by agency staff, a valid, current agency registration certificate for that establishment.

(3) The dry cleaning facility or dry cleaning drop station owner shall ensure that a valid, current agency registration certificate is displayed at a facility or drop station. The original registration certificate must be posted in a public area where the document is clearly visible.

(4) In the event of the sale of a dry cleaning facility or a dry cleaning drop station, the previous owner's valid, current certificate may be used to purchase dry cleaning solvent for 30 days after the effective date of sale.

(e) Annual registration certificate renewal.

(1) The initial registration certificate issued for a dry cleaning facility or dry cleaning drop station will be valid until the expiration date indicated on that certificate. It is the responsibility of the owner to ensure that an application for renewal of that certificate is properly and timely submitted to the agency.

(2) A registration certificate is renewed by timely and proper submission of a new registration form to the agency. The agency will not issue a new registration certificate for registration forms that are determined by the executive director to be incomplete or inaccurate.

(3) A new registration form must be completed by the owner of a dry cleaning facility or dry cleaning drop station and submitted to the agency by August 1st of each year.

(f) Revocation or denial of a certificate.

(1) The executive director may revoke or deny issuance of a certificate if:

(A) the certificate was acquired by fraud, misrepresentation, or knowing failure to disclose material information; or

(B) the owner of a dry cleaning facility or dry cleaning drop station is in violation of any of the requirements of this chapter, Chapter 37 of this title, or Texas Health and Safety Code, Chapter 374.

(2) Prior to revocation or denial of a certificate, the executive director shall provide notice to the owner of the dry cleaning facility or dry cleaning drop station of the facts alleged to warrant revocation or denial. The notice must be in writing and sent via certified mail, return receipt requested. If the certified mail is returned to the executive director as unclaimed, notice is presumed to be received by the owner five days after mailing when:

(A) the notice was sent to the address indicated on the owner's most current registration; and

(B) the notice was sent simultaneously via first class mail, postage paid.

(3) The owner shall have 30 days after receipt of notice to demonstrate to the executive director whether or not compliance has been maintained with all requirements of law for the retention of the certificate. The executive director shall make a determination whether to revoke or deny the certificate and shall provide such determination in writing to the owner.

§337.12. Registration for Distributors.

(a) Registration.

(1) Any distributor as defined in §337.3 of this title (relating to Definitions) in operation on or after September 1, 2003, shall register with the agency in accordance with this section.

(2) The distributor is responsible for compliance with the registration requirements of this section. A distributor may designate a legally authorized representative to complete and submit the required registration information. However, the distributor remains responsible for compliance with the provisions of this section by such representative.

(b) Changes or additional information.

(1) The distributor shall provide written notice to the executive director of any changes or additional information to the registration information. Types of changes or additional information subject to this requirement include change in owner, change in owner information (e.g., mailing address, contact person, and telephone number), or change in the location of records.

(2) Notice of any change or additional information must be submitted on the appropriate agency form, which has been completed in accordance with this section. The distributor's registration number must be included in the appropriate space on the form.

(3) Notice of any change or additional information must be submitted to the agency within 30 days from the date of the occurrence of the change or addition.

(c) Required form for providing distributor registration information.

(1) A distributor submitting registration information to the executive director shall provide the required information on the current agency dry cleaning solvent distributor report form.

(2) The distributor is responsible for ensuring that the dry cleaning solvent distributor report form is fully complete and accurate. The form must be dated and signed by the owner or a legally authorized representative of the owner, and must be submitted to the executive director prior to commencing operations or as set forth in subsection (a)(1) of this section.

(3) Distributors that maintain or use more than one place of business shall complete and submit a separate form for each place of business.

(4) When any of the required distributor registration information submitted to the executive director is determined to be incomplete or inaccurate (including illegible or unclear information), the executive director may require the distributor to submit additional information. A distributor shall submit any such required additional information within 30 days of receipt of such request.

§337.13. Distributor Registration Certificate.

(a) Completion of the dry cleaning solvent distributor report form. Upon the executive director's determination that a submitted dry cleaning solvent distributor report form has been completed in accordance with this chapter and that all fees, penalties, and interest owed to the agency have been paid, a distributor registration certificate will be issued for the place of business covered by that registration. This certificate is necessary for the delivery of dry cleaning solvent under §337.4 of this title (relating to General Prohibitions and Requirements).

(b) Incomplete or inaccurate dry cleaning solvent distributor report form or nonpayment. The executive director will not issue a distributor registration certificate for dry cleaning solvent distributor report forms determined by the executive director to be incomplete or inaccurate (including illegible or unclear information) or if any fees, penalties, or interest are owed to the agency. In order for a form to be complete, the form must contain all requested information with clear, legible, and true responses.

(c) Issuance of a registration certificate. The executive director's issuance of a registration certificate for a distributor does not constitute agency certification or affirmation of the compliance status of a location with this chapter, the Texas Water Code, or the Texas Health and Safety Code; or preclude the agency from investigating a location and pursuing enforcement action when apparent violations are discovered.

(d) Registration certificate availability.

(1) Prior to delivery of any dry cleaning solvent, a distributor shall make available to a person purchasing dry cleaning solvent a valid, current agency distributor registration certificate, or a legible copy of the certificate.

(2) A distributor shall immediately display, upon request by agency staff, a valid, current agency registration certificate for a place of business.

(3) A distributor shall display the original agency registration certificate at the place of business. The original registration certificate must be posted in a public area where the certificate is clearly visible.

(e) Revocation or denial of certificate.

(1) The executive director may revoke or deny issuance of a certificate if:

(A) the certificate was acquired by fraud, misrepresentation, or knowing failure to disclose material information; or

(B) the distributor is in violation of any of the requirements of this chapter or Texas Health and Safety Code, Chapter 374, including late remittance of solvent fees and non-remittance of solvent fees.

(2) Prior to the revocation or denial of a certificate, the executive director shall provide notice to the distributor of the facts alleged to warrant revocation or denial. The notice must be in writing and sent via certified mail, return receipt requested. If the certified mail is returned to the executive director as unclaimed, notice is presumed to be received by the distributor five days after mailing when:

(A) the notice was sent to the address indicated on the distributor's most current registration; and

(B) the notice was sent simultaneously via first class mail, postage paid.

(3) The distributor shall have 30 days after receipt of notice to demonstrate to the executive director whether or not compliance has been maintained with all requirements of law for the retention of the certificate. The executive director shall make a determination whether

to revoke or deny the certificate and shall provide such determination in writing to the distributor.

§337.14. Registration Fees.

(a) Each owner of an operating dry cleaning facility or dry cleaning drop station shall pay the registration fees set forth in Texas Health and Safety Code, §374.102. The owner of the dry cleaning facility or dry cleaning drop station on or after September 1 of each state fiscal year is responsible for the registration fees owed for the state fiscal year beginning on September 1. However, if a person acquires a dry cleaning facility or dry cleaning drop station that does not have a current registration certificate, the facility or drop station would have to be registered and the fee paid before a current registration certificate would be issued.

(b) Payment in full of registration fees is due within 30 days of the agency invoice date. The fees must be paid by check, certified check, money order, or electronic funds transfer made payable to the "Texas Commission on Environmental Quality."

(c) The registration certificate will not be issued until registration fees, penalties, and interest assessed are paid in full.

(d) Owners that fail to pay registration fees when due shall pay penalties and interest in accordance with Chapter 12 of this title (relating to Payment of Fees).

§337.15. Solvent Fees.

(a) Except as provided in subsection (b) of this section, an owner of a dry cleaning facility shall pay to the distributor the fees for the purchase of dry cleaning solvents, including reclaimed or recycled solvents, as set forth in Texas Health and Safety Code, §374.103.

(b) The following are exempt from the fees required in subsection (a) of this section:

(1) a nonparticipating facility as designated in accordance with Texas Health and Safety Code, §374.104, whereby the owner has submitted the appropriate affidavit to the executive director and received a nonparticipating non-perchloroethylene user registration certificate; and

(2) an owner that has been designated as a nonuser of perchloroethylene in accordance with Texas Health and Safety Code, §374.103(b)(1), has submitted the appropriate affidavit with the executive director, and has received a participating non-perchloroethylene user registration certificate.

(c) The person that distributes the dry cleaning solvent shall collect the fee when the dry cleaning solvent is sold and remit the fee to the agency as required by this section. Solvent is considered sold when it is paid for in full or when delivered or otherwise distributed to the dry cleaning facility, whichever occurs first. A distributor is required to remit solvent fees due to the agency for any solvent that is considered sold, regardless of whether or when the distributor collected the fee from the dry cleaning facility to which the solvent was delivered or otherwise distributed.

(1) On or before the due dates, the distributor shall submit a report to the executive director, on a form approved by the executive director, and remit the amount of fees required to be collected for the associated reporting period. The report must set forth each sale of dry cleaning solvent with the associated facility registration numbers, name, address, solvent types and amounts, and dates of delivery. The following are the due dates and associated reporting periods.

(A) The due date for the reporting period of September 1 - November 30 is December 20.

(B) The due date for the reporting period of December 1 - February 28/29 is March 20.

(C) The due date for the reporting period of March 1 - May 31 is June 20.

(D) The due date for the reporting period of June 1 - August 31 is September 20.

(2) Upon receipt of payment for the solvent or delivery or other distribution to the dry cleaning facility, whichever occurs first, the distributor shall obtain and record the registration number and registration expiration date of the facility to which the solvent is sold, delivered, or otherwise distributed.

(3) The distributor shall retain the invoice or a copy of the invoice or other appropriate record of the sale of the solvent for five years from the date of sale.

(4) For the amount of the fee due, the distributor shall:

(A) separately state the amount on the invoice, bill, or contract to the customer and identify it as the Texas solvent fee;

(B) in the case of a fraction of a gallon, compute the fee by multiplying the fraction by the amount of the fee imposed on a whole gallon;

(C) not include the fee in, or add the fee to, the solvent price for the purpose of calculating the amount of sales tax due, if any; and

(D) not explicitly or implicitly absorb, assume, or refund the fee.

(5) Solvent fees collected by the distributor are held in trust for the agency, are not property of the distributor, and are not to be used by the distributor for any other purpose.

(6) At any time, the executive director may request in writing that the distributor remit the amount of fees required to be collected up to a date certain as determined by the executive director. The distributor shall remit such amount to the agency within ten days of receiving the executive director's request.

(7) The distributor must pay the fees by check, certified check, money order, or electronic funds transfer made payable to the "Texas Commission on Environmental Quality."

(8) Late payment and returned checks.

(A) Distributors that fail to pay quarterly solvent fees when due shall pay penalties and interest in accordance with Chapter 12 of this title (relating to Payment of Fees).

(B) In addition to penalties, interest, and other amounts that may apply, if the distributor does not remit any of the required amount by the due date or a distributor's check is returned for insufficient funds, the executive director may require the distributor to remit collected fees on a different basis and time frame than set forth in this subsection.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER C. PERFORMANCE STANDARDS AND WASTE REMOVAL

30 TAC §§337.20 - 337.22

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.20. Performance Standards.

(a) Applicability. Unless otherwise specifically stated, these performance standards apply to all dry cleaning facilities and dry cleaning drop stations.

(b) Compliance deadlines.

(1) Owners of operating dry cleaning facilities with gross annual receipts that exceed $200,000 (as indicated on the most current registration form filed with the agency) shall comply with this section no later than January 1, 2006.

(2) Owners of operating dry cleaning facilities with gross annual receipts that are $200,000 or less (as indicated on the most current registration form filed with the agency) shall comply with this section no later than January 1, 2006, with the exception of subsections (f) and (g) of this section, which shall be complied with no later than January 1, 2007.

(3) Owners of each new dry cleaning facility shall construct and operate the facilities in compliance with this section.

(c) Storage, treatment, and disposal of dry cleaning wastes. Any person at a dry cleaning facility that generates hazardous wastes shall comply with the provisions specified under Chapter 335, Subchapter C of this title (relating to Standards Applicable to Generators of Hazardous Waste).

(d) Prohibition of the discharge of dry cleaning solvents and waste. No person shall discharge dry cleaning solvents, dry cleaning waste, or dry cleaning wastewater either directly or indirectly, into any sanitary sewer, storm sewer, or septic tank, or to the soil or water of the state, nor shall any person discharge dry cleaning waste into any underground tank.

(1) Dry cleaning wastewater may be misted or evaporated in an appropriate device plumbed directly to, or immediately adjacent to, the dry cleaning unit in accordance with the provisions specified under Chapter 335 of this title (relating to Industrial Solid Waste and Municipal Hazardous Waste.)

(2) If dry cleaning wastewater is not disposed of as stated in paragraph (1) of this subsection, the owner of a dry cleaning facility shall ensure that a record is created at the time of disposal describing the disposal of the dry cleaning wastewater. At a minimum, the record must indicate the:

(A) amount of water disposed;

(B) person that disposed of the water;

(C) date of disposal; and

(D) disposal method.

(e) Air emission standards.

(1) The owner of a dry cleaning facility shall comply with Chapter 106 of this title (relating to Permits by Rule) or Chapter 116 of this title (relating to Control of Air Pollution by Permits for New Construction or Modification).

(2) The owner of a dry cleaning facility using perchloroethylene and any person using perchloroethylene at a dry cleaning facility shall comply with emission standards for hazardous air pollutants as specified in 40 Code of Federal Regulations Part 63, Subpart M, in effect September 22, 1993.

(3) Each owner of a dry cleaning facility that is a major source as defined in Chapter 122 of this title (relating to Federal Operating Permits Program) shall obtain an operating permit.

(f) Dikes and other secondary containment structures.

(1) Applicability. Unless otherwise specifically stated, this subsection applies to:

(A) all dry cleaning facilities using chlorinated dry cleaning solvents; and

(B) all other dry cleaning facilities that replace or install a dry cleaning machine on or after September 1, 2005, with the exception of any dry cleaning facility that primarily uses carbon dioxide.

(2) Installation.

(A) Each owner of a dry cleaning facility shall install a dike or other secondary containment structure around each dry cleaning unit and around each storage area for dry cleaning solvents, dry cleaning waste, or dry cleaning wastewater.

(B) Each secondary containment structure must be maintained in good condition and capable of containing any leak, spill, or release of dry cleaning solvents in accordance with this subsection.

(C) Floor drains must not be located within any secondary containment structure required by this subsection.

(3) Construction materials.

(A) The materials used to construct each secondary containment structure must be impervious to, and compatible with, the dry cleaning solvents, dry cleaning wastes, and dry cleaning wastewater used or stored within the secondary containment structure.

(B) For any dry cleaning unit using chlorinated dry cleaning solvents and any storage area for chlorinated dry cleaning solvents, chlorinated dry cleaning wastes, or chlorinated dry cleaning wastewater, materials other than epoxy or steel may be used for the construction of the secondary containment structure only upon

approval by the executive director. Approval for the use of a material other than epoxy or steel will be granted upon satisfactory demonstration to the executive director that the material is as compatible with, and impervious to, dry cleaning solvent as epoxy or steel.

(C) All sealant and all caulk used on each secondary containment structure must be impervious to and compatible with the dry cleaning solvent, dry cleaning waste, or dry cleaning wastewater used or stored within the secondary containment structure.

(4) Storage capacity.

(A) Dry cleaning machine. Each secondary containment structure installed after September 1, 2005, must be capable of completely containing a minimum of 110% of the volume of liquids that can be held within the largest tank on a machine. The secondary containment area must be kept free of all materials or objects that would diminish its capacity to contain a leak, spill, or release.

(B) Storage area. Each secondary containment structure installed after September 1, 2005, must be capable of completely containing a minimum of 110% of the volume of liquids that can be held within the largest container in a storage area. The secondary containment area must be kept free of all materials or objects that would diminish its capacity to contain a leak, spill, or release.

(5) Inspections. The owner of each dry cleaning facility shall visually inspect each installed secondary containment structure weekly to ensure that the structure is not damaged.

(A) If there is no release or imminent threat of release of dry cleaning solvents, the owner of each dry cleaning facility shall ensure that any damage is repaired within seven days after the discovery. The owner may request an extension of this time limit from the executive director. If there is a release or imminent threat of release, the owner shall ensure that any damage is quickly repaired and any release is immediately contained and controlled.

(B) The owner of each dry cleaning facility shall keep a log of these inspections which include, as a minimum, the following information. This information must be provided to the executive director upon request:

(i) the date and time of each inspection;

(ii) the name of the person conducting the inspection;

(iii) a brief notation of findings; and

(iv) the date and nature of each repair or other action taken.

(C) For dry cleaning facilities using chlorinated solvents, inspection logs required under this section may be added to the leak inspection and repair records required by 40 Code of Federal Regulations Part 63, Subpart M, for dry cleaning equipment containing chlorinated solvent.

(D) Each inspection and repair log must be kept at the dry cleaning facility for not less than five years after the log has been completed.

(g) Delivery of solvents.

(1) Chlorinated dry cleaning solvents. All chlorinated dry cleaning solvents must be delivered to dry cleaning units and solvent storage containers by means of either of the following:

(A) a closed, direct-coupled delivery system; or

(B) an alternative method submitted to, and approved by, the executive director that provides protection of human health and safety and the environment that is equivalent to or greater than the protection provided by direct-coupled delivery systems.

(2) Non-chlorinated dry cleaning solvents, except for carbon dioxide solvents. All non-chlorinated dry cleaning solvents, except for carbon dioxide, must be delivered to dry cleaning units and solvent storage containers in a manner that will minimize releases to the environment.

§337.21. Removal of Dry Cleaning Solvents and Wastes.

(a) Disposal of dry cleaning wastes. Each owner of a dry cleaning facility shall ensure that all dry cleaning wastes are disposed of in accordance with §337.20 of this title (relating to Performance Standards).

(b) Dry cleaning facility that ceases operation. Each owner of a dry cleaning facility that ceases operation as a dry cleaning facility for 180 continuous days shall ensure that dry cleaning solvent (including dry cleaning solvent remaining in any dry cleaning machine), dry cleaning wastewater, and waste materials containing dry cleaning solvent, are removed from the dry cleaning facility within 30 days after the end of the 180-day period. An owner of a dry cleaning facility shall ensure that the dry cleaning solvent and solvent-containing residue from a dry cleaning machine is removed prior to the dry cleaning machine being disposed of, recycled, or reused.

(c) Dry cleaning machines temporarily removed from service.

(1) Dry cleaning machines that are temporarily removed from service for more than 180 days must be empty within 30 days after the end of the 180-day period and must meet all applicable performance standards.

(2) Each owner of a dry cleaning facility shall ensure that weekly inspections are continued on any dry cleaning machine that is temporarily removed from service and is not empty.

(3) Prior to a dry cleaning machine being put back in service, the owner of a dry cleaning facility must ensure that the machine meets all applicable performance standards.

(d) Dry cleaning machines permanently removed from service. Dry cleaning machines that are permanently removed from service must be empty prior to removal from the interior of the facility.

§337.22. Variances and Alternative Procedures.

(a) Prior to proceeding in any manner that differs from the requirements of this subchapter, the owner of a dry cleaning facility shall secure written approval from the executive director in the form of a variance in accordance with this section.

(b) The executive director may review and approve requests for variances that meet the requirements in this section. The executive director will approve such requests only if the owner can demonstrate to the executive director that the proposed alternative procedure and/or equipment is no less protective of human health and safety and the environment than the requirement(s) for which the variance is sought.

(c) Any request to the executive director for approval of a variance must be made in writing, signed and dated by the dry cleaning facility owner, and accompanied by the following additional documentation:

(1) written concurrence by the location owner, if different from the dry cleaning facility owner;

(2) complete project identification, including:

(A) location name, address, and location identification number (if known);

(B) location owner's name, address, and telephone number;

(C) name, address, and telephone number of dry cleaning facility owner's/operator's authorized representative; and

(D) proposed date for implementation of the alternative procedure and/or equipment;

(3) sufficient documentation to describe or illustrate the alternative procedure and/or equipment, such as:

(A) plans, drawings, and detail sheets (drawn to scale);

(B) design and construction specifications; and

(C) equipment manufacturers' specifications, operating instructions, and warranty information;

(4) documentation and supporting data that demonstrate, to the satisfaction of the executive director, the reliability and appropriateness of the proposed procedure and/or equipment;

(5) complete explanation of the reasons why the proposed procedure and/or equipment are considered preferable to the requirement for which the variance is sought or why that requirement is considered impracticable for the specified facility; and

(6) documentation that demonstrates, to the satisfaction of the executive director, that use of the proposed alternative procedure and/or equipment will be no less protective of human health and safety and the environment than adhering to the requirement(s) for which the variance is sought.

(d) If a variance is granted by the executive director, the dry cleaning facility owner shall maintain complete copies of the variance and supporting documentation (including the request for approval).

(e) When a variance is sought, the owner shall adhere to the requirement in question until such time as the owner receives a written variance that allows an alternative procedure and/or equipment for that requirement.

(f) Once an owner has received a written variance from the executive director under this section, the owner shall adhere to the terms of that variance as written, or to the terms of the requirement for which the variance was sought.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER D. PRIORITIZATION AND RANKING

30 TAC §§337.30 - 337.32

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.30. Prioritization of Sites.

(a) The executive director will prioritize sites for corrective action as follows.

(1) A site will only be eligible for prioritization if it has been ranked with the dry cleaning facility ranking system.

(2) Sites will be prioritized at least semiannually beginning on January 1 and July 1. Administratively and technically complete applications must be received on or before March 1 of each year to ensure consideration for prioritization starting July 1. Applications must be received on or before September 1 of each year to ensure consideration for prioritization starting January 1. The prioritization will be based on the ranking effective January 1 or July 1 and other considerations outlined in subsection (b) of this section.

(b) The relative priority for corrective action at a site will be based on the following factors:

(1) the dry cleaning facility ranking system;

(2) the benefit to be derived from corrective action compared to the cost of implementing the corrective action;

(3) the effect that interim or immediate remedial measures may have on future costs;

(4) the amount of money available in the Dry Cleaning Facility Release Fund for corrective action;

(5) cost savings to the Dry Cleaning Facility Release Fund realized when corrective action is undertaken during redevelopment or other activity near the site;

(6) necessity of emergency action; and

(7) any other factor the executive director considers relevant to the prioritization of sites.

(c) The executive director may re-prioritize sites during the semiannual prioritization in subsection (a)(2) of this section. This re-prioritization may result in a site being assigned a new priority below the level eligible for available funding, which may result in the termination or suspension of corrective action at the site.

§337.31. Ranking of Sites.

(a) Dry cleaning facility ranking system.

(1) The dry cleaning facility ranking system is a methodology designed to determine a numerical score for a facility based on the executive director's judgment regarding various factors that may impact human health or the environment.

(2) The executive director will rank dry cleaning facilities based on information provided in an application for ranking package.

An application for ranking will be accepted from persons eligible to apply for a site to be ranked under Texas Health and Safety Code, §374.154(b), including former owners of dry cleaning facilities and owners of real property on which a dry cleaning facility was formerly located that meet the eligibility criteria.

(3) An application for ranking package must contain:

(A) a completed application for ranking;

(B) proof that an owner of the real property has been notified of the application if the applicant is not an owner of the real property;

(C) proof that a lessee has been notified of the application if the applicant is an owner of the real property and the facility is leased;

(D) evidence that the deductible has been met in accordance with Subchapter E of this chapter (relating to Deductible);

(E) laboratory analyses of at least one groundwater sample (soil analyses may be substituted with written approval of the executive director);

(F) geologic well log(s) from a monitoring or supply well or hydrogeologic information from the contaminated site where the groundwater or soil sample was taken;

(G) field survey to locate potential receptors, including water wells and surface waters to at least 500 feet beyond the boundary of the property;

(H) a records survey to identify all water wells and surface water bodies within 1/2 mile of the boundary of the property;

(I) a full operational history of the facility including types of solvent currently and previously used; and

(J) any other information or evidence the executive director considers necessary.

(4) Application for ranking packages that are not administratively and technically complete as determined by the executive director will not be ranked. The executive director will notify the applicant in writing of such a determination.

(5) Factors the executive director may consider in ranking sites include:

(A) types of solvent currently in use;

(B) types of solvent used in the past;

(C) operational history of the facility;

(D) risk to drinking water supplies;

(E) surface water:

(i) demonstrated impact to surface water;

(ii) distance to surface water; and

(iii) probability of contamination;

(F) groundwater:

(i) aquifer impacted;

(ii) depth to groundwater;

(iii) distance to nearest known groundwater wells;

(iv) areal extent of groundwater contaminated;

(v) subsurface geology as it affects contamination migration;

(vi) concentrations of dry cleaning solvent in the groundwater;

(vii) probability of contamination; and

(viii) institutional controls prohibiting the use of groundwater for potable purposes;

(G) alternative water source availability;

(H) soil:

(i) soil type;

(ii) depth to groundwater;

(iii) depth of contamination;

(iv) concentrations of dry cleaning solvent in the soil;

(v) quantity of soil contaminated;

(vi) potential for exposure to the contaminated soils; and

(vii) soil on the outcrop of a major or minor aquifer, or the Edwards Aquifer recharge or transition zone;

(I) current and future land use; and

(J) air contamination:

(i) potential for exposure to vapors; and

(ii) potential for vapors to migrate into buildings or other receptors.

(6) For all applications that are technically and administratively complete, the executive director will rank the site and notify an applicant of the relative ranking assigned to the applicant's site on or before the 90th day after the date the application is received by the executive director.

(7) If a site has already been ranked by the executive director, an applicant may submit an updated application for ranking to reflect changes in site conditions as a result of corrective action or other circumstances. Such updates will be limited to one per state fiscal year per site.

(8) The executive director may re-rank sites where corrective action has occurred using monies from the Dry Cleaning Facility Release Fund to reflect changes in site conditions as a result of corrective action or other circumstances.

(b) Even if a site has been ranked, a person may take corrective action at the person's own expense at any time in accordance with commission rules. The resulting expenses will not be reimbursed by the agency. In addition to any other notice required, an applicant shall give the executive director notice of such corrective action within 30 days after the action is completed.

§337.32. Denial and Removal of Sites from Ranking.

(a) The executive director may deny or remove from ranking a site if:

(1) the owner of the dry cleaning facility or dry cleaning drop station is held responsible for the costs of corrective action under Texas Health and Safety Code, §374.202;

(2) the applicant denies access or unreasonably hinders or delays corrective action at the site;

(3) the applicant has failed to pay fees, penalties, and interest for any dry cleaning facility or dry cleaning drop station that the applicant is required to pay;

(4) the applicant has failed to register any dry cleaning facility or dry cleaning drop station that the applicant was required to register; or

(5) the applicant does not pay the deductible or provide satisfactory proof of expenditures to apply against the deductible in accordance with Subchapter E of this chapter (relating to Deductible) within the required time frames.

(b) An applicant who has been denied or removed from ranking may address the cause for denial or removal from ranking, provide additional information, and reapply for ranking.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER E. DEDUCTIBLE

30 TAC §337.40, §337.41

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.40. General Requirements.

(a) Eligible costs incurred by an applicant in performance of technical and scientific investigations, assessments, or corrective action associated with the site and related to the release of a dry cleaning solvent may be credited against the deductible required under Texas Health and Safety Code, §374.203.

(b) Eligible costs for credit against the deductible are only those costs submitted with the application for ranking package that are reasonable and appropriate costs for reasonable and appropriate actions as determined by the executive director.

(c) If the deductible is not met by eligible costs, the applicant shall submit a non-refundable payment of the difference at the time the application for ranking is submitted.

(d) In the case of multiple applications for the same dry cleaning facility, each applicant must individually meet the deductible requirements in this subchapter.

§337.41. Evidence of Eligible Costs.

(a) Evidence of eligible costs must be submitted with the application for ranking package and must contain:

(1) legible copies of invoices, providing a description of:

(A) any work performed;

(B) who performed the work;

(C) where the work was performed;

(D) the dates that the work was performed;

(E) the unit cost; and

(F) the total amount paid; and

(2) proof that the amounts shown on the invoices for which the credit toward the deductible is requested have been paid in full by the applicant. The submission must include either:

(A) business receipts or invoices from the person that performed the work, indicating compensation received;

(B) canceled checks;

(C) the certification of a certified public accountant that the expenses for which credit against the deductible is requested have been paid in full; or

(D) a notarized affidavit signed by the person that performed the corrective action, affirming that the amounts which the applicant represents as being paid to the person that performed the corrective action were paid in full.

(b) The executive director may require the applicant to provide additional information or return the application if the information is not sufficient to review the application. If the executive director requests additional information, the applicant shall provide such information within 30 days of receiving the request.

(c) The following types of costs are those that will not be considered eligible costs applicable to the deductible under this subchapter:

(1) replacement, repair, and maintenance of affected equipment;

(2) upgrading existing equipment;

(3) removal, transport, and disposal of equipment;

(4) loss of income or profits, including, without limitation, the loss of business income arising out of the review, processing, or payment of an application for ranking under this subchapter;

(5) decreased property values;

(6) bodily injury or property damage;

(7) attorney's fees;

(8) any administrative costs associated with the preparation, filing, and processing of an application for ranking under this subchapter;

(9) making improvements to the facility beyond those that are required for corrective action;

(10) compiling and storing records relating to costs of corrective action;

(11) corrective action taken in response to the release of a substance that is not a dry cleaning solvent;

(12) any activities, including those required by this chapter, that are not conducted in compliance with applicable state and federal environmental laws or laws relating to the transport and disposal of waste;

(13) interest on monies; and

(14) abatement or corrective action taken in response to a release of:

(A) a regulated substance that is not dry cleaning solvent; or

(B) a release of a dry cleaning solvent that has commingled with a regulated substance that is not a dry cleaning solvent unless the release of the dry cleaning solvent can be separately remediated.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406454
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 239-0348

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SUBCHAPTER F. CORRECTIVE ACTION

30 TAC §337.50, §337.51

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.50. Corrective Action.

(a) Corrective action will be conducted under Chapter 350 of this title (relating to Texas Risk Reduction Program) or other guidance established by the executive director.

(b) Corrective action at a site may be postponed or suspended indefinitely in order to make money available for corrective action at a site with a higher priority.

(c) Postponement or suspension of corrective action under subsection (b) of this section does not mean that the cleanup standards under Chapter 350 of this title have been met.

(d) Corrective action will allow for the use of new technologies as they become available.

§337.51. Eligibility for Corrective Action.

An owner or other person is eligible to have corrective action costs paid by the Dry Cleaning Facility Release Fund if:

(1) the owner or other person is eligible to apply for a site to be ranked under §337.31(a)(2) of this title (relating to Ranking of Sites);

(2) an application for ranking package under §337.31(a)(3) of this title has been properly submitted to, and accepted by, the executive director as administratively and technically complete;

(3) the owner or other person is not currently in violation of this chapter for any dry cleaning facilities or dry cleaning drop station that the person owns; and

(4) the owner or other person is not otherwise ineligible for corrective action under this chapter or Texas Health and Safety Code, Chapter 374.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-0348

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SUBCHAPTER G. NON-PERCHLOROETHYLENE USERS AND FACILITIES

30 TAC §§337.60 - 337.63

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.60. Nonparticipating Dry Cleaning Facility Financial Assurance.

(a) Except as provided in subsection (c) of this section, the owner of a dry cleaning facility that has submitted to the executive director the affidavit of nonparticipation for a facility that begins operation on or after September 1, 2003 and before January 1, 2004, shall provide financial assurance for corrective action in the amount of $500,000 per nonparticipating facility. The affidavit and financial assurance must be submitted to the agency before January 1, 2004.

(b) Financial assurance must be provided in accordance with Chapter 37, Subchapter W of this title (relating to Financial Assurance for Dry Cleaning Facilities).

(c) This section does not apply to a carbon dioxide facility.

§337.61. Participating Non-Perchloroethylene User Registration Certificate.

(a) To obtain a participating non-perchloroethylene user registration certificate, an owner of a dry cleaning facility must swear in an affidavit approved by the executive director that the owner has never used or allowed the use of the dry cleaning solvent perchloroethylene at any dry cleaning facility in the state.

(b) A facility is only eligible for a non-perchloroethylene user registration certificate, if perchloroethylene has not been, is not, and will not be used at the facility that is being registered for the certificate.

§337.62. Nonparticipating Non-Perchloroethylene Facilities.

(a) In accordance with Texas Health and Safety Code, §374.104, after a dry cleaning facility is designated as nonparticipating:

(1) the owner of the dry cleaning facility is not eligible for any expenditures of money from the Dry Cleaning Facility Release Fund or other benefits of participation for that facility;

(2) that dry cleaning facility may not later become a participating facility, regardless of whether the owner of the facility or the owner of the real property is applying for the facility's participation in Dry Cleaning Facility Release Fund benefits; and

(3) perchloroethylene must never be used at that facility.

(b) In any sales transaction of the nonparticipating non-perchloroethylene facility or of the real property on which the facility is located, the owner of the facility or the real property owner, as applicable, shall disclose the following to potential buyers prior to any sale:

(1) the nonparticipating status of the dry cleaning facility;

(2) the fact that the dry cleaning facility may not later become a participating facility; and

(3) the prohibition on the use of perchloroethylene at the dry cleaning facility.

§337.63. Owner Affiliation.

For the purposes of this subchapter, the term "owner" includes any entity or person affiliated with the owner through:

(1) any relationship within the third degree of consanguinity or second degree of affinity as described in Texas Government Code, Chapter 573, Subchapter B;

(2) any contractual, corporate, or financial relationship (other than a contractual, corporate, or financial relationship that is created solely by the instruments by which title to the facility is conveyed or financed, by a contract for the sale of goods or services, or by a contract for employment); or

(3) the result of a reorganization of a business entity that used perchloroethylene.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200406456
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 239-0348

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SUBCHAPTER H. RECORDKEEPING

30 TAC §§337.70 - 337.72

STATUTORY AUTHORITY

The new sections are proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new sections are also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new sections implement THSC, Chapter 374.

§337.70. General Provisions.

(a) Maintenance of records. All records required to be maintained by this chapter must be available for examination and copying by the executive director at all reasonable times. Upon request, all records required by this chapter must be assembled at a single location within the State of Texas.

(b) Records retention. A person that is required to keep records under this chapter shall keep those records for a minimum of five years from the date on which the record is made.

(c) Penalties for records violations. A person that violates this subchapter shall be subject to any action authorized by law to secure compliance, including the assessment of administrative penalties or civil penalties as prescribed by law, and the suspension or revocation of registration.

§337.71. Distributors.

Distributors shall maintain books, financial records, documents, and other evidence for sales of dry cleaning solvents and the fees collected and paid to the agency as required by this chapter. The records must include copies of all invoices for dry cleaning solvent sales and purchases showing the facility registration numbers, name, type, and quantity of the dry cleaning solvent purchased and sold, the name and address of the seller and purchaser, and the date of the sale or purchase.

§337.72. Dry Cleaning Facilities.

The owner of a dry cleaning facility shall retain the following records:

(1) invoices of dry cleaning solvent purchases showing the name, type, and quantity of the dry cleaning solvent purchased, the name and address of the seller, and the date of the purchase;

(2) waste disposal records as required by §337.20(c) and (d)(2) of this title (relating to Performance Standards); and

(3) secondary containment log required under §337.20(f)(4)(B) of this title.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200406457
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-0348

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SUBCHAPTER I. AUDITS AND INVESTIGATIONS

30 TAC §337.80

STATUTORY AUTHORITY

The new section is proposed under the authority granted to the commission by the Texas Legislature in THSC, Chapter 374. The new section is also proposed under TWC, §5.103, which authorizes the commission to adopt any rules necessary to carry out its powers and duties under TWC and other laws of the state; TWC, §7.002, which authorizes the commission to enforce provisions of TWC and THSC; THSC, §361.017, which provides the commission the powers necessary or convenient to carry out its powers under the Solid Waste Disposal Act (SWDA); THSC, §361.024, which authorizes the commission to adopt rules consistent with the SWDA and establish minimum standards for the management and control of solid waste; and HB 1366, 78th Legislature, 2003.

The proposed new section implements THSC, Chapter 374.

§337.80. Audits and Investigations.

(a) To achieve the purposes, proper administration, and enforcement of this chapter, the executive director may conduct audits or investigations of payments and fees authorized by Texas Health and Safety Code, Chapter 374, and concerning the veracity of information submitted to the agency in accordance with the *Government Auditing Standards* (2003 Revision). Such audits may include investigations of records from dry cleaning facilities, dry cleaning drop stations, distributors of dry cleaning solvents, and applicants for site ranking.

(b) Each person subject to or involved with an audit or investigation under subsection (a) of this section shall cooperate fully with the audit or investigation by the executive director.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200406458
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-0348

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TITLE 34. PUBLIC FINANCE

PART 3. TEACHER RETIREMENT SYSTEM OF TEXAS

CHAPTER 41. HEALTH CARE AND INSURANCE PROGRAMS

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

34 TAC §41.5

The Teacher Retirement System of Texas (TRS) proposes amendments to §41.5, relating to payment of contributions in the Texas Public School Retired Employees Group Benefits Program known as TRS-Care. The proposed amendments clarify the language and modify the results of a retiree, surviving spouse, or surviving dependent child (collectively, participants) failing to pay their monthly contribution (premium) when due. The 78th Legislature repealed the statute that defaulted participants into the basic coverage tier. Therefore, if a participant fails to pay the required premium and is enrolled in an optional coverage tier, which provides greater benefits, there is no longer a requirement that the participant automatically continue to be covered in the basic coverage tier. Consequently, the proposed amendments eliminate that requirement and provide a process for TRS to notify the participant of the failure to pay. To continue TRS-Care coverage, the participant must either (1) downgrade his or her coverage tier to TRS-Care 1 retiree-only or surviving spouse-only, as applicable, which has no premium associated with it; or (2) make payment in full within 62 days of the date of TRS's first notice of the failure to pay. The proposed amendments provide that a participant's failure to take one of these steps within the timeframe set out in the rule will result in termination of TRS-Care coverage effective the last day of the month immediately preceding the month in which the 62nd day falls. For example, if the 62nd day is January 15, 2005, TRS-Care coverage will be terminated as of December 31, 2004. The proposed amendments provide that if a participant downgrades his or coverage tier, that change will be effective on the first day of the month for which the premium was not received. Therefore, if the participant paid a premium for February 2005 but did not pay for March and notified TRS-Care within the allotted time period that he or she wanted to downgrade coverage to TRS-Care 1 retiree-only, that change in coverage would be effective on March 1, 2005.

Tony Galaviz, Chief Financial Officer, has determined that for each year of the first five-year period the proposed amendments are in effect, there will be no fiscal implications to state or local governments as a result of enforcing or administering the section as amended. There is no foreseeable effect on local employment or local economies as a result of the proposed amendments.

Mr. Galaviz has also determined that for each year of the first five years the proposed amendments are in effect the public benefit anticipated as a result of the amendments will be that participants will have notice of their rights and obligations concerning their premium payments and the results of failing to pay. Additionally, the rule will be consistent with the change in applicable law. There is no anticipated adverse economic effect on small businesses or micro-businesses as a result of compliance with

the proposed amendments. Mr. Galaviz has determined that there are no anticipated economic costs to persons required to comply with the proposed amendments for each year of the first five years the proposal will be in effect.

Comments on the proposal may be submitted to Ronnie Jung, Executive Director, 1000 Red River, Austin, Texas 78701.

These amendments are proposed under Insurance Code, §1575.052, which gives TRS the authority to adopt rules as necessary to administer and operate the TRS-Care program. The amendments are also proposed under Government Code, Chapter 825, §825.102, which authorizes the Board of Trustees of the Teacher Retirement System to adopt rules for the administration of the funds of the retirement system and for the transaction of business of the Board.

There are no other codes affected.

§41.5. Payment of Contributions.

(a) Retirees, surviving spouses, and surviving dependent children or their representative (collectively, "participants") shall pay monthly contributions as set by the trustee for their and their dependents' participation in TRS-Care [~~to cover the cost of optional plans~~].

[~~(b) Surviving spouses shall pay monthly contributions to cover the cost of insurance for the surviving spouse.~~]

[~~(c) Retirees and surviving spouses shall pay monthly contributions to cover the cost of insuring dependents.~~]

[~~(d) Surviving dependent children, or their representative, shall pay monthly contributions to cover the cost of insurance for the surviving dependent children.~~]

(b) [~~(e)~~] To [~~In order to~~] be eligible for TRS-Care [~~optional~~] coverage, a participant [~~retiree, surviving spouse, or surviving dependent child, or his or her representative,~~] must authorize the trustee in writing to deduct [~~the deduction by the trustee of the amount of~~] the contribution amount [~~contributions~~] from the [~~their~~] annuity payment. After such authorization, the trustee may [~~shall~~] deduct the amount of the contribution [~~each month~~] from the annuity payment.

[~~(f) In order to pay for dependent coverage, the retiree or surviving spouse shall authorize in writing the deduction of the contribution payment from their annuity payment. After authorization by the retiree or surviving spouse, the trustee shall deduct the amount of the contribution each month from the retiree's or surviving spouse annuity payment.~~]

(c) [~~(g)~~] If [~~In the event that~~] the amount of the contribution is more than the amount of the annuity payment, the participant will be billed directly by TRS or the TRS-Care administrator [~~the carrier~~] for the entire contribution amount.

(d) [~~(h)~~] Failure to make any required contribution [~~for coverage of a non-retiree~~] will result in termination of coverage if, within 62 days following the date of the first notice of failure to pay the amount due for TRS-Care coverage, the participant either: [~~at the end of the month for which the last contribution was made.~~]

(1) does not downgrade his or her coverage tier to TRS-Care 1, retiree-only or surviving spouse-only, as applicable; or

(2) fails to make payment in full.

(e) If the participant fails to take either of the steps set forth in subsection (d) of this section within the specified timeframe, TRS-Care coverage will be terminated effective the last day of the month immediately preceding the month in which the 62nd day falls.

(f) If a participant chooses to downgrade his or her TRS-Care coverage tier to TRS-Care 1, retiree-only or surviving spouse-only, as applicable, within the timeframe specified in subsection (d) of this section, that change in coverage will be effective on the first day of the first month for which payment of the contribution in full was not received.

[~~(i) Failure to make any required contribution for coverage of a retiree under an optional plan will result in termination of coverage from the optional plan and enrollment in the basic plan, resulting in a decrease in coverage, at the end of the month for which the last contribution was made.~~]

[~~(j) Disability retirees shall be required to pay monthly contributions to cover the cost of coverage during periods when their annuity payments are suspended. Failure to make required contributions will result in a termination of coverage from the optional plan and enrollment in the basic plan, resulting in a decrease in coverage.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406508
Ronnie G. Jung
Executive Director
Teacher Retirement System of Texas
Proposed date of adoption: December 16, 2004
For further information, please call: (512) 542-6115

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SUBCHAPTER E. ACTIVE EMPLOYEES HEALTH REIMBURSEMENT ARRANGEMENTS

34 TAC §§41.101 - 41.104

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Teacher Retirement System of Texas or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Teacher Retirement System of Texas (TRS) proposes the repeal of Chapter 41, Subchapter E, §§41.101 - 41.104, concerning Active Employees Health Reimbursement Arrangements.

House Bill 3257, 78th Legislature, Regular Session, 2003, amended article 3.50-8, Insurance Code and established an active employees health reimbursement arrangement program (TRS-HRAccount). The program was to be implemented effective September 1, 2004. TRS adopted Subchapter E and the rules contained therein to implement the TRS-HRAccount program. In September 2004, the joint chairs of the Legislative Budget Board (LBB) determined that the TRS-HRAccount program was not funded. In response to this determination, the TRS Board of Trustees at is September 2004 meeting directed staff to terminate the contract for administration of the TRS-HRAccount program and to distribute health care funds as supplemental compensation. Given the determination by the joint chairs of the LBB, the TRS board response, and the need to avoid confusion, TRS is proposing repeal of Chapter 41, Subchapter E, relating to the TRS-HRAccount program rules.

Tony Galaviz, Chief Financial Officer, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeal.

Mr. Galaviz has also determined that, for each of the first five years the repeal as proposed will be in effect, the anticipated public benefit will be the avoidance of confusion concerning an unfunded program. No economic cost will be incurred by a person required to comply with the repeal, and there will be no adverse effect on small businesses.

Comments on the proposal may be submitted in writing to Ronnie Jung, Interim Executive Director, 1000 Red River, Austin, Texas 78701. The deadline for comments is 30 days after publication in the *Texas Register*.

The repeal is proposed under the Government Code, Chapter 825, §825.102, which authorizes the Board of Trustees of the Teacher Retirement System to adopt rules for, among other things, the transaction of business of the board. The repeal is also proposed under article 3.50-8, section 4, Insurance Code, which authorizes TRS, as trustee, to adopt rules to implement the article.

There are no other codes affected.

§41.101. Organizations Eligible To Respond.

§41.102. Proposal Procedure.

§41.103. Definition of Dependent.

§41.104. Eligibility Reporting.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406507
Ronnie G. Jung
Executive Director
Teacher Retirement System of Texas
Proposed date of adoption: December 16, 2004
For further information, please call: (512) 542-6115

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PART 10. TEXAS PUBLIC FINANCE AUTHORITY

CHAPTER 221. DISTRIBUTION OF BOND PROCEEDS

34 TAC §§221.2, 221.3, 221.6

The Texas Public Finance Authority proposes amendments to §§221.2, 221.3, and 221.6, concerning the distribution of bond proceeds. These sections provide necessary definitions, explain the bond issuance process, and provide client agencies required information as to how to file complaints. The amendments are technical updates of statutory citations and information concerning the Board's regular meeting schedule.

Judith Porras, General Counsel, has determined that for the first five years the amendments are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Ms. Porras has also determined that for each year of the first five years the amendments are in effect, the public benefit expected as a result of the amendments is the public having accurate information. The rules have no effect on small or micro businesses and there will be no economic cost to persons required to comply with the rules as proposed.

Comments on the proposed amendments may be submitted to Judith Porras, General Counsel, Texas Public Finance Authority, 300 W. 15th St., Suite 411, Austin, TX 78701, or electronically to judith.porras@tpfa.state.tx.us.

The amendments are proposed under the authority of Texas Government Code, Chapter 1232, §1232.067, which authorizes the Board to adopt rules reasonably necessary to carry out its functions.

Texas Government Code, Chapters 1232 and 1403 are affected by the proposed amendments.

§221.2. Definitions.

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

(1) Act--The Texas Public Finance Authority Act, Texas Government Code, Chapter 1231 [~~Civil Statutes, Article 601d~~].

(2) - (3) (No change.)

(4) Bond Review Board--The Bond Review Board as created by the Texas Legislature pursuant to Texas Government Code, Chapter 1231 [~~Civil Statutes, Article 717k-7~~].

(5) - (9) (No change.)

(10) Constitutional provision--A provision of the Texas Constitution that authorizes the issuance of general obligation bonds by the Authority; namely: Article III, §49-h, Article III, §49(e), Article III, §49-l, Article III, §49-n, or Article III, §50-f [~~The Texas Constitution, Article III, §49-h, or Article III, §49-e~~].

(11) - (29) (No change.)

§221.3. Bond Issuance Process.

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

(d) Board action. The request for financing will be posted for consideration by the board at its next regularly scheduled open meeting following the authority's receipt of the request.If the client agency's request is received eight days before the board's regularly scheduled meeting date, which schedule shall be posted on the authority's website, the request will be timely for the board's consideration at the scheduled meeting. [~~Since the Board's regularly scheduled open meetings are held usually on the third Wednesday of each month, if the client agency's request is received by the second Tuesday of the month, it will be timely for board consideration in the month in which it is received.~~] The client agency will be informed promptly of a change in the board's meeting date for the month and the exact date on which the request will be considered.

(1) - (2) (No change.)

(3) If the board determines to sell the bonds through a competitive sale, it will authorize the executive director and financial advisor to prepare [~~issue~~] an invitation for competitive bids in the time and manner required so that the board approve the distribution of the invitation and the Preliminary Official Statement [~~may accept a bid, and sell the bonds,~~] at its open meeting in the month immediately following.

(e) Procedures following board approval of a request for financing. As soon as possible following the board's approval of a request for financing, the authority staff, financial advisors, bond counsel, representatives of the client agency, and, for negotiated sales, the senior manager of the underwriting syndicate and its counsel, will convene an organization meeting to prepare a schedule of events for the financing, and begin work on the financing documents and an application for Bond Review Board approval of the financing.

(1) In most cases, the application for Bond Review Board approval will be submitted timely for consideration and approval of the Bond Review Board at its next regularly scheduled meeting [~~in the month~~] following the board's approval of the request, however, the timing of the submission is within the discretion of the executive director.

(2) (No change.)

§221.6. Complaints to the Authority.

In accordance with the requirements of §1232.113(e) [~~§9D~~] of the Act, the authority will notify client agencies of the name, mailing address, and telephone number of the authority for the purpose of directing complaints to the authority by direct mail, notifying and reminding client agencies periodically of the authority's electronic mail address, and by distributing a fact sheet on the authority during the orientation meeting described in [~~section in~~] §221.3 of this title (relating to the Bond Issuance Process) of this Chapter 221.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406478
Kimberly Edwards
Executive Director
Texas Public Finance Authority
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-5544

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CHAPTER 225. MASTER LEASE PURCHASE PROGRAM

34 TAC §§225.1, 225.3, 225.5, 225.7

The Texas Public Finance Authority proposes amendments to §§225.1, 225.3, 225.5, and 225.7, concerning the master lease purchase program. These sections explain the purpose and requirements of the master lease purchase program and provide necessary definitions. The amendments are technical updates of statutory citations and program information.

Judith Porras, General Counsel, has determined that for the first five years the amendments are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Ms. Porras has also determined that for each year of the first five years the amendments are in effect, the public benefit expected as a result of the amendments is the public having accurate information. The rules have no effect on small or micro businesses and there will be no economic cost to persons required to comply with the rules as proposed.

Comments on the proposed amendments may be submitted to Judith Porras, General Counsel, Texas Public Finance Authority, 300 W. 15th St., Suite 411, Austin, TX 78701, or electronically to judith.porras@tpfa.state.tx.us.

The amendments are proposed under the authority of Texas Government Code, Chapter 1232, §1232.103.

Texas Government Code, §1232.103 is affected by the proposed amendments.

§225.1. Purpose of the Rules.
The Texas Public Finance Authority proposes these new rules, as Chapter 225, concerning the administration of the State of Texas Master Lease Purchase Program authorized by Texas Government Code, §1232.103 [~~Civil Statutes, Article 601d §9A~~]. This chapter defines certain terms pertaining to the operation of the Texas Master Lease Purchase Program, identifies the responsibilities of various parties in administering the Texas Master Lease Purchase Program, and establishes basic procedures under which state agencies may participate in the Texas Master Lease Purchase Program.

§225.3. Definitions.
The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Public Finance Authority Act, Texas Government Code, Chapter 1232 [~~Civil Statutes, Article 601d~~], as amended.

(2) - (6) (No change.)

(7) Bond Review Board--The board created by Texas Government Code, Chapter 1231 [~~Civil Statutes, Article 717k-7~~], or any successors or assignees to its duties and functions.

(8) Bundled purchases--Those purchases of multiple eligible projects individually valued at a minimum of $100 [~~$500~~] for and on behalf of one or more client agencies, which are aggregated into one vendor contract for acquisition.

(9) - (13) (No change.)

(14) Eligible project--Any physical structure that has been authorized by the legislature for the authority to finance and is used by a client agency to conduct official state business, together with the land and major equipment or personal property that is functionally related to the physical structure, or any other fixed asset used by a client agency to conduct official state business, including, without limitation, telecommunications devices or systems, automated information systems, computers and computer software, provided, that such property has a useful life of at least three years, and a value of at least $10,000, valued either individually or as a group of individual items of property, each having a minimum value of $100 [~~$500~~] per item.

(15) - (17) (No change.)

(18) Lease payments--Those amounts specified in the lease supplements and made pursuant to the comptroller's intercept payable annually on [~~semiannully on the first day of February and~~] the first day of August. The term "lease payments' also includes all payments made while the eligible project is in the interim financing and to lease revenue bond holders.

(19) Lease revenue bonds--The long-term bonds issued by the authority either to refinance eligible project that has been initially financed [~~finance~~] through interim financing, or to fund the purchase of eligible project.

(20) - (25) (No change.)

(26) State lease fund account--The account [~~fund~~] by that name created by the Act.

(27) (No change.)

§225.5. Procedures for Financing Eligible Projects.

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

(c) After acceptance of the request for financing by the authority and execution of the master lease agreement, the client agency will proceed to procure the eligible project in compliance with all applicable laws and rules governing such procurement, including obtaining the approval, if any is required, of the Bond Review Board, the Department of Information Resources, the Texas Building and Procurement Commission [~~General Services Commission~~], or other state agency.

(d) - (g) (No change.)

(h) No later than on or before 48 hours prior to a lease payment, the authority will submit a voucher directing the comptroller to transfer sufficient monies from each client agency into the state lease fund account and the authority will provide a voucher to the comptroller to effect debt service payment. The monies will then be transferred out of the state lease fund account and lease payments will be made [~~treasurer will then transfer monies out of the state lease fund and make lease payments~~].

(i) (No change.)

(j) The authority may issue lease revenue bonds in order to refinance the lease supplements initially funded through the interim financing. The final maturity of lease revenue bonds shall not exceed the latest maturity of the lease supplements being financed upon the occurrence of any of the following events:

(1) any date on which the aggregate volume of lease supplements then being financed through the interim financing reaches $150 [~~$75~~] million; or

(2) (No change.)

(k) - (n) (No change.)

§225.7. Recovery of Costs.

(a) The authority may recover its administrative costs by assessing each client agency on a pro rata basis for reimbursement of administrative costs. This pro rata reimbursement [~~reimburesement~~] shall be calculated on an annual [~~a semiannual~~] basis to cover the ongoing costs of the program. The exact amount assessed each client agency shall be separately disclosed on the debit memo. In no event shall administrative costs assessed each client agency exceed 1 1/2% per annum of their pro rata participation in the program.

(b) The costs of issuance shall be calculated on a pro rata basis for each client agency and included as an addition to principal along with the purchase price of the eligible project, if necessary.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406479
Kimberly Edwards
Executive Director
Texas Public Finance Authority
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-5544

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 1. TEXAS DEPARTMENT OF PUBLIC SAFETY

CHAPTER 15. DRIVER LICENSE RULES

SUBCHAPTER J. DRIVER RESPONSIBILITY PROGRAM

37 TAC §15.161, §15.162

The Texas Department of Public Safety proposes new Subchapter J, §15.161 and §15.162, concerning Driver Responsibility Program.

Chapter 708 of the Transportation Code grants the department the authority to adopt rules to implement the Driver Responsibility Program (DRP). This program was created during the 78th Legislative Session (2003) and requires the department to assess fees based on an individual's driver history. DRP has two major components, a point system and a conviction surcharge system. The point system is based on the accumulation of Class C traffic offenses. An individual receives two points for each traffic conviction and three points if the offense resulted in an accident. The conviction surcharge system is based on a one-time conviction of certain more serious traffic offenses. The program requires the individual to pay the fee, ranging from $100 to $2000 every year for three years.

The statute specifically requires the department to establish rules regarding the acceptance of installment payments. The department has contracted with a vendor to process the surcharge payments. As such, the vendor acting on behalf of the department will accept installment agreements to the extent outlined in these sections.

Oscar Ybarra, Chief of Finance, has determined that for each year of the first five-year period the rules are in effect there will be no fiscal implications for state or local government, or local economies.

Mr. Ybarra also has determined that for each year of the first five-year period the rules are in effect the public benefit anticipated as a result of enforcing the rules will be to provide the general public the necessary information regarding the acceptance of installment agreements under DRP. There is no anticipated adverse economic effect on small businesses, or micro-businesses. There will be a fiscal impact to individuals should they chose to utilize the installment agreement option for payment of surcharges under DRP.

Comments on the proposal may be submitted to Rebecca Blewett, Senior Staff Attorney, Driver License Division, Texas Department of Public Safety, P.O. Box 4087, Austin, Texas 78773-0300, (512) 424-5231.

The new sections are proposed pursuant to Texas Government Code, §411.004(3), which authorizes the Public Safety Commission to adopt rules considered necessary for carrying out the department's work; and Texas Transportation Code, §708.002 and §708.153.

Texas Government Code, §411.004(3) and Texas Transportation Code, §708.002 and §708.153 are affected by this proposal.

§15.161. General Information.

(a) The department has contracted with a vendor to process payments under the Driver Responsibility Program. The vendor will produce and send all surcharge notices, accept all payments and report all transactions to the department.

(b) All payments must be submitted to the vendor. The department will not accept payments for surcharges under the Driver Responsibility Program at Department of Public Safety (DPS) facilities.

(c) An individual who fails to pay the surcharge, including any additional costs or fails to enter an installment agreement within 30 days from the date of the Surcharge Notice will be subject to revocation action.

§15.162. Installment Agreements.

(a) The department, through the vendor, will accept installment payments for surcharges required under the Driver Responsibility Program.

(b) There is an additional processing fee required per each payment submitted in accordance with an installment agreement. The fee is set by the department and is provided on all original notifications.

(c) To enter into an installment agreement, the individual must submit the minimum amount due. The vendor's acceptance of the minimum amount due constitutes an installment agreement and denotes that the individual is aware of the agreement as well as the consequences for failing to uphold the agreement. The individual is not required to provide written declaration of the installment agreement.

(d) To prevent revocation, the minimum amount due must be received within 30 days of the original Surcharge Notification.

(e) If a revocation action has occurred, an individual who has not submitted any partial payments can enter into an installment agreement to lift the revocation.

(f) The driver license and/or driving privileges of an individual who attempts to enter an installment but does not submit the minimum payment by the date required will be revoked. This individual will not be eligible to enter into an installment agreement for that specific surcharge requirement. The revocation will remain in effect until the surcharge and associated fees are paid in full.

(g) Subsequent payments are due each month on the same date as the date of the Surcharge Notification received for that particular surcharge.

(1) If the date on the Notice is the 29th, 30th or 31st, payments are due on the last date of the month in months that do not have those dates.

(2) Payment due dates return to the same date as the Notification for following months that have the corresponding date.

(h) If an individual fails to provide a timely payment and defaults on the installment agreement, the license and/or driving privileges will be revoked. The individual will not be eligible to enter into another installment agreement for that specific surcharge requirement. The revocation will remain in effect until the surcharge and associated fees are paid in full.

(i) If revoked, an individual may continue to make partial payments; however, the license will remain revoked until the specific surcharge has been paid in full.

(j) To submit an installment payment, the individual must include the full name, driver license/identification number and the surcharge reference number with all payments.

(1) If an individual has multiple surcharge notifications and does not provide the reference number, the payment will be applied to the oldest outstanding surcharge requirement.

(2) If the individual submits a payment and provides a reference number, the payment will be applied as requested even if this results in a default or revocation on another surcharge owed by the same individual.

(k) Minimum payments are determined by dividing the total amount due by the maximum payments allowed and adding the partial payment fee. The maximum number of payments is determined by the amount of the surcharge required.

(1) For surcharge requirements of $100 - $259 an individual may make a maximum of four (4) payments.

(2) For surcharge requirements of $260 - $999 an individual may make a maximum of ten (10) payments.

(3) For surcharge requirements of $1000 - $2000 an individual may make a maximum of twelve (12) payments.

(4) For surcharge requirements of $2001 and over an individual may make a maximum of twenty-four (24) payments.

(l) An individual may pay the balance in fewer payments, but a payment of less than the minimum required will result in the revocation of the license and/or driving privileges.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406497
Thomas A. Davis, Jr.
Director
Texas Department of Public Safety
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 424-2135

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 1. MANAGEMENT

SUBCHAPTER E. PROCEDURES IN CONTESTED CASES

43 TAC §§1.21 - 1.24, 1.26, 1.30

The Texas Department of Transportation (department) proposes amendments to §§1.21-1.24, §1.26, and §1.30, concerning procedures in contested cases.

EXPLANATION OF PROPOSED AMENDMENTS

Government Code, §2003.050, provides that in contested cases before the State Office of Administrative Hearings (SOAH), all proceedings are governed by SOAH's procedural rules unless SOAH has specifically adopted the procedural rules of the agency.

Section 9.2 of this title (relating to Contract Claim Procedure) is being simultaneously amended in this publication. All contract claims must be heard through the contested case procedure before they can be appealed to SOAH.

The department proposes the amendments to §§1.21-1.24, §1.26 and §1.30 to update and clarify the types of claims that are considered contract claims and procedures before SOAH, and to clarify that the department may bring a contested case.

The amendments to §1.21 update the cross-reference to the Occupations Code relating to the sale or lease of motor vehicles, which was codified by House Bill 2813, 77th Legislature, 2001.

The amendments to §1.22 add the definition of "claim." This definition includes the statutory claims that are eligible to be appealed to SOAH. The definition for contract claim is updated to include all the types of claims that are considered contract claims and to add a description of the type of claim to the citation for ease of reference. Contract claims differ from other claims in that they go through the department's contract claim committee as outlined in §9.2 of this title (relating to Contract Claim Procedure).

The main substance of the definition of "person" is deleted from §1.22 and moved to §1.23 as a more appropriate location. The part of the definition excluding the department is removed since it would prevent the department from filing a petition under this section, and the department is specifically authorized to initiate a contested case under existing §1.26. The statement that a contract claim may not be appealed to SOAH unless the contract claim procedure had been completed has been added to comply with the spirit of Transportation Code, §201.112, which authorizes the Texas Transportation Commission (commission) to establish a contract claim procedure, and allows a person who is dissatisfied with the department's resolution of a claim to request a formal administrative hearing before SOAH.

The amendments to §1.24 clarify that the statement of facts should include as an attachment the document issued by the department notifying the petitioner of the decision or action challenged by the petitioner. This attachment will serve as an immediate reference for the basis of the claim. A requirement for the department reference number is added in order for the department to more easily route the claim and assemble the appropriate documents and response. References to the department regarding settlement have been changed to "a party" because the department may also be a petitioner in accordance with the existing §1.26 and the non-department party may offer a settlement.

Section 1.26 is amended to add service of notice of hearing, standard of review, and burden of proof. The threshold for what has been considered adequate notice of a hearing has differed with the administrative judges. This amendment clarifies the notice. A notice of a hearing will be considered sufficient if it includes a copy of the petition and the following information (unless it is stated in the petition): a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing is to be held; and reference to the particular sections of the statutes and rules involved. This notice complies with the requirements of Government Code, §§2001.051-2001.053, concerning contents of notice, and gives each party notice of the substance of the claim.

Pursuant to 1 TAC §155.41(b), the department may allocate the burden of proof, but only allocates the burden to the department where money is sought by the department. In all other instances, the party challenging a department decision or action bears the burden of proof. The standard of review for claims that have already received a review is whether the agency's actions were based on fraud, misconduct, or such gross mistake as would imply bad faith or failure to exercise an honest judgment. The categories that fall under this standard are those categories related to: contract claims; denial or cancellation of sign permits; the denial, suspension, or revocation of a license; and the suspension or revocation of registration for motor carriers and leasing companies. All contract claims fall under the jurisdiction of the contract claim committee pursuant to §9.2 of this title (relating to Contract Claim Procedure), which renders a proposal. The rule pertaining to denial of a permit of a sign along a rural road specifically states that issuance of a permit does not create a property right.

A manager's determination that revocation, suspension, or cancellation of a license or permit, or the suspension or revocation of registration for motor carriers or leasing companies, is the appropriate sanction for the violations found by the inspector is an official act for which there is a presumption in favor of its legality. Under the common law of Texas, there has been a rebuttable presumption in favor of the legality of official acts at least as far back as 1937. This presumption guided the state courts prior to the establishment of SOAH in the mid 1990s, as part of the legislature's attempts to limit the need for judicial recourse while still ensuring independent, third-party review of executory actions. Such orders are not only made prima facie valid by statute, but being official acts there is a presumption in favor of their legality; and the one attacking them upon the grounds that there was not sufficient evidence before the board or administrator to authorize agency action or decision must prove that fact on an appeal from the order canceling such license, permit, or registration.

The manager is not depriving petitioner of a legitimate liberty or property interest, which would invoke a right to a higher level of procedural due process under the Fourteenth Amendment to the U.S. Constitution. Numerous state courts have determined that a permitee or licensee has no vested right to participate in a regulated activity, but has a mere privilege of participation in accordance with the terms of the relevant law, and accepts his permit or license subject to the authority of the executive regulatory authority to cancel it for any violation of the statute or any regulation promulgated by the executive regulatory authority under the authority of the relevant act.

Although a license is a privilege that may be revoked or suspended, an agency's power to do so is limited by constitutional proscriptions against unreasonable or arbitrary action.

The standard of review is higher for claims that are not reviewed by a decision maker. These include claims made under Transportation Code, §681.012, concerning seizure and revocation of disabled placards.

Subsection (d) is added to §1.26 to clarify which party bears the burden of proof. A party seeking monetary damages or penalties shall bear the burden of proof. In all other instances, the party challenging a department decision or action shall bear the burden of proof. This is consistent with case law and standards of proof in court cases.

Section 1.30(a) is amended to allow for parties to file exceptions if the administrative law judge amends the proposal for decision so that the parties have an opportunity to respond to the judge's decision.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five years the amendments as proposed are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Richard D. Monroe, General Counsel, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT

Richard D. Monroe has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be to provide the public with more accurate information about the types of claims that can be contested and the procedures followed in the department's contested cases. There will be no adverse economic affect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the amendments may be submitted to Richard D. Monroe, General Counsel, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on December 13, 2004.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department; and more specifically Transportation Code, §201.112, which provides the commission with the authority to establish rules governing procedures in certain contract claims; and under Government Code, §2001.004, which requires each agency to adopt rules stating the nature and requirements of all available formal and informal procedures.

CROSS REFERENCE TO STATUTE: Government Code, §2001.004.

§1.21. Scope and Purpose.

The sections in this subchapter describe the procedures to be followed in contested cases arising under Government Code, Chapter 2001, with the exception of contested cases arising under Occupations Code, Chapter 2301, Sale or Lease of Motor Vehicles [~~the Motor Vehicle Commission Code, Texas Civil Statutes, Article 4413(36)~~], or under Transportation Code, Chapter 503, Dealer's and Manufacturer's Vehicle License Plates, which are governed by 16 TAC Chapter 111. Except as provided in this subchapter, all contested cases shall be governed by the procedural rules of the State Office of Administrative Hearings.

§1.22. Definitions.

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

(1) Administrative Law Judge--A person appointed by the State Office of Administrative Hearings to conduct a hearing on matters within the department's jurisdiction.

(2) Claim--A claim made pursuant to Occupations Code, Chapter 2302, Salvage Vehicle Dealers; Occupations Code, Chapter 2303, Vehicle Storage Facilities; Transportation Code, §681.012, Seizure and Revocation of Placard; Transportation Code, Chapter 643, Motor Carrier and Leasing Company Registration; Transportation Code, Chapter 645, Single State Registration for Motor Carriers; §21.572 of this title (relating to Notice and Appeal) concerning control of signs along rural roads; 21.149(f) of this title (relating to Licenses) concerning revocation or suspension of a county sign license; or §21.150(k) of this title (relating to Permits) concerning cancellation of a permit.

(3) Contract claim--Any claim arising under a contract governed by Transportation Code, §22.018 (concerning the designation of the department as agent in contracting and supervising for aviation projects); by Transportation Code, Chapter 223 (concerning bids and contracts for highway improvement projects); Transportation Code, §391.091 (concerning erection and maintenance of specific information logo signs, major area shopping guide, and major agricultural interest signs); Chapter 361 (concerning state highway turnpike projects); or by Government Code, Chapter 2254 (concerning professional or consulting services).

[~~(2) Contract claim--Any claim arising under a contract governed by Transportation Code, §22.018, by Transportation Code, Chapter 223, or by Government Code, Chapter 2254.~~]

(4) [~~(3)~~] Department--The Texas Department of Transportation.

(5) [~~(4)~~] Executive director--The chief administrative officer of the department or, if permitted by law, the director's designee.

(6) [~~(5)~~] Party--The department or a person named or permitted to participate in a contested case.

[~~(6) Person--An individual, representative, partnership, corporation, association, governmental subdivision, or public or private organization, or any other entity, other than the department.~~]

(7) Petition--The document that initiates a contested case.

(8) Petitioner--A party who [~~person that~~] files a petition.

§1.23. Filing of Petition.

An individual, representative, partnership, corporation, association, governmental subdivision, or public or private organization, the department, or any other entity [~~A person~~] may seek to initiate a contested case by filing an original and one copy[~~four copies~~] of a petition with the executive director at the department's headquarters building in Austin. A contract claim regarding sanctions cannot be appealed to the State Office of Administrative Hearings unless the Contract Claim Committee procedure is completed.

§1.24. Content of Petition.

(a) A petition must include [~~the following~~]:

(1) the name of the petitioner;

(2) the names of all other known persons with an interest in the outcome of the contested case;

(3) a concise statement of the facts on which the petitioner relies, including as an attachment, if applicable, the document issued by the department that notified the petitioner of the decision or action challenged by the petitioner;

(4) a statement of the relief demanded by the petitioner;

(5) any other matter required by statute; [~~and~~]

(6) the signature of the petitioner or the petitioner's authorized representative; and[~~.~~]

(7) a department reference number, if applicable.

(b) No document including a settlement offer by a party [~~the department~~] may be enclosed with the petition, and the petition may not refer to the substance of a settlement offer [~~made by the department~~].

(c) If the petition concerns a contract claim, a copy of the detailed report and request filed under §9.2(b)(2) of this title (relating to Contract Claim Procedure) must be enclosed with the petition, and the petition must state the date on which the petitioner received written notice of the proposed disposition by the contract claim committee under §9.2(b)(6) [~~§9.2(b)(5)~~] of this title. The petition and its attachments may not otherwise refer to the proposed disposition and may not include a copy of the written notice of the proposed disposition.

§1.26. Initiation of Contested Cases, Service of Notice of Hearing, Standard of Review, and Burden of Proof.

(a) Initiation.

(1) If the executive director finds that a petition meets all legal requirements, the department will initiate a contested case in accordance with the rules of the State Office of Administrative Hearings.

(2) [~~(b)~~] The department may initiate a contested case on its own initiative in accordance with the rules of the State Office of Administrative Hearings.

(b) Service of notice of hearing. Service of the Notice of Hearing shall be accomplished by certified or registered mail to the party's last known address as shown in the department's records. A notice of a hearing in a contested case is sufficient for purposes of notice if it includes a copy of the petition prepared in accordance with §1.24 of this subchapter (relating to Content of Petition), and the following information, unless it is included in the petition:

(1) a statement of the time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing is to be held; and

(3) reference to the particular sections of the statutes and rules involved.

(c) Standard of review.

(1) The standard of review is reasonableness, if not otherwise specified, and for claims made pursuant to Transportation Code, §681.012, Seizure and Revocation of Placard.

(2) The standard of review is whether the agency's actions were based on fraud, misconduct, or such gross mistake as would imply bad faith or failure to exercise an honest judgment for:

(A) contract claims;

(B) claims related to Occupations Code, Chapter 2302, Salvage Vehicle Dealers;

(C) claims related to Occupations Code, Chapter 2303, Vehicle Storage Facilities;

(D) claims related to revocation or suspension of a county sign license under §21.149(f) of this title (relating to Licenses);

(E) claims related to cancellation of a permit under §21.150(k) of this title (relating to Permits);

(F) claims related to control of signs along rural roads under §21.572 of this title (relating to Notice and Appeal);

(G) claims related to motor carrier and leasing company registration, Transportation Code, Chapter 643; and

(H) claims related to single state registration for motor carriers, Transportation Code, Chapter 645.

(d) Burden of proof. A party seeking monetary damages or penalties shall bear the burden of proof. In all other instances, the party challenging a department decision or action shall bear the burden of proof.

§1.30. Filing of Exceptions and Replies.

(a) A party may file exceptions to an administrative law judge's proposal for decision or an amended proposal for decision no more than 20 days after service of the proposal for decision. A reply to exceptions must be filed no more than 15 days after the filing of the exceptions.

(b) Exceptions and replies to exceptions must be filed with the executive director at the department's headquarters building in Austin. A copy [~~Copies~~] must be filed simultaneously with the administrative law judge.

(c) A request for an extension of time in which to file exceptions or a reply must be filed with the executive director no later than three days before the date sought to be extended. The request must be served on all parties by facsimile or hand delivery on the date on which it is filed, or if that is not feasible, by overnight delivery service. A request for an extension of time will be granted only in extraordinary circumstances when it is necessary in the interest of justice.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406466
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-8630

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CHAPTER 9. CONTRACT MANAGEMENT
SUBCHAPTER A. GENERAL

43 TAC §9.2

The Texas Department of Transportation (department) proposes amendments to §9.2, concerning contract claim procedure.

EXPLANATION OF PROPOSED AMENDMENTS

Transportation Code, §201.112, governs contract claims that are heard before the department's contract claim committee.

On April 16, 2004, the Texas Supreme Court issued an opinion on certified questions from the Fifth Circuit concerning the case *Interstate Contracting Corporation v. the City of Dallas*. The decision was that prime contractors could bring pass through claims for subcontractors if the prime contractor had continuing liability to the subcontractor. The amendments include the subcontractor's claims that are brought through the prime contractor, but require the prime contractor to remain liable to the subcontractor for damages caused by the prime contractor to the subcontractor.

Because of this recent court decision, §§1.21-1.24, §1.26, and §1.30 of this title (relating to Contested Case Procedure) are simultaneously amended in this publication along with these amendments to §9.2. All contract claims heard by the State Office of Administrative Hearings (SOAH) must be heard first by the contract claim committee before they can be reviewed by SOAH in accordance with Transportation Code, §201.112.

The proposed amendments to subsection (a) include changing the definition of "commission" to the Texas Transportation Commission. The number of members was changed from three to five by Senate Bill 409, 78th Legislature, Regular Session, 2003, and the number of members is not necessary to the definition. The definition of "contract claim" is amended to add a description of the type of claim to the citation for ease of reference. The definition is further clarified to include new claims that have been authorized by recent case law. These are claims that may be brought based on privity of contract or on a prime contractor's continuing liability to a subcontractor for alleged damages sustained by the subcontractor arising from the contract, but not if the subcontractor releases the prime contractor from liability for damages caused by the prime contractor to the subcontractor. The definition of "contractor" has been moved to the definition of "prime contractor," to avoid confusion with references to subcontractor. A definition has been added for a "project" to include that portion of a contract that can be separated into a distinct facility or work unit from the other work in the contract.

In subsection (b) the disputes involved are clarified to be those disputes relating to the project engineer's final decision since a project engineer has the authority to make a final decision's regarding the project, and that authority had been recognized in case law. A reference to the "contractor" regarding resolution of a claim has been changed to "either party" because the department may initiate a contested case on its own initiative in accordance with §1.26 of this title (relating to Initiation of Contested Cases). If the department can initiate a case with SOAH under §1.26 of this title, and because the contract claim cases must first go before the contract claim committee before they can be filed with SOAH under §1.24 of this title (relating to Content of Petition), then the department needs to have the ability to go before the contract claim committee. "Contractor" is also changed to "claimant" in several areas for the same reason.

A statute of limitations of two years to file a claim has been added to subsection (b)(2). The claim must be filed within one year after the date of the acceptance of the project, as defined in Subsection (a). The current rules do not state a deadline for filing. One year is a reasonable time for a claimant to determine whether a claim exists. Dividing the project into units enables claims to be filed as each segment of a long term contract is completed.

Subsection (b)(3) is added to clarify that a party with a contract claim, even when related to a direct appeal to the State Office of Administrative Hearings (SOAH) of a contract sanction, must complete the contract claim committee procedure before an appeal can be made to SOAH. This discourages the bringing of claims on a piecemeal basis, and encourages the opportunity for the entire claim to be resolved at the contract claim committee level.

Subsection (b)(6) relates to the 20 day requirements for acceptance of the contract claim committee's final order or for an appeal by either party.

The substance of subsection (b)(8) has been moved to subsection (b)(7) and the subsequent subparagraphs renumbered as a more logical flow. The current subsection (b)(8) relates to the contract claim committee's decision being final if there is no appeal within 20 days. New subsection (b)(7) adds that the recommendation is forwarded to the executive director for adoption as a final order, and that further litigation is barred by the doctrines of issue and claim preclusion. The issuance of a final order by the executive director, rather than the contract claim committee, better fits within structure of Government Code, Chapter 2001, the Administrative and Procedure Act.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five years the amendments are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments as proposed. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Richard D. Monroe, General Counsel, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT

Richard D. Monroe has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be to provide the public with more accurate information about the types of claims that can be contested and the procedures followed in the department's contested cases. There will be no adverse economic affect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the amendments may be submitted to Richard D. Monroe, General Counsel, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on December 13, 2004.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.112, which provides for the department to establish rules for the informal resolution of a claim arising out of certain contracts.

CROSS REFERENCE TO STATUTE: Transportation Code, §201.112.

§9.2. Contract Claim Procedure.

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

(1) Commission--The [~~three member body appointed by the governor to compose the~~] Texas Transportation Commission.

(2) Committee--The Contract Claim Committee.

(3) Contract claim--A claim for additional compensation, time extension, or any other reason, arising out of a contract between the State of Texas, acting in its own capacity or as an agent of a local government, and a prime contractor, which is entered into and administered by the Texas Department of Transportation pursuant to Transportation Code, Section 22.018 (concerning the designation of the department as agent in contracting and supervising for aviation projects), Section 391.091 (concerning erection and maintenance of specific information logo, major area shopping guide, and major agricultural interest signs), Chapter 223 (concerning bids and contracts for highway improvement projects, Chapter 361 (concerning state highway turnpike projects, or Government Code, Chapter 2254, Subchapters A and B (concerning professional or consulting services). The claim may be brought by the department or a prime contractor:

(A) based on privity of contract; or

(B) on a prime contractor's continuing liability to a subcontractor for alleged damages sustained by the subcontractor arising from the contract, but not if the subcontractor releases the prime contractor from liability for damages caused by the prime contractor.

[(4) Contractor--An individual, partnership, corporation, or other business entity that is a party to a written contract with the State of Texas which is entered into and administered by the Texas Department of Transportation pursuant to Transportation Code, Section 22.018, Section 391.091, Chapter 223, Chapter 361, or Government Code, Chapter 2254, Subchapters A and B.]

(4) [(5)] Department--The Texas Department of Transportation.

(5) [(6)] Department office--The department district, division, or office responsible for the administration of the contract.

(6) [(7)] Department office director--The chief administrative officer of the responsible department office, such officer to be a district engineer, division director, or office director.

(7) [(8)] District--One of the 25 districts of the department.

(8) [(9)] Executive director--The executive director of the Texas Department of Transportation.

(9) Prime contractor--An individual, partnership, corporation, or other business entity that is a party to a written contract with the State of Texas which is entered into and administered by the Texas Department of Transportation pursuant to Transportation Code, Section 22.018, Section 391.091, Chapter 223, Chapter 361, or Government Code, Chapter 2254, Subchapters A and B.

(10) Project--The portion of a contract that can be separated into a distinct facility or work unit from the other work in the contract.

(b) Contract claim committee.

(1) The executive director will name the members and chairman of a contract claim committee or committees to serve at the executive director's [his or her] pleasure. The chairman may add members to the committee, including one or more district engineers who will be assigned to the committee on a rotating basis, with a preference, if possible, for district engineers of districts that do not have a current contractual relationship with the prime contractor involved in the contract claim. It will be the responsibility of a committee to gather information, study, and meet informally with prime contractors, if requested, to resolve any disputes relating to the department's project engineer's final decision [that may exist between the department office] and the prime contractor, and which result in one or more contract claims.

(2) The commission stresses that, to every extent possible, disputes between a prime contractor and the department's project engineer [or other department employee in charge of a project] should be resolved during the course of the contract. If, however, after completion of a contract, or when required for orderly performance prior to completion, resolution of a contract claim is not reached by the parties [with the department office], either party [the contractor] may file a detailed report and contract claim request with the department office director under whose administration the contract was or is being performed, the department's Construction Division, or the committee. The claim must be filed within one year after the date of the acceptance of the project. Documents filed with the office director or the Construction Division will be transmitted to the committee.

(3) A contract claim, even when related to a direct appeal to the State Office of Administrative Hearings (SOAH) of a contract sanction, cannot be appealed to SOAH before the Contract Claim Committee procedure is completed.

(4) [(3)] The committee will secure detailed reports and recommendations from the responsible department office, and may confer with any other department office deemed appropriate by the committee.

(5) [(4)] The committee will then afford the prime contractor an opportunity for a meeting to informally discuss the disputed matters and to provide the prime contractor an opportunity to present relevant information and respond to information the committee has received from the department office.

(6) [(5)] The committee chairman will give written notice of the committee's proposed disposition of the claim to the parties [contractor]. If that disposition is acceptable, the claimant [contractor] shall advise the committee chairman in writing within 20 days of the date such notice is received, and the chairman will forward to the commission an agreed order [disposition] involving, when required, payment either to the department or the [to the] prime contractor [, for a final and binding order] on the claim. If the claimant [contractor] is dissatisfied with the proposal of the committee, the claimant [contractor] may petition the executive director for a formal administrative hearing to litigate the claim pursuant to the provisions of §§1.21 et seq. of this title (relating to Contested Case Procedure).

(7) If the claimant fails to petition the executive director within 20 days after notice of the committee's recommendation is received, that recommendation will be forwarded to the executive director for adoption as a final order, and all further litigation of claims on the project or contract by the claimant shall be barred by the doctrines of issue and claim preclusion.

(8) [(6)] Proceedings before the department office director or the committee are in the nature of an attempt to mutually resolve a contract claim without litigation and are not admissible for any purpose in a formal administrative hearing provided in paragraph (6) [(5)] of this subsection. All oral communications, reports, or other written documentation prepared by department staff in connection with the analysis of a contract claim are part of the attempt to mutually resolve a contract claim without litigation, and are also not admissible for any purpose in a formal administrative hearing provided in paragraph (6) [(5)] of this subsection.

(9) [(7)] The administrative law judge's proposal for decision in a formal administrative hearing provided in paragraph (6) [(5)] of this subsection shall be submitted to the executive director for adoption. The executive director may change a finding of fact or conclusion of law made by the administrative law judge or may vacate or modify an order issued by the administrative law judge. The executive director shall provide a written statement containing the reason and legal basis for any change.

[(8) If the contractor fails to submit the petition within 20 days after notice of the committee's recommendation is received, that recommendation will be final, and all further appeal by the contractor shall be barred.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406467

Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-8630

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SUBCHAPTER C. CONTRACTING FOR ARCHITECTURAL, ENGINEERING, AND SURVEYING SERVICES

The Texas Department of Transportation (department) proposes amendments to §§9.30 - 9.39, §9.41, and §9.42, new §9.43, and the repeal of §9.40 and §9.43, concerning contracting for architectural, engineering, and surveying services.

EXPLANATION OF PROPOSED AMENDMENTS, NEW, AND REPEALED SECTIONS

Architectural, engineering, and surveying services are procured by the department in accordance with Government Code, Chapter 2254, Subchapter A, and 23 CFR §172.5.

The proposed amendments clarify and refine the language to improve consistency in the interpretation and application of procedures for provider precertification, and the selection, negotiation, management, and evaluation of contracts with architects, engineers, and surveyors.

Section 9.30 is amended to revise the reference to Transportation Code §361.042, which was renumbered as §361.032 by the 78th Legislature, Regular Session, 2003. Section 9.30 is also amended to update the title of referenced §9.33 to its proposed revised title (relating to Notice of Intent and Letter of Interest).

Section 9.31 is amended to: delete the definitions of "constructability," "construction engineering," "construction inspection," "construction management," "consultant review committee (CRC)," "FONSI," "graduate engineer," "IESNA," "ITS," and "small business concern" as they are no longer used; clarify the definition of "administrative qualification;" add a definition for "Audit Office;" add a definition for "specific deliverable contract," which replaces deleted "project specific contract" and clarifies the types of contracts; clarify the definition of "department project manager" to include management of contracts; add a definition for "Design Division;" revise the definition of "historically underutilized business" to reflect the name change of the General Services Commission to the Texas Building and Procurement Commission; clarify the term and definition of "indefinite deliverable contract;" add a definition for "indirect cost rate guidance" to help determine indirect costs and to replace the term "overhead guidelines" which is deleted; add a definition for "letter of interest" (LOI) which is the prime provider's responsive document; revise the definitions of "licensed state land surveyor" to include the citation to the laws concerning this license as re-codified in Occupations Code by the 78th Legislature, Regular Session; revise the definitions of "long list" to include that the LOI must be acceptable, "lower tier debarment certification" to remove a reference to a form that is no longer used, and "metropolitan district" to add the Pharr, El Paso, Corpus Christi and Lubbock districts; add a definition for "notice of intent" (NOI) as the department's indication it intends to enter into professional contracts;" revise the definition of "short list meeting" to include distribution of the Interview and Contract Guide; and delete the term "technical precertification," which is replaced with the clearer term "precertification."

Section 9.32 is amended by reorganizing the section into subsections (a) and (b). Subsection (a) is titled "Policy" and includes paragraphs (1)-(8) as they currently exist. Subsection (b) is added and titled "Organizations" and is equivalent to §9.33(a)(3) which is proposed to be deleted and relocated to this section as a more appropriate location.

Section 9.33 is amended to change the section title to "Notice of Intent and Letter of Interest" to clarify the two distinct processes that this section covers. Subsection (a) is renamed "Notice of Intent (NOI)" for clarification. References to an RFP number are deleted because there is no longer a defined RFP number. References throughout this section to listed categories in §9.43 are revised because the proposed repeal of §9.43 will eliminate listed categories since they will be posted on the department's website. The list of what the NOI identifies is expanded to include the assigned HUB or DBE participation goal for the contracts with additional text relocated to this more appropriate location from §9.37(c). Subparagraphs (a)(2)(F)-(H) are deleted because this information is no longer contained in the newspaper notices. Only the essential information is published in the newspaper, and a reference to the department's website is given for more information. Paragraph (a)(3) is deleted and relocated to a more appropriate location in §9.32. The requirement for the Design Division Director to approve an increase in the maximum number of pages in the letter of interest (LOI) is eliminated. The previously required approval adds unnecessary time to the process and is not warranted based on review of request history. Clarification is added to indicate that stated requirements, including length, apply unless specified otherwise in the NOI because the need for additional pages is typically associated with larger and more complicated projects. Clauses (i) and (ii) under subsection (b)(4)(B) are reversed for clarity and amended to allow the prime provider's and subprovider's key personnel to be replaced during the selection process and before contract execution only by another person from the prime provider's or subprovider's proposed team in the LOI and approved by the consultant selection team (CST). This provides a consistent process for a situation that occurs frequently and allows the decision control to remain with the CST. Wording for replacement of the project manager during the selection and award process is clarified to indicate replacement is acceptable by a team member during the selection process and before contract execution. Under the list of what the LOI shall include, the reference to similar project-related experience is revised to eliminate reference to information in the precertification database. This data is only accessible to precertification review officers for the purpose of precertification only. The data is not collected in a format for the purpose of evaluating an individual's experience for contract selection. The name and contact information for references is clarified to be for references from the department or other entities.

Section 9.34 is renamed "Short List Determination" for consistency in section titles. The consultant selection team composition requirements are modified to require a minimum of one professional engineer for engineering contracts, a minimum of one professional engineer or registered or licensed professional land surveyor for surveying contracts, and a minimum of one registered architect for architectural contracts. This change further ensures a qualified selection team for the purpose of evaluating and selecting providers based on their proposed qualifications.

In order to protect the department and the general public, firms may be disqualified from the long list if the department or the firm's references have knowledge that the firm or an employee of the firm has a record of unprofessional conduct, including, but not limited to, whether the appropriate licensing board has cited the firm or employee for a violation of its rules concerning conduct. The long list qualification is clarified to indicate that the letters of interest are what are specifically reviewed for submittal requirements and precertification requirements. The team is not actually evaluated until after the long list is determined. The long list evaluation was revised to clarify that the CST and not the department reviews the LOIs. It is also clarified that the CST will consider the identified criteria in its review of the long-listed providers and not all interested providers. The second criterion listed is revised to clarify that the project manager's experience refers to the provider's project manager. The acronym RIF is identified as relative importance factor. Subsection (f) is renamed Short List to more appropriately represent the information addressed. The acronym RFP is identified as request for proposal.

Section 9.35 is amended to delete language regarding the opportunity to conduct a short list meeting. A short list meeting is at the discretion of the managing officer who best knows the complexity of the project. Subsection (e) clarifies where or when references are identified. Reference to Consultant Review Committee (CRC) approval of other criteria is eliminated because the CRC no longer functions in this capacity.

Section 9.36 is renamed "Short List Interviews and Evaluation" for consistency and clarification in section titles. The section is amended to delete the last sentence of subsection (a) because it potentially conflicts with the previous sentence that clearly states the required attendance of the prime provider's project manager at an interview. Subsection (d) is renamed "Interview evaluation criteria" for consistency and clarification in subsection titles. Subsection (d) is revised to incorporate language consistent with the previous section and clarify that the CST will evaluate interviews based on the listed criteria. The criteria wording is revised to be consistent with the previous section, §9.35. Performance scores or references will now be considered in the interview evaluation, whereas currently they are only considered if no proposal is required. Past performance is an important indicator as to how a firm will perform and the addition here allows it to be considered in the possible procurement scenarios of an interview with no proposal, a proposal with no interview, and an interview and proposal. Reference to CRC approval of other criteria is eliminated because the CRC no longer functions in this capacity.

Section 9.37 is amended to add additional steps for breaking a tie. Subsection (c) is deleted and relocated to a more appropriate location in §9.33. Reference to the CRC is replaced by reference to the Design Division for review of the selection package. Renumbered subsection (f) is revised to clarify information required by the selected provider for negotiation. References to the relevant law regarding negotiation requirements have been added. The reference to 23 CFR §172.9 is replaced by the reference to 23 CFR §172.5(c) which is the current CFR section addressing federally funded contracts not being based on percentage of construction cost. Subsection (f)(2) is renamed "Negotiation Period" to more appropriately reflect the information covered. The section is amended to allow approval of a unique negotiation schedule for any contract and not just multiple contract selections. The section is amended to clarify order of negotiation for single and multiple contract selection processes. Reference to the professional provider is clarified to refer to the prime provider.

Section 9.38 is amended to clarify applicable credit for DBE/HUB participation and eliminate the unnecessary statement that a HUB prime provider perform at least 25% of the work. The section already states that a prime provider shall perform at least 30% of the contracted work. The section is amended to delete the restriction that no subprovider may perform a higher percentage of work than the prime provider. The prime provider is required to perform at least 30% of the work and is ultimately responsible for the contracted work. Elimination of this constraint will allow the prime provider more flexibility in determining the optimum distribution of work among subproviders. Language is also deleted regarding subcontract content and review requirements since current standard prime contract language adequately addresses subcontract requirements. The section is amended to specify prior written consent of the department for prime provider project manager replacement. Reference to department Form 132 is eliminated since this is no longer a form required by the department. A subsection is added for indefinite deliverable contract work authorizations, which are negotiated during the contract period. The subsection addresses the procedure of ending unsuccessful negotiations for a work authorization with one provider before initiating negotiations with another. The section is amended to clarify that the department's audit office may perform an audit. The section is also amended to reflect the pending changes to the department's provider performance evaluation form and process regarding when and how a provider is evaluated.

Section 9.39 is renamed "Selection and Contract Types" to reflect section content. Subsection (a) is added to address selection types. The number of selection types is changed from four to three since one of the four currently identified is best addressed as a contract type. The cause for an emergency contract selection is clarified and subparagraphs are added to address eligibility of the firm's project manager, the notification process, and the selection process. Subsection (b) is added to address contract types that are identified as indefinite deliverable and specific deliverable. Limitations of the indefinite deliverable contract type are clarified to specify divisions as eligible for the same $5 million dollar amount as a metropolitan or border district. The rules have never limited the divisions, except for the turnpike division, which was limited to $5 million. Since the divisions support 25 districts statewide, the higher number is necessary. The Lubbock and Corpus districts' limitations are increased from $2 million to $5 million since population growth has resulted in their addition to the definition of "metropolitan district." El Paso and Pharr have also been added to that definition, but their limitation was already at $5 million since they also are border districts.

Amendments also allow the maximum amount of $5 million and the two year work authorization period to be exceeded if approved by the Texas Transportation Commission (commission) prior to NOI publication to accommodate some of the very large projects such as the Trans-Texas Corridor. This will allow for additional flexibility, if warranted, in the use of this contract type.

Section 9.40 is repealed. Information in this section related to DBE/HUB goals is adequately addressed in §§9.50 et.seq. of this chapter (relating to Business Opportunity Program).

Section 9.41 is amended to appropriately reference §9.43 as it is proposed to be repealed and reenacted as a new section. Subsections (a) and (d)-(g) are renamed for clarification. Subsection (b) is revised to clarify who may apply. Precertification questionnaire is changed to precertification application. Reference to the CRC is changed to the Design Division. Reference to a precertification information packet is deleted because the information is now available on the department's website. The list of information now available is clarified. Reference to prime providers and subproviders is revised to simply reference providers or a firm for clarification and consistency where appropriate. Former subsection (c), regarding Instructions, is deleted since there is no need to annually publish the instructions in the Texas Register because the process and instructions are currently maintained on a daily basis on the department's website. Under renumbered subsection (e), clarification is added with respect to a firm's precertification status and a firm employee's precertification status. Under renumbered subsection (h), regarding Appeals, the reference to CRC is changed to Design Division in one instance and in another instance it is changed to the department for review of the information to determine precertification as the CRC no longer serves this function. The last sentence is revised to clarify a written complaint regarding precertification denial may be filed with the executive director or his or her designee.

Section 9.42 is amended to clarify which firms are exempt from administrative qualification. The reference to §9.43 is replaced by a reference to the department's website as a result of proposed repeal of §9.43. The typical compensation type for firms exempt from administrative qualifications is more appropriately indicated as units of service and lump sum is deleted. Reference to the CRC is replaced by reference to the Design Division. References to overhead rate are replaced by indirect cost rate as a more appropriate term. The list of acceptable indirect cost rate audit preparers is revised to include an agency of the federal government, another state transportation agency, or a local transit agency in accordance with the Single State Audit Act. The department's Audit Office will be given access to the audit work papers if the audit is performed by an independent certified public accountant. The regulations and guidelines applicable to audit report preparation are clarified. Procedures related to an indirect cost rate projection are clarified for providers who have been in operation for less than one fiscal year. Rates the department will consider by job classification are revised to include salary rates, range of rates, or average rates.

Section 9.43 is repealed and new §9.43, "Precertification Requirements," is proposed. The repeal of §9.43 eliminates the work categories, descriptions, and requirements for precertification since new §9.43 provides that this information will be maintained on the department's website. The addition of or any change to a work category will require a commission minute order. The agenda for commission meetings is posted with the Secretary of State's Office and also on the department website. By using a minute order to change the work categories, the public is afforded an opportunity to comment. Maintenance of the work categories on the website will provide more flexibility in updating categories to meet the outsourcing needs of the districts and divisions without the requirement of proposing changes to the Texas Administrative Code. New §9.43 reestablishes the following provisions from the repealed §9.43. The section allows a firm to be precertified in the technical work categories by providing the listed requirements that are maintained on the department's website. A firm may only submit an application for an individual who is employed by that firm at the time of submittal for precertification, and allows the provider to use experience that is either prior to or after licensure unless otherwise stated in a specific category. The employee must be licensed to practice in any state that is recognized by the appropriate Texas board of licensing.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five years the amendments, new section, and repeals as proposed are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the amendments, new section, or repeals. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Mark A. Marek, P.E., Director, Design Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments, new section, or repeals.

PUBLIC BENEFIT

Mr. Marek has also determined that for each of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments, new section, and repeals will be to improve consistency in the interpretation and application of procedures for provider precertification and the selection, negotiation, management, and evaluation of contracts. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments, new section, or repeals may be submitted to Mark A. Marek, P.E., Director, Design Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on December 13, 2004.

43 TAC §§9.30 - 9.39, 9.41 - 9.43

STATUTORY AUTHORITY

The amendments and new section are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Government Code, Chapter 2254, Subchapter A, which sets forth requirements governing the procurement of professional services.

CROSS REFERENCE TO STATUTE: Government Code, Chapter 2254, Subchapter A.

§9.30. Purpose.

This subchapter establishes standard procedures for selection and contract management of architectural, professional engineering, and land surveying service providers in accordance with Government Code, Chapter 2254, Subchapter A, the Professional Services Procurement Act, and Transportation Code, §223.041, and §361.032 [~~§361.042~~]. This subchapter only applies to a contract that requires a professional engineer, registered architect, or registered or licensed professional land surveyor. Prime providers and subproviders shall be precertified for contracts which require architectural, engineering, or surveying services, except as described in §9.33(b)(3) of this title (relating to Notice of Intent and Letter of Interest).

§9.31. Definitions.

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

(1) AASHTO--American Association of State Highway and Transportation Officials.

(2) Administrative qualification--A department process conducted to determine if a prime provider or subprovider can:

(A) support all the various rates proposed to do the work;

(B) has an indirect cost rate audit that meets department requirements;

(C) has a job cost accounting system adequate for segregating direct and indirect costs; and

(D) is aware of federal cost eligibility and documentation requirements.

(3) Audit Office--An office of the department whose internal function conducts independent and objective reviews of departmental operations and procedures to ensure that they are functioning as intended and whose external function has the responsibility to audit cost reimbursement/negotiated contracts external to the department including review of indirect cost rate data.

[~~(2) Administrative qualification--A department process conducted to determine if a prime provider or subprovider meets the requirements of 23 Code of Federal Regulations (CFR) 172.5(c) concerning the administration of engineering and design related service contracts.~~]

(4) [~~(3)~~] Available personnel--The total number of personnel employed by the provider proposed to be used on the advertised contract.

(5) [~~(4)~~] Border district--One of the geographical areas of the department managed by a district engineer that is headquartered in El Paso, Laredo, or Pharr.

(6) [~~(5)~~] Business opportunity programs section of the Construction Division (CSTB)--The department section that certifies DBEs and administers the DBE and HUB programs.

(7) [~~(6)~~] CCIS--Consultant Certification Information System.

(8) [~~(7)~~] Close out--The actions required to close out or complete the contract, including receipt and acceptance of deliverables, resolution of audit findings, receipt of outside approvals if applicable, resolution of other contract-related issues, and issuance of final payment.

[~~(8) Constructability--The ability of a project to be accurately constructed from information presented in plans and specifications.~~]

[~~(9) Construction engineering--The interpretation of plans and specifications and formulation of engineering decisions during the period that the project is under construction.~~]

[~~(10) Construction inspection--Inspection of construction methods and materials by inspectors who report directly to the department's project manager.~~]

[~~(11) Construction management--Construction engineering performed by the professional engineer in responsible charge of the construction project to direct the contractor concerning changes, additions, or deletions to the project.~~]

[~~(12) Consultants review committee (CRC)--The department committee that oversees the provider review process.~~]

(9) [~~(13)~~] Consultant selection team (CST)--The department's managing office team that selects the long list and short list and evaluates proposals and interviews.

(10) [~~(14)~~] Disadvantaged business enterprise (DBE)--Any business certified by the department in accordance with 49 CFR Part 26.

(11) [~~(15)~~] DBE/HUB goal participation--The participation goal for DBE/HUB providers expressed as a percentage of the total cost of the contract.

(12) [~~(16)~~] DBE/HUB special provision--A special provision to the provider contract that identifies DBE/HUB program requirements.

(13) [~~(17)~~] Debarment certification--A certification that the provider and its principals are not debarred from participation and not under consideration for debarment anywhere, and are eligible to perform the contract.

(14) [~~(18)~~] Department--The Texas Department of Transportation.

(15) [~~(19)~~] Department project manager--The department employee designated [~~in the contract~~] as the official contact for management of the contract and all correspondence between the department and the provider.

(16) Design Division--The department division responsible for overseeing the contracting procedures for professional services, including engineering, architectural, and surveying services.

(17) [~~(20)~~] FHWA--The Federal Highway Administration.

[~~(21) FONSI--Finding of No Significant Impact.~~]

(18) [~~(22)~~] Good faith effort--A provider must demonstrate to the department's satisfaction, that sufficient effort on its part was made to obtain DBE/HUB participation. Good faith effort is identified in the DBE/HUB Special Provision to the contract.

[~~(23) Graduate engineer--An individual who meets the educational requirements for registration as provided in the Texas Engineering Practice Act.~~]

(19) [~~(24)~~] Historically underutilized business (HUB)--Any business so certified by the Texas Building and Procurement [~~General Services~~] Commission.

[~~(25) IESNA--The Illuminating Engineering Society of North America.~~]

(20) Indefinite deliverable contract--A contract containing a general scope of services that identifies the types of work that will be later required under work authorizations, but does not identify deliverables, locations, or timing in sufficient detail to define the provider's responsibilities under the contract.

(21) Indirect cost rate guidance--*Uniform Audit and Accounting Guide* for audits of transportation consultants published by AASHTO. This guidance is modified by the *Differences Between TxDOT and AASHTO Requirements* as described on the department's website.

[~~(26) Indefinite delivery contract--A contract that contains a general scope of services, maximum contract amount, and contract termination date in which contract rates are negotiated prior to contract execution and work is authorized as needed.~~]

(22) [~~(27)~~] Interview and Contract Guide (ICG)--An instructional document furnished to providers on the short list when a Request for Proposals is not used.

(23) Letter of Interest (LOI)--A letter from a prime provider to be prepared and submitted in response to and according to instructions in a Notice of Intent.

[(28) ITS--Intelligent Transportation System.]

(24) [(29)] Licensed state land surveyor--A professional land surveyor described in Occupations Code, Chapter 1071 [Texas Civil Statutes, Article 5282c, §2(4)].

(25) [(30)] Long list--The list of qualified providers submitting an acceptable [a] letter of interest for a contract.

(26) [(31)] Lower tier debarment certification [(form 1734)]--A debarment certification form that is completed by subproviders or other lower tier participants.

(27) [(32)] Lower tier participant--A subprovider or other participant in the contract, other than the state, that is not the prime provider.

(28) [(33)] Managing office--The division, office, or district with the responsibility for awarding and managing the contract.

(29) [(34)] Managing officer--The division director, office director, or district engineer of the managing office.

(30) [(35)] Metropolitan district-- One of the geographical areas of the department managed by a district engineer that is headquartered in Austin, Corpus Christi, Lubbock, Dallas, El Paso, Fort Worth, Houston, Pharr, or San Antonio.

(31) Notice of Intent (NOI)--Formal notice of the department's intent to enter into one or more professional service contracts with instructions or reference to instructions for preparation and submittal of a Letter of Interest.

(32) Precertification --A review process conducted by the department to determine if a prime provider or subprovider meets the minimum technical requirements to perform work identified in a work category.

[(36) Overhead guidelines--Instructions prepared by the department's Audit Office to assist the provider in administrative qualification.]

(33) [(37)] Prime provider--The provider awarded a department provider contract.

(34) [(38)] Professional engineer--An individual licensed to practice engineering in the state or states that he or she performs professional services.

(35) [(39)] Professional services provider (provider)--An individual or entity that provides engineering, architectural, or surveying services.

[(40) Project specific contract--A contract that contains a specific scope of services, maximum contract amount, and contract termination date and authorizes the provider to perform the entire scope of work.]

(36) [(41)] Registered architect--An individual licensed to practice architecture in the state or states that he or she performs professional services.

(37) [(42)] Registered professional land surveyor--An individual licensed to perform land surveying in the state or states that he or she performs professional services.

(38) [(43)] Request for proposal (RFP)--A request for submittal of a technical proposal from a provider that demonstrates competence and qualifications to perform the requested services, and shows an understanding of the specific contract.

(39) [(44)] Relative importance factor (RIF)--The numerical weight of each evaluation criterion as it relates to a particular contract.

(40) [(45)] Short List--The list of providers from the long list, selected by the CST, that best meet the requirements indicated by the letter of interest.

(41) [(46)] Short list meeting--A meeting held with the providers on the short list to answer questions regarding the contract and distribute the RFP or ICG prior to submittal of proposals or interviews.

[(47) Small business concern--A small business as defined in the Small Business Act, codified in 15 United States Code §632, and relevant regulations.]

(42) Specific deliverable contract--A contract containing a specific scope of services that identifies deliverables, locations, and timing in sufficient detail to define the provider's responsibilities under the contract, although additional particulars may later be enumerated in work authorizations.

(43) [(48)] Subprovider--A provider proposing to perform work through a contractual agreement with the prime provider.

(44) [(49)] Team--The provider and all proposed subproviders who will be working on a particular contract.

[(50) Technical precertification--A review process conducted by the department to determine if a prime provider or subprovider meets the technical requirements to perform work identified in a work category.]

§9.32. Provider Services Policy.

(a) Policy. Pursuant to Transportation Code, §223.041, it is the policy of the department to use private sector professional services to assist in accomplishing its activities in providing transportation projects. In order to do so, the department may contract the following types of work:

(1) preliminary engineering, design, plan work, specifications, and estimates;

(2) construction engineering and inspection;

(3) bridge inspection and scour analysis services;

(4) environmental engineering, project observation, and inspection;

(5) architectural design, plan work, specifications, and estimates;

(6) architectural observation and inspection;

(7) surveying and mapping; and

(8) other engineering, architectural, or surveying services as defined in Government Code, Chapter 2254, Subchapter A.

(b) Organizations. The department will publish quarterly a statewide list of projected contracts for consulting engineering, architectural, and surveying services and will provide upon request, or make available on the department's web site, a copy of each list to community, business, and professional organizations for dissemination to their membership.

§9.33. Notice of Intent and Letter of Interest.

(a) Notice of Intent (NOI).

(1) Electronic notice. Not less than 21 days before the letter of interest due date, the department will post on an electronic bulletin board a notice identifying:

(A) the proposed contract [~~or RFP~~] number;

(B) work category codes;

(C) type of selection in accordance with §9.39 of this title (relating to Selection Types);

(D) the general description of the project and work to be done;

(E) the due date for providers to send letters of interest to the department;

(F) qualification information if the work type is not an approved category according to [~~listed as a category in~~] §9.43 of this title (relating to Precertification Requirements [~~Qualification Requirements by Work Group~~]);

(G) whether the department has waived the precertification requirement of §9.41 of this title (relating to Precertification) when the total contract fee for professional services is anticipated to be less than $250,000 on an individual contract; [~~and~~]

(H) selection criteria to be used to determine the short list; and

(I) the assigned HUB or DBE participation goal for the contract(s) (The department may assign individual contract DBE or HUB goals pursuant to 49 CFR Part 26 or 1 TAC §111.13, respectively.).

(2) Newspaper notice. Not less than 21 days before the letter of interest due date, the department will publish a notice in a local newspaper within the geographical area of the district, division, or office in which the work will be performed. If the newspaper fails to print the notice, the department will consider the notice posted. The notice will contain:

(A) the proposed contract [~~or RFP~~] number;

(B) the general description of the project and work to be done;

(C) the due date for providers to send letters of interest to the department;

(D) the contact person; and

(E) the location of the electronic bulletin board that contains more information. [~~;~~]

[~~(F) the type of work needed and its minimum qualifications, if the work category is not listed in §9.43 of this title (relating to Qualification Requirements by Work Group);~~]

[~~(G) the department's determination as to whether to waive the precertification requirement of §9.41 of this title (relating to Precertification) when the total contract fee for professional services is anticipated to be less than $250,000 on an individual contract; and~~]

[~~(H) selection criteria to be used to determine the short list.~~]

[~~(3) Organizations. The department will publish quarterly a statewide list of projected contracts for consulting engineering, architectural, and surveying services and will provide upon request, or make available on the department's Web site, a copy of each list to community, business, and professional organizations for dissemination to their membership.~~]

(b) Letter of interest (LOI).

(1) The provider shall send a letter of interest to the department notifying the department of the provider's interest in the contract not later than the deadline published in the notice.

(2) The following requirements apply unless otherwise specified in the LOI. The letter of interest will consist of a minimum of three and a maximum of five pages plus attachments[~~, unless otherwise approved by the director of the Design Division~~]. The maximum page length will be stated in the notice. Attachments will be restricted to precertification information required in subsection (b)(3) of this section. The department will accept a letter of interest by electronic facsimile.

(3) To be considered:

(A) a prime provider or a subprovider, that will be performing work in any individual work category which is 5.0% or more of the contract, must be precertified by the deadline for receiving the letter of interest in accordance with §9.41 of this title (relating to Precertification) unless the work category is not approved according to [~~listed in~~] §9.43 of this title (relating to Precertification Requirements [~~Qualification Requirements by Work Group~~]);

(B) a prime provider or subprovider must demonstrate in an attachment to the LOI how it meets the minimum qualifications for work that does not fall within any work category approved according to [~~outlined in~~] §9.43 of this title (The attachment may be in addition to the maximum pages allowed for the LOI.);

(C) if the work in any individual work category as shown in the notice is less than 5.0% of the contract, a provider or subprovider that is not precertified must demonstrate in an attachment to the LOI how it meets the minimum requirements specified for the work category on the department's web site [~~in §9.43(b) of this title (relating to Qualification Requirements by Work Group)~~] or how it possesses the knowledge and skill to perform the work in those categories (The attachment may be in addition to the maximum pages allowed for the LOI.);

(D) if the total contract fee for professional services is anticipated to be less than $250,000 on an individual contract and the department has waived the precertification requirement of §9.41 of this title (relating to Precertification), then a provider or subprovider that:

(i) is not precertified must submit an attachment with the LOI which describes how the firm meets the minimum requirements specified for the work category approved according to [~~in~~] §9.43(b) of this title [~~(relating to Qualification Requirements by Work Group)~~] or how it possesses the knowledge and skill to perform the work in those categories (The attachment may be in addition to the maximum pages allowed for the LOI.); or

(ii) is precertified must submit a LOI, but is not required to submit an attachment describing its qualifications in precertified categories (If the firm proposes to do work in categories in which it has [~~is~~] not been precertified, then it must submit an attachment describing how the firm meets the minimum requirements or how it possesses the knowledge and skill to perform the work in those categories.); and

(E) the proposed team must demonstrate that they have a professional engineer, architect, or surveyor registered or licensed in Texas who will sign and/or seal the work to be performed on the contract.

(4) The letter of interest shall include;

(A) the contract [~~or RFP~~] number;

(B) an organizational chart containing:

(i) the prime provider's project manager (who may be replaced during the selection process and before contract execution only by another person proposed for the prime provider's team and approved by the director of the Design Division); and

(ii) names of the prime provider's and any subprovider's key personnel (who may be replaced during the selection process and before contract execution only by another person from the prime provider's or subprovider's team proposed in the LOI and approved by the CST)

~~*f(i)* names of the prime provider's and any subprovider's key personnel proposed for the team and their contract responsibilities by work category; and]~~

~~*f(ii)* the prime provider's project manager (who may be replaced during the selection and award process only by another person proposed for the prime provider's team approved by the director of the Design Division)];~~

(C) information addressing the criteria stated in the notice;

(D) evidence of compliance with the assigned DBE/HUB goal through the prime provider and [~~or~~] subproviders identified on the team, or a written commitment to make a good faith effort to meet the assigned goal;

(E) similar project related experience [~~that is not already included in the precertification database~~];

(F) name and contact information for references from the department or other entities; and

(G) other pertinent information addressed in the notice.

§9.34. Short List Determination [~~of the Short List~~].

(a) Composition of the Consultant Selection Team. The CST shall be composed of:

(1) the managing office staff member designated by the managing officer to be the chair;

(2) the department project manager; [~~and~~]

(3) at least one other department employee designated by the managing officer; and[~~.~~]

(4) a minimum of one professional engineer for engineering contracts, a minimum of one professional engineer or registered or licensed professional land surveyor for surveying contracts, and a minimum of one registered architect for architectural contracts.

(b) Qualification for long list.

(1) The department may disqualify a firm if the department or the firm's references have knowledge that the firm or an employee of the firm has a record of unprofessional conduct, including, but not limited to, whether the appropriate licensing board has cited the firm or an employee of the firm for a violation of its rules concerning conduct.

(2) If firm is not disqualified under paragraph (1), the [~~The~~] CST will review [~~evaluate~~] each [~~team submitting a~~] letter of interest to see if it meets the submittal requirements and precertification requirements of §9.33(b)(3) of this subchapter.

(c) Long list evaluation. The CST will review the information submitted in the letters of interest and evaluate each team on the long list to determine the short list based on the criteria described in subsection (d) of this section and as listed in the notice. [~~The department will review the information submitted in the letter of interest.~~]

(d) Criteria. The CST will consider the following criteria in its review of long-listed [~~all interested~~] providers:

(1) project understanding and approach;

(2) the provider project manager's experience with similar projects;

(3) similar project related experience of the task leaders responsible for the major work categories identified in the notice; and

(4) other criteria approved by the [~~director of the~~] Design Division and listed in the notice.

(e) Score. The CST will assign a relative importance factor (RIF) [~~RIF~~] weight to each criterion. The RIF total for all criteria will equal 100. Each criterion will be scored separately on a 0-10 point scale with 10 considered the best qualified. The maximum possible score that a CST member may give is 1000 points.

(f) Short list [~~Contract selection~~]. For individual contract selections, the CST will prepare a short list containing a minimum of three of the most highly qualified providers unless fewer than three qualified providers submitted a letter of interest. For multiple contract selections, the short list shall contain a minimum number of providers equal to the desired number of contracts plus three unless fewer than the desired minimum submitted a letter of interest.

(g) Notification. The department will notify a firm submitting a letter of interest that it was or was not selected for the short list. If a firm is selected for the short list, the department will either notify it that a meeting will be held, or if a meeting is not held, the department will provide a Request for Proposal (RFP) [~~an RFP~~] or an Interview and Contract Guide (ICG). The department will also notify selected firms of any additional required reference information and the deadline for submission.

§9.35. Short List Meeting, Proposals, and Evaluation.

(a) Short list meeting. The managing office may require [~~, or offer the opportunity to conduct,~~] a short list meeting which will include an explanation of the proposal and/or the interview format and requirements. The department will furnish a Request for Proposal (RFP) or an Interview and Contract Guide (ICG) to providers on the short list either prior to or at the short list meeting. If a short list meeting is held, the department will not accept proposals from or conduct interviews with providers that did not have a representative at the short list meeting.

(b) Request for proposals. If a written proposal is required, the managing office will provide an RFP to the short listed providers. The RFP will include:

(1) instructions for:

(A) a written proposal preparation and/or the interview process; and

(B) submittal of the proposal;

(2) scope of services to be provided by the department;

(3) scope of services to be provided by the provider;

(4) proposed contract duration;

(5) proposed method of payment;

(6) a debarment certification form;

(7) a lower tier debarment certification form;

(8) a lobbying certification/disclosure form;

(9) any special contract requirements; and

(10) the interview format and requirements if interviews are conducted subsequent to the proposal.

(c) Proposal format. When a written proposal is required, the proposal shall be limited to the specific length and information outlined in the RFP.

(d) Receipt of proposals. A proposal must be received by the date, time, and place specified in the RFP. The department will not accept a proposal by electronic facsimile.

(e) Proposal evaluation criteria. The CST will evaluate proposals based on the following criteria:

(1) understanding of scope of services;

(2) experience of the project manager and project team;

(3) ability to meet the project schedule;

(4) if no interview is required, past performance scores included in the database for department contracts or references identified in the LOI or provided in response to an additional request [~~from the department or other entities~~]; and

(5) other [~~CRC approved~~] criteria listed in the RFP.

(f) Proposal evaluation scale. The CST will assign a RIF weight to each criterion. The RIF total for all criteria will equal 100. Each criterion will be scored separately on a 0-10 point scale with 10 considered the best qualified. The maximum possible score that a CST member may give is 1000 points.

§9.36. Short List Interviews and Evaluation.

(a) Interviews. The CST may conduct interviews with the providers on the short list if a written proposal is required. If a written proposal is not required, then an interview will be conducted, and the managing office will give participating providers an Interview and Contract Guide. If proposals and interviews will be required, proposal and interview requirements can be included in the RFP. The CST may elect to perform telephone interviews. In order for a member of the CST to score a provider, the member must be present for all interviews. The prime provider's project manager is required to be present for the interview. [~~Lack of attendance by the project manager may be reason to consider the provider nonresponsive, and dropped from further consideration.~~]

(b) Interview and Contract Guide. The ICG includes:

(1) a description of the interview format;

(2) instructions for content and subject matter for a provider's presentation, if required;

(3) the scope of services to be provided by the department;

(4) the scope of services to be delivered by the provider;

(5) the proposed contract duration;

(6) the proposed method of payment;

(7) a debarment certification form;

(8) a lower tier debarment certification form;

(9) a lobbying certification/disclosure form; and

(10) any special contract requirements.

(c) Interview structure. The interview allows providers to demonstrate their understanding of the project and knowledge of applicable rules, regulations, codes, and special information to be gathered. The CST may allow a provider team to make a presentation with written material for the CST to reference in evaluating the interview. The CST may require a provider team to answer a predetermined written set of questions in the interview.

(d) Interview evaluation [~~Evaluation~~] criteria. The CST will evaluate interviews based on [~~consider~~] the following criteria [~~in its evaluation of the provider~~]:

(1) understanding of the scope of services;

(2) experience of the project manager and project team;

(3) ability to meet the project [~~proposed contract~~] schedule;

(4) responses to interview questions;

(5) past performance scores included in the database for department contracts or references identified in the LOI or provided in response to an additional request [~~from the department or other entities~~]; and

(6) other [~~CRC approved~~] criteria listed in the RFP or ICG.

(e) Interview evaluation scale. The CST will assign a RIF weight to each criterion. The RIF total for all criteria will equal 100. Each criterion will be scored separately on a 0-10 point scale with 10 considered the best qualified. The maximum possible score that a CST member may give is 1000 points.

§9.37. Selection.

(a) Basis of final selection.

(1) If a proposal and interview are both required, the final selection will be made by using the CST proposal score for 30% of the total score and the interview score for 70% of the total score.

(2) If an interview is not required, the final selection will be made by using the written proposal score.

(3) If a written proposal is not required, the final selection will be made by using the interview score.

(b) Tie scores. In the event of a tie, the managing officer will break the tie using the following method.

(1) The first tie breaker, if needed, will be the score for the experience of the project manager and the project team.

(2) The second tie breaker, if needed, will be the score for ability to meet the proposed project schedule.

(3) The third tie breaker, if needed, and if an interview was conducted, will be the score for the responses to interview questions; if proposals were submitted, it will be the score for understanding of scope of services.

(4) The fourth or additional tie breakers, if needed, and if an interview was conducted, will be the next criterion listed; if proposals were submitted, it will be the next criterion listed. The remaining criteria should be compared in the order listed until the tie is broken.

(5) [~~(3)~~] If there is still a tie, the provider will be chosen by random selection.

[~~(c) DBE/HUB Goals. The department may assign individual contract DBE or HUB goals pursuant to 49 CFR Part 26 and Title 1, Texas Administrative Code, §111.13, respectively.~~]

(c) [~~(d)~~] Selection summary. The CST will prepare a contract evaluation summary containing the scores of the prime providers on the short list, for consideration by the managing officer.

(d) [~~(c)~~] Submittal of selection. The managing officer will submit the contract evaluation summary, evaluation documentation, certification that the procedures provided by this subchapter were used and recommendation for selection to the Design Division [~~CRC~~] for review. If the procedural review is acceptable, the executive director or the director's designee will concur with the selection.

(e) [~~(f)~~] Notification. The department will:

(1) prepare a letter to notify the provider selected for contract negotiation and arrange a meeting to begin contract negotiations;

(2) prepare a letter to each of the providers remaining on the short list that were not selected, naming the provider that was selected; and

(3) publish the short list and the provider selected for a contract on an electronic bulletin board.

(f) [~~(g)~~] Negotiations.

(1) Selected provider. The department will enter into negotiations with the selected provider. The provider shall submit the information required for the contract. [~~, including a work outline, work schedule,~~] The provider shall also provide a a list of all suppliers and subproviders contacted relative to this project in accordance with §9.53(d)(5) of this title (relating to Disadvantaged Business Enterprise (DBE) Program)[~~, and cost proposal~~]. Any information necessary to meet the administrative qualification requirements found in §9.42 of this title (relating to Administrative Qualification), that has not been submitted to the department prior to selection shall be submitted so that the department may determine the fairness and reasonableness of the contract price. This process complies with Transportation Code, §223.041, Government Code, Chapter 2254, Subchapter A, and 23 CFR §172.5(a)(4). State funded architectural contracts are based on percentage of construction cost as provided in the General Appropriations Act. Pursuant to 23 CFR §172.5(c) [~~23 CFR §172.9~~], federally funded contracts are not based on percentage of construction cost.

(2) Negotiation period [~~Contract execution~~]. The provider shall sign the contract within 30 working days from the date of notification to the provider. An extension must be authorized before the expiration of the negotiation period or previous extension. Extensions or schedules will be used as provided in this paragraph.

(A) Automatic extensions. Automatic extensions for multiple contracts selected under one advertisement in which negotiations will be conducted at the same time are entitled to an automatic extension of the initial negotiation [~~negotiating~~] period. For each individual contract that has been awarded as part of a multiple contract package and that is anticipated to be valued at:

(i) $1 million or more each, the initial negotiating period is extended by five working days for each contract; or

(ii) less than $1 million each, the initial negotiating period is extended by five working days for every two contracts.

(B) Discretionary extensions. Discretionary extensions of the initial negotiating period may be granted to providers.

(i) Upon submission by the managing officer of sufficient written justification indicating that adequate progress is being made to conclude successful negotiations, the director of the Design Division will grant an extension not to exceed 30 working days.

(ii) Upon submission by the managing officer of sufficient written justification establishing that additional time to conduct negotiations is necessary due to the uniqueness or complexity of the project scope of services, the executive director or the director's designee not below the level of assistant executive director may grant additional extensions.

(C) Unique negotiating schedules. The director of the Design Division may approve a unique negotiating schedule submitted by the managing officer prior to the start of negotiations [~~for multiple contract selections~~].

(3) Selection of alternative providers. If the department and the selected provider are unable to execute a satisfactory contract containing a fair and reasonable price within the allotted time period, the managing officer shall end negotiations with that provider and commence negotiations with alternative providers.

(A) Single contract selection. If negotiations are ended, the department shall negotiate with the next highest ranked provider [~~on the short list~~] and shall follow in this sequence through the third highest ranked provider. If a satisfactory contract containing a fair and reasonable price is not negotiated with any of the three highest-ranked providers within the time frame specified in this section, the proposed contract shall be canceled. If the proposed contract is canceled, it may be readvertised.

(B) Multiple contract selection. Beginning with the next highest ranked provider, after the last provider selected for the multiple contracts, and within the acceptable range of scores as required by §9.39 of this subchapter (relating to Selection and Contract Types), negotiations shall be undertaken until a satisfactory contract containing a fair and reasonable price is agreed upon. If a satisfactory contract is not negotiated with any of the providers within the acceptable range of scores within the time frame specified in this section, the proposed contract shall be canceled. If the proposed contract is canceled, it may be readvertised.

(4) DBE/HUB goal documentation. The selected provider shall provide information to the department documenting its satisfaction or attempts to satisfy the DBE/HUB goal. The department will cease negotiation with the provider and enter into negotiation with the next provider in the order of preference for this contract if the selected provider fails to submit the required documentation. The selected provider shall submit to the managing officer, through the department's project manager, for review and acceptance:

(A) names and addresses of DBE/HUB firms that will participate in the contract;

(B) a description of the work that each DBE/HUB will perform;

(C) the dollar amount of the participation of each DBE/HUB firm participating;

(D) written documentation of the providers commitment to use a DBE/HUB subprovider whose participation it submits to meet a contract goal;

(E) written confirmation from the DBE/HUB that they will participate; and

(F) when applicable, evidence of good faith efforts.

(g) [~~(h)~~] Appeal. A provider may file a written complaint concerning the selection process with the executive director or the director's designee.

§9.38. Contract Management.

(a) DBE/HUB participation.

(1) HUB program goals may be satisfied by a HUB prime provider [~~as long as the HUB prime provider performs at least 25% of~~

~~the work with its own forces~~]. DBE prime providers may receive DBE credit for work performed by its own forces or performed by a DBE subprovider, but not by a non-DBE subprovider.

(2) If the prime provider or the subprovider is a DBE/HUB, the DBE/HUB provider and subprovider may subcontract in accordance with §9.56 of this title (relating to Contract Compliance). [~~If the DBE prime provider subcontracts a portion of the work to a non-DBE subprovider on a federal-aid contract, the value of the work performed by the non-DBE subprovider will not count towards the DBE goal.~~]

(b) Subcontracts. A prime provider shall perform at least 30% of the contracted work with its own work force unless approved by the director of the Design Division when the work is so specialized that the prime provider cannot perform at least 30% of the work.

~~[(b) Subcontracts.]~~

~~[(1) A prime provider shall perform at least 30% of the contracted work with its own work force. No subprovider may perform a higher percentage of the work than the prime provider, unless approved by the director of the Design Division when the work is so specialized that the prime provider cannot perform at least 30% of the work.]~~

~~[(2) The department will review subcontracts for compliance with the requirements of this subsection. Subcontracts shall incorporate by reference all of the provisions of the prime contract.]~~

~~[(3) Subcontracts shall:]~~

~~[(A) refer to the prime contract and have the same purpose;]~~

~~[(B) include nondiscrimination attachment;]~~

~~[(C) include DBE/HUB special provision;]~~

~~[(D) include lower tier debarment certification (negotiated contracts); and]~~

~~[(E) provide clear payment terms.]~~

~~[(4) Subcontracts shall not include:]~~

~~[(A) multipliers, such as supplies plus 10%; and]~~

~~[(B) the state as a party to the subcontract.]~~

(c) Operations.

(1) Management responsibility. The department's project manager will be designated by the managing officer.

(2) Project manager. The prime provider's project manager may not be changed without prior written consent of the department.

(3) Commencement of work. The provider shall not proceed with any contract work until advised in writing by the department to proceed.

(4) Suspension of work. The department may suspend the work by:

(A) verbally notifying the provider; and

(B) providing written notification of the suspension, including:

(i) identifying the reason for suspension; and

(ii) identifying approximate length of suspension and payment based on actual work completed as of the date of suspension.

(5) Payment on provider contracts. Payment for eligible costs will be made within 30 days after receiving a correct invoice. Payment may be withheld pending verification of satisfactory work performed. To receive payment for services, the provider shall submit to the department project manager:

(A) a monthly progress report;

(B) an itemized and certified invoice [~~(department form 132 or other acceptable format)~~]; and

(C) a DBE/HUB report (The CSTB may require proof of DBE/HUB use, including submittal of canceled checks that are properly identified by department project number or contract number).

(6) Interim audit. The department may perform interim audits.

(d) Supplemental agreements.

(1) The original executed contract will require a supplemental agreement if:

(A) additional funding is required in accordance with terms of the contract;

(B) additional time is needed to complete work in progress; or

(C) changes in scope of services are necessary.

(2) The supplemental agreement will be executed:

(A) prior to the expiration date of the original contract;

(B) prior to exceeding the contract amount; and

(C) prior to performance of unauthorized work.

(e) Indefinite deliverable contract work authorization. If the department and the provider are unable to execute a satisfactory work authorization containing a fair and reasonable price, the department project manager shall end negotiations with that provider. Only after negotiations have been ended will the department contact another provider with an indefinite deliverable contract to initiate negotiations for the work.

(f) [~~(e)~~] Errors and omissions.

(1) Policy. It is the department's policy to require providers to correct errors or omissions in the providers' services which are required under the contract without undue delay and without additional cost to the department.

(2) Procedure.

(A) Notification. The department will notify the provider of the errors and omissions.

(B) Resolution. A dispute involving errors and omissions shall be resolved in accordance with §9.2 of this title (relating to Contract Claim Procedure).

(g) [~~(f)~~] Contract close out.

(1) Final audit. The department's Audit Office may perform an audit.

~~[(1) Final audit. The department audit office will perform an audit of the provider's records in accordance with the terms of the contract.]~~

(2) Time. A contract is ready for close out when:

(A) services have been provided;

(B) products have been received and accepted;

(C) approval has been received from the U.S. Department of Transportation, when federally funded;

(D) payments have been made;

(E) audit findings have been resolved;

(F) the contract expires unless extended by supplemental agreement; and

(G) the final DBE/HUB report has been submitted.

(h) [~~(g)~~] Provider performance evaluations.

(1) The department will document [~~a prime provider's~~] demonstrated competence and qualifications by evaluating the prime provider and project manager's performance [~~in the categories of management, innovation, quality, and timeliness~~].

(A) The evaluation shall be conducted annually at twelve month intervals during ongoing contract activity, upon completion of a contract, or when the managing office determines that the work is behind schedule or not being performed according to the contract.

(B) Optional evaluations may be conducted upon completion of a contract phase [~~or to document exemplary performance~~].

~~[(2) The department will evaluate the prime provider in the categories of cost administration and the firm's expertise as further demonstration of qualifications and competence.]~~

(2) [~~(3)~~] The department may evaluate project constructability every 12 months during project construction [~~the contract period~~] and upon completion of the construction contract.

~~[(4) The department may evaluate a subprovider's performance when it has completed its work, upon exemplary performance, or if the managing office determines that the subprovider is delaying the progress or completion of the work or that work is not being performed according to the contract.]~~

(3) [~~(5)~~] The department will give a copy of the performance evaluation to the prime provider [~~or subprovider~~] for review and comment. If the prime provider [~~or subprovider~~] responds with comments on its evaluation, the department will include the comments in the CCIS database identified in §9.41 of this title (relating to Precertification).

(4) [~~(6)~~] Performance evaluation [~~Evaluation~~] scores will be entered into the CCIS database and may be used in determining the qualifications of the prime provider or subprovider in accordance with §9.35 (relating to Short List Meeting, Proposals, and Evaluation) or §9.36 (relating to Short List Interviews and Evaluation) of this subchapter.

§9.39. Selection and Contract Types.

(a) Selection types. The department will perform three [~~four~~] types of contract selections.

(1) Individual contract selection. One contract will result from the contract notice.

(2) Multiple contract selection. More than one contract of similar work types will result from the contract notice. The notice will indicate the number and type of contracts to result from the advertisement, and specify a range of scores for prime providers that will be considered qualified to perform the work.

(A) If more prime providers fall within the specified range than the anticipated number of contracts, prime providers will be selected in order of ranking in the evaluation process.

(B) If the anticipated number of contracts is greater than the number of prime providers that fall within the specified range, then each prime provider will be selected for one contract [~~on a random basis for the excess contracts~~]. Each of the remaining contracts will be randomly awarded to the prime providers who fall within the specific range until all providers have two contracts or all contracts have been awarded. If there is still an excess of contracts, then the process repeats.

(3) Emergency contract selection. To utilize the emergency selection procedure, the executive director of the department or the director's designee must certify in writing that there is good cause to believe that an emergency situation exists, including safety hazards or a substantial disruption of the orderly flow of traffic and commerce for the department.

(A) Eligibility. To be eligible to work on an emergency contract, a firm's project manager must be precertified pursuant to §9.41 of this title (relating to Precertification) or must complete a precertification application form prescribed by the department.

(B) Notification.

(i) After an emergency is certified, the managing officer will review the department's file of eligible firms. If there is a sufficient number of firms, the managing officer will notify at least three of those firms.

(ii) Consistent with and contingent upon the nature of the emergency, the managing officer may contact prospective firms by telephone, letter, telefacsimile, or other appropriate form of communication.

(iii) The managing officer will inform each firm of the nature of the emergency and furnish specifications for the remedy, including time constraints, and any additional information needed for the firm to prepare a project team.

(C) Selection. The department will select the firm based on demonstrated competence and qualifications. The department will negotiate at a fair and reasonable price with the top-ranked provider. If agreement cannot be reached, the department will negotiate with the subsequent firms, in order of selection, until an agreement is reached. If no eligible firm is able to provide the required type of service, the managing officer may take any measure necessary to identify and locate an available firm who is able to provide the required service. If selected, the prospective contractor thus identified must complete the precertification application prior to execution of the contract.

(b) Contract types. The department will offer two types of contracts.

(1) [~~(3)~~] Indefinite deliverable [~~delivery~~] contract [~~selection~~]. This contract may be for an individual project [~~contract~~] or for multiple projects [~~contracts~~]. The typical type of work will be described in the notice. The total of the contract work authorizations shall not exceed $5,000,000 in a division, metropolitan district, or border district of the department, unless approved by the commission prior to NOI publication [~~or in contracts of the Texas Turnpike Authority Division of the department~~]. The total of the contract work authorizations shall not exceed $2,000,000 in a district of the department other than a metropolitan or border district. The contract period [~~duration~~], in which initial work authorizations may be issued, may not be longer than two years from the date of contract execution, unless approved by the commission prior to NOI publication. Supplemental agreements may be issued to extend the contract period beyond the two years, but only as necessary to complete work on an initial work authorization.

(2) Specific deliverable contract. This contract may be for an individual project or for multiple projects. The notice will describe the specific deliverables to be procured under the contract. There is no dollar limit on the size of the contract, and there is no time restriction on the contract period.

[(4) Emergency Selection. If the executive director of the department or the director's designee certifies in writing that there is good cause to believe that an emergency situation exists, including safety hazards and imminent expiration of a contract on an incomplete project, he or she will authorize the CST to select a provider on an emergency basis.]

§9.41. Precertification.

(a) Contract Eligibility. To be eligible to perform work in the categories approved according to [described in] §9.43 of this title (relating to Precertification Requirements [Qualification Requirements by Work Group]), a prime provider and a subprovider must be precertified in accordance with this section unless:

(1) the anticipated work in an individual work category is less than 5.0% of the contract; or

(2) the department has waived the precertification requirements for a contract that is less than $250,000.

(b) Application.

(1) Registered architects, registered professional engineers, [and] registered or licensed professional surveyors, and other technical staff [or their related subproviders] who desire to be precertified by the department to perform work on architectural, engineering, or surveying contracts, shall submit a completed precertification application [questionnaire] to the Design Division [CRC] for review and determination of precertification status.

(2) An application form [A questionnaire, in a form] prescribed by the department, [or a precertification information packet] may be obtained by contacting the Texas Department of Transportation, Design Division [- Consultant Review Committee], 125 East 11th Street, Austin, Texas 78701-2483, or through the department's web site.

(3) The application form [questionnaire] will request [include] information concerning the experience of the individual [prime provider or subprovider].

(4) The precertification web site [information packet] will include:

(A) a copy of the application form [questionnaire];

(B) instructions concerning submittal of information for precertification, including [regarding the] format and length restrictions for data to be submitted; and

(C) the requirements for precertification in each category [as described in §9.43 of this title (relating to Qualification Requirements by Work Group);]

[(D) copies of the department's standard contracts, with attachments;]

[(E) instructions for administrative qualification; and]

[(F) department overhead guidelines].

(5) The submittal date for review deadlines as described in subsection (f)[(g)] of this section shall be the date the precertification application [questionnaire] is received by the Design Division [CRC].

(6) The precertification of a [prime] provider [or subprovider] by the department does not guarantee that work will be awarded to that [prime] provider [or subprovider].

[(c) Instructions. The department will publish instructions concerning submittal of information for precertification annually in the Texas Register and daily on an electronic bulletin board.]

(c) [(d)] Deadline. [Precertification deadline.] When precertification is required as described in subsection (a) of this section, prime providers and subproviders must be precertified in the technical categories by the deadline for receipt of the letter of interest to be eligible for selection. The department will not delay the consultant selection process or contract execution for a prime provider or subprovider that has not been precertified.

(d) [(e)] Data management. [CCIS.] The department will maintain the CCIS containing qualification information submitted in the precertification application [questionnaire] by the firm for an employee [prime provider or subprovider].

(e) Firm and employee status.

(1) A firm may be precertified in a work category if the firm has a current employee precertified in the category.

(2) A firm employee may be precertified in a work category if the employee possesses the skills and experience to meet the requirements. An employee is not precertified based on the firm's experience.

[(f) Technical precertification.]

[(1) A prime provider or subprovider may be precertified in a technical category if the firm has current employees possessing the skills and experience to meet the requirements. A prime provider or subprovider is not precertified based on the firm's experience.]

(3) [(2)] A precertification will transfer with the employee if the employee leaves the firm.

(4) [(3)] The department may [will] review a firm's information [prime provider or subprovider] to evaluate whether the support, equipment, and other resources necessary to do the work are provided to the employee.

(5) [(4)] A firm with one employee who is precertified in multiple work categories is precertified in those categories. [A prime provider or subprovider with one employee who meets the appropriate requirements of multiple technical categories may be precertified in those categories.] When required, prime providers and subproviders must be precertified in the categories of work they will be performing; however, a provider or subprovider is not required to be precertified in every category of work involved in the contract, unless it will be performing in a lead capacity on all categories of work [all of the work].

[(5) The department will not precertify joint ventures.]

(f) [(g)] Review process. [Precertification review.]

(1) An individual, and therefore the firm, [A prime provider or subprovider] will be precertified within 60 days of receipt of complete and accurate information for the submittal or notified in writing within the same time period that they did not meet the requirements for precertification or that additional submittals will be required for review.

(2) If the submittal is incomplete, a firm [prime provider or subprovider] will be requested to submit additional information for review. The firm [prime provider or subprovider] shall submit such information within 30 days of receipt of the department's request for such information. If the information is not provided within 30 days

after receipt of the request, the application for precertification will be processed with the information available. The department will make a determination on precertification status within 60 days of receipt of the additional information.

(3) The department will consider the following factors in reviewing the precertification applications [~~questionnaires as specified in §9.43 of this title (relating to Qualification Requirements by Work Group)~~]:

(A) current license or registration;

(B) personal experience and training; and

(C) work category requirements as maintained on the department's web site [~~other requirements of §9.43 of this title (relating to Qualification Requirements by Work Group)~~].

(g) [~~(h)~~] Updates. A firm [~~prime provider or subprovider~~] must report any change in the information included in the original application [~~questionnaire~~] no later than 45 days after the change occurs.

(h) [~~(i)~~] Appeal. A firm [~~prime provider or subprovider~~] may appeal denial of precertification by submitting additional information within 30 days of receipt of written notification of denial to the Design Division [~~CRC in Austin~~]. This information shall justify why the applicant [~~prime provider or subprovider~~] meets the requirements for precertification. The department [~~CRC~~] will review the information and make a determination regarding precertification. A firm [~~provider~~] may file a written complaint regarding [~~selection for~~] precertification denial with the executive director or his or her designee.

§9.42. Administrative Qualification.

(a) Exception. Administrative qualification is not necessary for non-engineering firms and provider services included in Group 6 - bridge inspection, Group 12 - materials inspection and testing, Group 14 - geotechnical services, Group 15 - surveying and mapping, and/or Group 16 - architecture as listed on the department's web site for precertification [~~of §9.43 of this title (relating to Qualification Requirements by Work Group)~~]. Providers compensation for these services is typically based on units of service rates [~~or a lump sum contract~~].

(b) Time to provide information. Prime providers and subproviders may provide information described in this section prior to selection. If the information is not furnished before selection, it must be provided after selection and before contract execution. The administrative qualification submittal is a separate submittal from the precertification submittal, and is submitted to the Texas Department of Transportation, Audit Office, 125 E. 11th Street, Austin, Texas 78701-2483. Administrative qualification submittals will not be received by the Design Division [~~CRC~~]. Submission prior to selection is encouraged to facilitate timely contract execution requirements.

(c) Evaluation factors. The department will consider the following factors in determining qualifications of prime providers or subproviders.

(1) Adequate accounting system. The prime provider or subproviders must demonstrate the existence of an adequate accounting system that meets the department's audit requirements, as evidenced by certification by an independent certified public accountant or governmental agency. The system must be adequate to support all billings made to the department and other clients.

(2) Indirect cost [~~Overhead~~] rate audit. The prime provider or subprovider must submit an indirect cost [~~overhead~~] rate audit for the time period specified in subparagraph (C) [~~(D)~~] of this paragraph performed by an independent certified public accountant, an agency of the federal government, another state transportation agency, or a local transit agency [~~an independent audit organization, or governmental agency~~] except as provided in subparagraphs (D) [~~(E)~~] and (E) [~~(F)~~] of this paragraph. If the audit is performed by an independent certified public accountant, the provider or subprovider must assure that the department will be given access to the audit work papers.

(A) The audit report shall include statements that the audit was performed in accordance with generally accepted auditing standards and the indirect cost rate was developed in accordance with the Federal Acquisition Regulations, 48 CRF 31.

(i) AASHTO Uniform Audit and Accounting Guide is acceptable guidance for the audit of the indirect cost rate.

(ii) Department requirements that differ from the AASHTO guide are contained in the Indirect Cost Rate Guidance available through the department's website.

[~~(A) The audit report shall include statements that the audit was performed in accordance with the criteria required by the department and generally accepted auditing standards including:~~]

[~~(i)~~] ~~Federal Acquisition Regulations, 43 CFR 31; and~~]

[~~(ii)~~] ~~department overhead guidelines, a copy of which will be included in the precertification information packet.~~]

[~~(B) The audit report shall describe the estimating system used by the prime provider or subprovider, and state whether estimates are prepared in accordance with the accounting system.~~]

(B) [~~(C)~~] The department may perform indirect cost [~~overhead~~] rate audits of any prime provider or subprovider under contract to, or desiring to do business with the department. These audits will be conducted consistent with the criteria outlined in this subsection.

(C) [~~(D)~~] The end of the fiscal period of the audit report must be within eighteen months of the provider selection.

(D) [~~(E)~~] The department may contract with a prime provider or allow utilization of a subprovider lacking an approved indirect cost [~~overhead~~] rate audit if:

(i) the value of the contract is less than $250,000;

(ii) the prime provider or subprovider can adequately document and support all proposed costs; and

(iii) all other qualification requirements of this subsection are met.

(E) Prime providers or subproviders who have been in operation with an accounting system acceptable to the department, for less than one fiscal year since organization or comprehensive reorganization shall prepare a projected indirect cost rate for the first fiscal year of operation. The indirect cost rate will be supported by estimated expenditures and be in accordance with the Indirect Cost Rate guidance referred to in subparagraph A of this paragraph. The department's Audit Office will review the estimate and establish a provisional indirect cost rate for use in contract negotiations.

[~~(F) Prime providers or subproviders who have been in business for less than one complete fiscal year of the provider, have reorganized to the extent that the most recent overhead rate audit does not reflect a currently valid overhead rate, or have established and operated an accounting system acceptable to the department for a period of less than one year shall prepare a projected overhead rate which will be supported by estimated expenditures in accordance with the department's overhead rate audit guidelines for the first fiscal year's operation since organization, reorganization, or implementation of the acceptable~~

~~accounting system.~~ ~~The department's audit office shall review the estimate and establish a provisional combined overhead rate for use in contract negotiations.~~]

(3) Salary rates. The department will consider current salary rates, range of rates, or average rates [~~salaries and salary ranges~~] by job classification.

(4) Direct costs. The department will consider other direct costs such as copies, Computer Aided Design and Drafting (CADD), or other direct costs.

(d) Provision of administrative qualification information. The department's Audit Office will provide administrative qualification information when requested by a managing office upon selection of a provider for the contract, for use in negotiations as identified in §9.37 of this title (relating to Selection).

(e) Prohibited actions. Administrative qualification information obtained through this section will not be made available to the CST by the department's Audit Office prior to contract selection.

§9.43. Precertification Requirements.

(a) Requirements.

(1) Eligible employees. A firm may be precertified in the technical work categories maintained on the department's web site by providing the listed requirements. A firm may only submit an application for an individual who is employed by that firm at the time of submittal for precertification.

(2) Experience. The experience used to meet requirements may be either prior to or after licensure unless otherwise stated in a specific category. For the purpose of experience for precertification, the employee may be licensed to practice in any state for which that experience is recognized by the:

(A) Texas Board of Professional Engineers for engineers;

(B) Texas Board of Architectural Examiners for architects; or

(C) Texas Board of Professional Land Surveying for land surveyors.

(b) Work categories. The approved precertification work category definitions and requirements will be maintained on the department's web site. The Texas Transportation Commission, by minute order, may add, revise, or delete a work category.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406468
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-8630

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43 TAC §9.40, §9.43

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repealed sections are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Government Code, Chapter 2254, Subchapter A, which sets forth requirements governing the procurement of professional services.

CROSS REFERENCE TO STATUTE: Government Code, Chapter 2254, Subchapter A.

§9.40. DBE/HUB Goals.

§9.43. Qualification Requirements by Work Group.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

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General Counsel
Texas Department of Transportation
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CHAPTER 21. RIGHT OF WAY
SUBCHAPTER C. UTILITY ACCOMMODATION

The Texas Department of Transportation (department) proposes the repeal of §§21.31 - 21.51 and simultaneously proposes new §§21.31 - 21.41, concerning utility accommodation.

EXPLANATION OF PROPOSED REPEALS AND NEW SECTIONS

Existing §§21.31 - 21.51 provide the current regulations for the accommodation of utilities on highway right of way. The Texas Transportation Commission (commission) is repealing §§21.31 - 21.51 and proposing new §§21.31 - 21.41 in a revised form to: reorganize the rules for clarity; allow the use of updated utility construction methods and materials; and improve the state's management of its right of way by requiring a better quality of plans and record drawings for utility installations. Improved utility location information will allow the earlier identification and resolution of utility conflicts with transportation projects prior to the highway construction letting.

New §21.31 defines words and terms used in this subchapter. The definitions are updated from the proposed repeal for clarity of engineering terms, new utility procedures and processes, job functions, and occupational and departmental titles.

New §21.32 is a statement of the purpose of the subchapter and is reworded for clarity.

New §21.33 describes the types of facilities to which the subchapter applies. New subsections have been added to make the subchapter applicable to utility lines not specifically covered elsewhere in the subchapter, according to the nature of the line,

and to allow each district engineer to make special requirements based on factors unique to the area. These changes will allow the department to better protect the right of way and to better accommodate utilities by making allowances for unique and unforeseen circumstances.

New §21.34 describes the scope of the subchapter and includes new language describing the means by which a district may impose supplemental requirements and providing a means by which a utility may appeal a supplemental requirement. Because conditions may differ greatly from area to area within the state, these additions will allow the districts to better manage their right of way on a local level, while protecting utilities by providing for a higher level of review of district decisions.

New §21.35 includes the requirements for requesting and criteria for consideration of an exception to the provisions of this subchapter. Providing for exceptions allows the department to better meet the needs of utilities for which the requirements of the subchapter would impose extreme hardship.

New §21.36 describes the legal authority of utilities to install lines on state highway right of way. This section is included for clarity.

New §21.37 describes the design requirements for a utility installation. In order to allow the department to more efficiently manage and protect its right of way, new language has been added restricting the locations of utilities within the right of way and adding new requirements regarding the submission of plans, including a provision for a district to require signed and sealed plans under certain circumstances, the design of utility tunnels and bridges, and the joint use of highway and utility structures. More specific requirements are also added relating to the removal, trimming, or replacement of trees, bushes, shrubbery, or any other aesthetic features.

New §21.38 describes the standards and requirements for the construction and maintenance of utility lines on the right of way. This section includes expanded requirements for revegetation, traffic control, work restrictions, and site cleanup. These changes are designed to protect the safety of the traveling public as well as to protect the right of way from damage.

New §21.40 describes the requirements for the installation of underground utilities on the right of way. The section includes new and expanded requirements for standards for materials, conditions under which underground utilities may be placed on the right of way, multiple conduits, abandonment, location and placement, and markers. These changes are designed to allow the department to better manage its right of way and to better protect the right of way, as well as providing better protection for utility lines.

New §21.41 describes the requirements for the installation, maintenance, and relocation of overhead power and communication lines on the right of way. This section includes expanded and new requirements for construction, location, and marking of overhead power and communication lines to protect the safety of the traveling public and to allow the department to better manage its right of way.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five years the repeals and new sections are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeals and new sections. There are no anticipated economic costs for persons required to comply with the sections as proposed.

John P. Campbell, P.E., Director, Right of Way Division has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeals and new sections.

PUBLIC BENEFIT

Mr. Campbell has also determined that for each of the first five years the repeals and new sections are in effect, the public benefit anticipated as a result of enforcing or administering the repeals and new sections will be enhanced management of state right of way. There will be no adverse economic effect on small businesses.

PUBLIC HEARING

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed repeals and new rules. The public hearing will be held at 9:00 a.m. on November 23, 2004, in the first floor hearing room of the Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 8:30 a.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Randall Dillard, Director, Public Information Office, 125 East 11th Street, Austin, Texas 78701-2483, 512/463-8588 at least two working days prior to the hearing so that appropriate services can be provided.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeals and new sections may be submitted to John P. Campbell, P.E., Director, Right of Way Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on December 13, 2004.

43 TAC §§21.31 - 21.51

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeals are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: None.

§21.31. Definitions.
§21.32. Purpose.
§21.33. Application.
§21.34. Scope.
§21.35. Exceptions.
§21.36. Authority of Utilities.
§21.37. Location.
§21.38. Design.
§21.39. Aesthetics.
§21.40. Safety.
§21.41. Site Clean-up.
§21.42. Pipelines--General.
§21.43. High Pressure Gas and Liquid Petroleum Lines.
§21.44. Low Pressure Gas Lines.
§21.45. Water Lines.
§21.46. Sanitary Sewer Lines.
§21.47. Utility Structures.
§21.48. Traffic Structures.
§21.49. Overhead Power and Communication Lines.
§21.50. Underground Power Lines.
§21.51. Underground Communication Lines.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406470
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-8630

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43 TAC §§21.31 - 21.41

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: None.

§21.31. Definitions.

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

(1) AASHTO--American Association of State Highway and Transportation Officials.

(2) Abandoned utility--A utility facility:

(A) that no longer carries a product or performs a function and for which the owner is unknown or cannot be located; or

(B) whose owner has requested abandonment and the abandonment has been approved by the district.

(3) Access denial line--A line concurrent with the common property line across which access to the highway facility from the adjoining property is not permitted.

(4) As-Built plans--Engineering drawings showing the actual locations of installed or relocated utilities.

(5) Border width--The area between the edge of pavement structure or back of curb to the right of way line.

(6) Bridge abutment joint--The joint between the approach slab and bridge structure.

(7) Center median--The area between opposite directions of travel on a divided highway.

(8) Commission--The Texas Transportation Commission.

(9) Common carrier--As defined in the Natural Resources Code, §111.002.

(10) Conduit--A pipe or other opening, buried or above ground, for conveying fluids or gases, or serving as an envelope containing pipelines, cables, or other utilities.

(11) Controlled access highway--A highway so designated by the commission on which owners or occupants of abutting lands and other persons are denied access to or from the highway main lanes.

(12) Department--The Texas Department of Transportation.

(13) Depth of cover--The minimum depth as measured from the top of the utility line to the ground line or top of pavement.

(14) Design vehicle load (HS-20)--A design load designation used for bridge design analysis representing a three-axle truck loaded with four tons on the front axle and 16 tons on each of the other two axles. The HS-20 designation is one of many established by AASHTO for use in the structural design and analysis of bridges.

(15) Distribution line--That part of a utility system connecting a transmission line to a service line.

(16) District--One of the 25 geographical districts into which the department is divided.

(17) District engineer--The chief administrative officer in charge of a district, or his or her designee.

(18) Duct--A pipe or other opening, buried or above ground, containing multiple conduits.

(19) Engineer--A person licensed to practice engineering in the state of Texas.

(20) Executive director--The chief administrative officer of the department.

(21) Freeway--A divided highway with frontage roads or full control of access.

(22) Frontage road--A street or road auxiliary to, and located alongside, a controlled access highway or freeway that separates local traffic from high-speed through traffic and provides service to abutting property.

(23) Gathering line--A line that delivers raw product from various sites to a central distribution or feed line for the purposes of

refining, collecting, or storing the product, and is private in function and does not directly or indirectly serve the public.

(24) Hazardous material--Any gas, material, substance, or waste that, because of its quantity, concentration, or physical or chemical characteristics, is deemed by any federal, state, or local authority to pose a present or potential hazard to human health or safety or to the environment. The term includes hazardous substances, hazardous wastes, marine pollutants, elevated temperature materials, materials designated as hazardous in the Hazardous Materials Table (49 CFR §172.101), and materials that meet the defining criteria for hazard classes and divisions in 49 CFR Part 173 (49 CFR §171.8).

(25) High-pressure gas or liquid petroleum lines--Gas or liquid petroleum pipelines that are operated, or may reasonably be expected to operate in the future, at a pressure of over 60 pounds per square inch.

(26) Horizontal clearance--The areas of highway roadsides designed, constructed, and maintained to increase safety, improve traffic operation, and enhance the appearance of highways.

(27) Idled facility--A utility conduit or line which temporarily does not carry a product, or does not perform a function and whose owner has not provided a date for its return to operation.

(28) Inclement weather--Weather conditions that are hazardous to the safety of the traveling public, highway or utility workers, or the preservation of the highway.

(29) Low-pressure gas or liquid petroleum lines--Gas or liquid petroleum pipelines that are operated at a pressure not exceeding 60 pounds per square inch.

(30) Main lanes--The traveled way of a freeway or controlled access highway that carries through traffic.

(31) Maintenance Division--The administrative office of the department responsible for the maintenance and operation of the state highway system.

(32) Noncontrolled access highway--A highway on which owners or occupants of abutting lands or other persons have direct access to or from the main lanes by department permit.

(33) Outer separation--The area between the main lanes of a highway for through traffic and a frontage road.

(34) Pavement structure--The combination of the surface, base course, and subbase.

(35) Private utility--Any utility facility, its accessories, and appurtenances, including gathering lines devoted exclusively to private use.

(36) Public utility--A person, firm, corporation, river authority, municipality, or other political subdivision engaged in the business of transporting or distributing a utility product for public consumption.

(37) Ramp terminus--The entrance or exit portion of a controlled access highway ramp adjacent to the through traveled lanes.

(38) Right of Way Division (ROW)--The administrative office of the department responsible for the acquisition and management of the state right of way.

(39) Riprap--An appurtenance placed on the exposed surfaces of soils to prevent erosion, including a cast-in-place layer of concrete or stones placed together.

(40) Service line--A utility facility that conveys electricity, gas, water, or telecommunication services from a main or conduit located in the right of way to a meter or other measuring device that services a customer or to the outside wall of a structure, whichever is applicable and nearer the right of way.

(41) TMUTCD--The most recent edition of Texas Manual on Uniform Traffic Control Devices for Streets and Highways.

(42) Transmission line--That part of a utility system connecting a main energy or material source with a distribution system.

(43) Utility--Any entity owning a public or private utility.

(44) Utility appurtenances--Any attachments or integral parts of a utility facility, including fire hydrants, valves, and gas regulators.

(45) Utility facilities--All lines and their appurtenances within the highway right of way except those for highway-oriented needs, including underground, surface, or overhead facilities either singularly or in combination, which may be transmission, distribution, service, or gathering lines.

(46) Utility strip--The area of land established within a control of access highway, located longitudinally within the border width, where an assignment may be designated for a utility delineating the area of use, occupancy, and access.

(47) Utility structure--A pole, bridge, tower, or other aboveground structure on which a conduit, line, pipeline, or other utility is attached.

§21.32. Purpose.

This subchapter prescribes the minimum requirements for the accommodation, method, materials, and location for the installation, adjustment, and maintenance of public and private utilities within the right of way of the state highway system. These requirements are provided in the interests of the safety, protection, use, and future development of highways with due consideration given to the public service afforded by adequate and economical utility installations.

§21.33. Applicability.

(a) For highways under department jurisdiction, the provisions of this subchapter concerning utility accommodation apply to:

(1) new utility installations;

(2) additions to or maintenance of existing utility installations;

(3) adjustments or relocations of utilities; and

(4) existing utility installations retained within the right of way.

(b) The provisions of this subchapter concerning utility accommodation do not apply to utilities located within the rights of way of completed highways for which agreements with the department were entered into before the effective date of this subchapter. Future adjustments, additions to, or maintenance of these facilities will be subject to this subchapter.

(c) This subchapter applies to utility lines not specifically mentioned in accordance with the nature of the line. All lines carrying caustic, flammable, or explosive materials shall conform to the provisions for high-pressure gas and liquid fuel lines.

(d) The district engineer or designee may prescribe special district requirements on a specific installation or adjustment based on the specific soil, terrain, climate, vegetation, traffic characteristics, type of utility line, or other factors unique to the area.

§21.34. Scope.

This subchapter governs matters concerning accommodation, location, and methods for the installation, adjustment, relocation, and maintenance of utilities on state highway rights of way, but do not alter current authority for their installation nor determination of financial responsibilities for placement or adjustment. Any law, code, regulation, rule, or order that prescribes a higher degree of protection for highway facilities or the traveling public shall supersede this subchapter. District supplemental accommodation requirements shall be detailed where more than the minimums of this subchapter are required. If a utility contests such supplemental requirements, they may appeal to the district engineer. The district engineer's decision may be appealed to the Maintenance Division or Right of Way Division, as appropriate.

§21.35. Exceptions.

(a) Exceptions to any provisions contained in these sections and relating to utility accommodation shall be justified and recommended for approval by the district engineer and authorized by:

(1) the Right of Way Division Director using the form entitled "Certification for Utility Accommodation" for all utilities occupying the right of way under a utility joint use agreement; or

(2) the Maintenance Division Director, when a Utility Installation Request form or any instrument other than a utility joint use agreement is received for a proposed utility installation on an existing highway.

(b) Requests for exceptions will be considered only where the utility shows that extreme hardship or unusual conditions provide justification and where alternate measures can be prescribed in keeping with the intent of this subchapter. All requests for exceptions must be fully documented with design data and other pertinent information.

(c) For each request for exception the utility must clearly demonstrate that:

(1) the accommodation will not adversely affect the safety, design, construction, operation, maintenance, or stability of the highway;

(2) the accommodation will not be constructed or serviced by direct access from the main lanes of a freeway or connecting ramps;

(3) the accommodation will not interfere with or impair the present use or future expansion of the highway; and

(4) any alternative location would be contrary to the public interest, demonstrated by an evaluation of the direct and indirect environmental and economic effects that would result from the disapproval of the proposed use of the right of way.

§21.36. Rights of Utilities.

(a) Under state law, certain utilities have a right to operate, construct, and maintain their lines over, under, across, on, or along highways, subject to highway purposes. This includes utilities authorized by law to transport or distribute natural gas, water, electric power, telephone, cable television, or salt water and those that are authorized to construct and operate common carrier petroleum and petroleum product lines.

(b) Private lines may cross, but are not permitted longitudinally on highway rights of way. This includes privately-owned lines from gas or oil wells, lines owned by oil companies within refinery and oil storage complexes or by firms engaged in businesses other than those described in subsection (a) of this section, private purpose lines of an entity described in subsection (a) of this section, and service lines owned by individuals.

§21.37. Design.

(a) General. The design of any utility installation, adjustment, or relocation is the responsibility of the utility. Utility design will be accomplished in a manner and to a standard acceptable to the department. The location and manner in which a utility installation, adjustment, or relocation work will be performed within the right of way must be reviewed and approved by the department. The department will review the measures to be taken to preserve the safety and free flow of traffic, structural integrity of the highway or highway structure, ease of highway maintenance, appearance of the highway, and the integrity of the utility facility. Utility installations shall conform with:

(1) the requirements of this subchapter;

(2) the National Electrical Safety Code rules for the installation and maintenance of electric supply and communication lines;

(3) 23 CFR Part 645B, Accommodation of Utilities;

(4) 49 CFR Part 192, Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards;

(5) 49 CFR Part 195, Transportation of Hazardous Liquids by Pipeline;

(6) the latest American Society for Testing and Materials (ASTM) specifications;

(7) the latest edition of the Texas Manual on Uniform Traffic Control Devices;

(8) 30 TAC §§290.38 - 290.47, relating to Rules and Regulations for Public Water Systems; and

(9) applicable state and federal environmental regulations, including storm water pollution prevention, endangered species, and wetlands.

(b) Location.

(1) Utility lines shall be located to avoid or minimize the need for adjustment for future highway projects and improvements, to allow other utilities equal access in the right of way, and to permit access to utility facilities for their maintenance with minimum interference to highway traffic.

(2) Longitudinal installations, if allowed, shall be located on uniform alignments to the right of way line to provide space for future highway construction and possible future utility installations.

(3) New utility lines crossing the highway shall be installed at approximately 90 degrees to the centerline of the highway.

(4) The horizontal and vertical location of utility lines shall conform with §21.41(c) of this subchapter, consistent with the clearances applicable to all roadside obstacles. No aboveground fixed objects will be allowed in the horizontal clearance.

(5) The utility is responsible for determining whether other utility lines exist at, or if plans have been submitted to the department regarding, the proposed installation area. The utility must insure that the proposed installation is compatible with existing and approved future utilities.

(6) Utilities on controlled access highways or freeways shall be located to permit maintenance of the utility by access from frontage roads, nearby or adjacent roads and streets, or trails along or near the right of way line without access from the main lanes or ramps. Utilities shall not be located longitudinally in the center median or outer separation of controlled access highways or freeways.

(7) On highways with frontage roads, longitudinal utility installations may be located between the frontage road and the right of

way line. Utility lines shall not be placed or allowed to remain in the center median, outer separation, or beneath any pavement, including shoulders.

(8) When a longitudinal installation is proposed within existing access denial lines of a controlled access highway or freeway without frontage roads and meets the conditions of §21.35 of this subchapter, the department may establish a utility strip, specific to the requesting utility, designating the area of use, occupancy, and access. All existing and proposed fences shall be located at the freeway right of way line. Denial of access regarding property adjoining the right of way line will not be altered.

(c) Plans. Utilities shall be responsible and accountable for protecting the public investment in the highway, inclusive of all its components, and to maintain traffic capacity and safety for each highway user.

(1) All utility installations shall be of durable materials designed for long life expectancy and relatively free from the need for routine servicing or maintenance. In addition to the requirements of this subchapter, any existing utility lines to remain in place must be of satisfactory design and condition in the opinion of the district.

(2) Utilities shall avoid disturbing existing drainage courses. In addition, soil erosion shall be held to a minimum and sediment from the construction site shall be kept away from the highway and drain inlets.

(3) Utility expansions shall be planned to minimize hazards to, and interference with, future highway projects or other utility installations.

(4) Plans shall include the design, proposed location, vertical elevations, and horizontal alignments of the utility facility based on the department's survey datum, the relationship to existing highway facilities and the right of way line, traffic safety and access procedures, and location of existing utilities that may be affected by the proposed utility facility.

(5) As-built plans or the certification of construction plans shall include the installed location, vertical elevations and horizontal alignments of the utility facility based upon the department's survey datum, the relationship to existing highway facilities and the right of way line, and access procedures for maintenance of the utility facility. Certified construction plans shall be signed by a utility official as approved by the department. If approved by the director of the Maintenance Division or Right of Way Division, a district may require a utility to deliver final as-built plans that are signed and sealed by an engineer or registered professional land surveyor. In determining whether to authorize a requirement for signed and sealed plans, the director shall consider:

(A) the amount of available right of way or the proposed utility facility's proximity to department facilities and other utility facilities that may be impacted; and

(B) past performance of the utility in providing accurate location data and conformance with its construction plans.

(6) If approved by the director of the Maintenance Division or the Right of Way Division, a district may require a utility to deliver plans that are signed and sealed by an engineer. In determining whether to authorize a requirement for signed and sealed plans, the director shall consider:

(A) the amount of available right of way or the proposed utility facility's proximity to department facilities or other utility facilities that may be impacted;

(B) the complexity of required traffic control plans;

(C) whether the installation or adjustment activity requires a storm water pollution prevention plan; and

(D) the utility's past performance in providing accurate location data and conformance with its construction plans.

(d) Tunnels and bridges.

(1) Interstate highways. In providing a utility tunnel or utility bridge, the requirements in subparagraphs (A) - (I) apply.

(A) Mutually hazardous transmittants, such as fuels and electric energy, shall be isolated by compartmentalizing or by auxiliary encasement of incompatible carriers.

(B) The utility tunnel or utility bridge structure shall conform in design, appearance, location, bury, earthwork, and markings to the culvert and bridge practices of the department.

(C) Where a pipeline on or in a utility structure is encased, the casing shall be effectively opened or vented at each end to prevent possible build up of pressure and to detect leakage of gases or fluids.

(D) Where a casing is not provided for a pipeline on or in a utility structure, additional protective measures shall be taken, such as employing a higher factor of safety in the design, construction, and testing of the pipeline than would be required for cased construction.

(E) Communication and electric power lines shall be insulated, grounded, and carried in protective conduit or pipe from the point of exit from the ground to reentry, and the cable carried to a manhole located beyond the backwall of the structure.

(F) Carrier and casing pipe for gas, liquid petroleum, hazardous product, and water lines shall be insulated from electric power line attachments.

(G) Sectionalized block valves shall be installed in lines at or near ends of utility structures, pursuant to 49 CFR §192.179, Transmission Line Valves, unless segments of the lines can be isolated by other sectionalizing devices within a distance acceptable to the department.

(H) Any maintenance, servicing, or repair of the utility lines will be the responsibility of the utility.

(I) The utility shall notify the district 48 hours in advance of any maintenance, servicing, or repair; however, in an emergency situation, the utility shall notify the district as soon as practicable.

(2) Non-interstate highways. If a utility's line exists on its own easement and it would be more economical to the department to adjust the line across a highway by use of a utility tunnel or bridge rather than to provide separately trenched and cased crossing, consideration should be given to provision of such a structure. Where the utility line was placed through an approved utility installation request and the adjustment of the utility is the sole responsibility of the utility owner, the department may allow for the provision of a utility structure without cost to the department, provided the conditions outlined in subsection (a) of this section and all other pertinent requirements are met. If a structure is to serve as a joint utility/pedestrian crossing or a joint utility/sign support structure, the department will participate to the extent necessary for accommodation of pedestrians or highway signs only.

(e) Joint use of utility and highway structures.

(1) The attachment of utility lines to bridges and grade separation structures is prohibited if other locations are feasible and reasonable.

(2) Where other arrangements for a utility line to span an obstruction are not feasible, the utility may submit a request to the district for attachment of the line to a bridge structure through a bridge attachment agreement. Each attachment will be considered on an individual basis, and permission to attach will not be considered as establishing a precedent for granting of subsequent requests for attachment.

(A) When it is impractical to carry a self-supporting communication line across a stream or other obstruction, the department may permit the attachment of the line to its bridge. If approved on existing bridges, the line must be enclosed in a conduit and so located on the structure as not to interfere with stream flow, traffic, or routine maintenance operations. When a request is made before construction of a bridge, if approved, suitable conduits may be provided in the structure if the utility bears the cost of all additional work and materials involved.

(B) If it is the department's responsibility to provide for the adjustment of telephone lines or telephone conduits to accommodate the construction of a highway and the adjustment provides for the placement of telephone conduits in a bridge, the department will allow a reasonable number of spare telephone conduits in the structure if the spares are placed at the time of construction and the telephone company bears the cost of the spare conduits.

(C) Gas or liquid fuel lines shall not be attached to a bridge without the written approval of the executive director.

(D) Power lines carrying greater than 600 volts shall not be permitted on bridges under any condition.

(E) When a utility is granted permission to attach a pipeline to a proposed bridge prior to construction, any additional costs associated with the design or construction to accommodate the pipeline are the responsibility of the utility.

(F) A utility requesting permission to attach a pipeline to an existing bridge shall submit sufficient information to allow the department to conduct a stress analysis to determine the effect of the added load on the structure. The department may require other details of the proposed attachment as they affect safety and maintenance

(f) Aesthetics. A utility will notify the department before removing, trimming, or replacing trees, bushes, shrubbery, or any other aesthetic features. The department must approve the extent and method of removal, trimming, or replacement of trees, bushes, shrubbery, or any other aesthetic feature.

§21.38. Construction and Maintenance.

(a) General.

(1) The provisions of this section apply to all utility types, unless otherwise specified in §21.40 and §21.41 of this subchapter.

(2) Utilities with facilities on the right of way shall be responsible and accountable to maintain and protect the safety of the traveling public and the public's investment in the highway facility.

(3) When an existing approved utility requires maintenance, the utility shall notify the district 48 hours before the start of any work. In an emergency situation, the utility shall notify the district as soon as possible.

(4) The utility shall not cut into the pavement or concrete riprap without written permission from the department.

(5) Utilities shall reimburse the department for the cost of measures taken in the interest of public safety, restoration, clean-up, and repairs to the highway and right of way made necessary by the utility's failure to comply with the provisions of this subchapter.

(b) Vegetation and site clean-up.

(1) When utility installation is complete, the utility shall return the right of way to a condition, at a minimum, equal to its original condition, including reseeding or resodding to prevent erosion. After the area is brought to grade, the entire disturbed area shall be covered in accordance with the department's Standard Specifications for Construction and Maintenance of Highways Streets & Bridges.

(2) To preserve and protect trees, bushes, and other aesthetic features on the right of way, the department may specify the extent and methods of tree, bush, shrubbery, or any other aesthetic feature's removal, trimming, or replacement, in conjunction with paragraph (1) of this subsection. The district engineer shall use due consideration in establishing the value of trees and other aesthetic features in the proximity of a proposed utility line and any special district requirements justified by the value of the trees and other aesthetic features.

(3) If settlement or erosion occurs due to the actions of the utility, the utility shall, at its expense, reshape, reseed, or resod the area as directed by the department. Reseeding, resodding, or repair under this section shall be completed within a reasonable period of time acceptable to the department.

(4) Pruning of trees shall comply with the department's Roadside Vegetation Management Manual. When unapproved pruning or cutting occurs, the utility shall be responsible for the replacement of trees or for damages to existing trees and bushes.

(5) Highways adjacent to utility construction sites shall be kept free from debris, construction material, and mud. At the end of every construction day, construction equipment and materials shall be removed from the horizontal clearance, placed as far from the pavement edge as possible, and properly protected.

(6) The utility shall reimburse the department for all costs incurred to repair damage from the actions of the utility. These costs may include restoration of and repairs to roads, drives, terrain, landscaping, or fences.

(c) Traffic control.

(1) The utility shall be responsible for the safety of, and shall minimize disruption to, the traveling public with proper traffic control.

(2) Appropriate measures shall be taken in the interests of safety, traffic convenience, and access to adjacent property that meet the requirements of the department's Compliant Work Zone Traffic Control Device List. The utility shall place appropriate signs, markings, and barricades before beginning work and shall maintain them to warn motorists and pedestrians properly. All traffic control devices shall conform to the TMUTCD and the National Cooperative Highway Research Project Report 350.

(3) All utility pits opened within the horizontal clearance shall be properly protected, in compliance with National Cooperative Highway Research Project Report 350, with concrete traffic barriers, metal beam guard fencing, appropriate end treatments, or other appropriate warning devices.

(d) Work restrictions.

(1) The department reserves the right to halt construction or maintenance during hazardous situations, such as inclement weather, peak traffic hours, special events, or holidays, or for

non-compliance with a Utility Joint Use Acknowledgement or Utility Installation Request. Requests for emergency maintenance shall be directed to the appropriate district office.

(2) If the department determines that the facility was not installed in the location shown on the approved construction plans, the department may require the utility to take appropriate corrective action as determined by the department.

§21.39. Ownership/Abandonment/Idling.

(a) General. When, due to a highway construction project, a utility is required to relocate its facility from property in which it owns a property interest, the department will acquire the utility's abandoned property interest within the new highway right of way.

(b) Change of ownership or function. If a utility sells, assigns, or conveys its facility to another company, the new owner must notify the department of the sale within a reasonable period of time and provide the name, address, and phone number of a person to be contacted on matters concerning the utility facility, and must update all call signs and markers within a reasonable period of time.

(c) Abandonment or idling of facility.

(1) Abandonment in place.

(A) A utility that wishes to abandon a utility facility in place must submit a written request to the district engineer for each type of facility. The request must include the following detailed information for each facility proposed for abandonment:

(i) offsets from property lines and the centerline of the highway;

(ii) coordinates based on the global positioning system (GPS) or a survey datum as directed by the department;

(iii) the age, condition, material type, current status, quantity, and size of the facility;

(iv) a legend explaining symbols, characters, abbreviations, scale, and other data shown on any as-built drawing or record mapping;

(v) a statement certifying that the facility does not contain, or is not composed of, hazardous or contaminated materials; and

(vi) any additional information requested by the department.

(B) If the district engineer approves the abandonment in place, the utility facility owner shall continue to map, locate, and mark its abandoned facilities as required by this subchapter, federal regulations, or standards adopted by industry organizations, whichever is more restrictive.

(C) Abandonment shall not be construed as a change in ownership of the facility.

(2) Abandonment costs and restoration of public right of way. The utility shall be responsible for all costs associated with the maintenance or removal of its abandoned or idled lines within the right of way, unless adjustment of the line is the financial responsibility of the department.

(3) Voids. Significant voids beneath the right of way are prohibited. The department, at the discretion of the district engineer, may require that a facility be filled with cement slurry or backfilled in accordance with department standards.

(4) High and low pressure gas pipeline abandonment. Each owner/operator shall conduct abandonment or deactivation of pipelines within the right of way in compliance with the requirements of this section, current federal, state, or local laws or codes, or industry standards, whichever are more stringent. If the line is approved for abandonment, the utility shall:

(A) purge, cut, and cap or plug the ends of all facilities at the right of way lines;

(B) submit to the department a written certification that the abandonment conforms with all requirements of this section, current federal, state, or local laws or codes, or industry standards, whichever are more stringent;

(C) slurry-fill the facility, if the department determines it is needed due to the age, condition, material type, quantity, and size of the facility; and

(D) disconnect each pipeline from all sources and supplies of gas, purge each pipeline of gas and, in the case of submerged pipelines, fill each pipeline with water or other approved materials, and seal it at the ends.

(5) Abandoned service lines or lines not in use. For each service line approved for abandonment, the utility shall:

(A) provide a locking device or other means designed to prevent opening on each valve that is closed, to prevent the flow of gas to the customer;

(B) install in the service line or in the meter assembly a mechanical device or fitting that will prevent the flow of gas;

(C) physically disconnect the customer's piping from the gas supply and seal the open pipe ends;

(D) insure that a combustible mixture is not present after purging; and

(E) fill each abandoned vault with a suitable compacted material.

(6) Record keeping for abandoned facilities. A record of underground utility facilities abandoned in the right of way shall be maintained in a utility's permanent files until the facility is completely removed from the ground, and shall be provided to the department promptly upon request. This record must include:

(A) offsets from property lines and the centerline of the right of way;

(B) coordinates derived from the global positioning system being used by the department or a survey datum as directed by the department;

(C) the type, quantity, and size of the equipment;

(D) a legend explaining symbols, characters, abbreviations, scale, and other data shown on map;

(E) the location of the abandoned facilities; and

(F) any additional information requested by the department.

§21.40. Underground Utilities.

(a) General.

(1) Encasement.

(A) Underground utilities crossing the highway shall be encased in the interest of safety, protection of the utility, protection of the highway, and for access to the utility. Casing shall consist of a pipe or other separate structure around and outside the carrier line.

The utility must demonstrate that the casing will be adequate for the expected loads and stresses.

(B) Casing pipe shall be steel, concrete, or plastic pipe as approved by the district, except that if horizontal directional drilling is used to place the casing, high-density polyethylene (HDPE) pipe must be used in place of plastic pipe.

(C) Encasement may be of metallic or non-metallic material. Encasement material shall be designed to support the load of the highway and superimposed loads thereon, including that of construction machinery. The strength of the encasement material shall equal or exceed structural requirements for drainage culverts and it shall be composed of material of satisfactory durability for conditions to which it may be subjected. The length of any encasement under the roadway shall be provided from top of backslope to top of backslope for cut sections, five feet beyond the toe of slope for fill sections, and five feet beyond the face of the curb for curb sections. These lengths of encasement include areas under center medians and outer separations, unless otherwise specifically addressed in subsections (b) - (f) of this section.

(D) The department will provide an example graphic upon request of a typical section showing encasement lengths

(2) Depth. Where placements at the depths in this section are impractical or where unusual conditions exist, the department may allow installations at a lesser depth, but will require other means of protection, including encasement or the placement of a reinforced concrete slab. Reinforced concrete slabs or caps shall meet the following standards:

(A) width--five feet, or three times the diameter of the pipe, whichever is greater;

(B) thickness--six inches, at minimum;

(C) reinforcement--#4 bars at 12 inch centers each way or equivalent reinforcement; and

(D) cover--no less than six inches of sand or equivalent cushion between the bottom of the slab/cap and the top of the pipe.

(3) Manholes and handholds.

(A) Manholes shall not be installed unless necessary for installation and maintenance of underground lines. In no case shall a manhole be placed or permitted to remain in the pavement or shoulder of a highway. However, on noncontrolled access highways in urban areas, the district may, in its discretion, allow existing lines to remain in place under existing or proposed highways. In these cases, manholes may remain in place or be installed under traffic lanes of low volume highways in municipalities only if measures are taken to minimize the installations and to avoid locating them at intersections or in wheel paths.

(B) To conserve space, a manhole's dimensions shall be the minimum acceptable by appropriate engineering and safety standards. The only equipment that may be installed in manholes located on the right of way is that essential to the normal flow of the utility, such as circuit reclosers, cable splices, relays, valves, and regulators. Other equipment, such as substation equipment, large transformers, and pumps, shall be located outside the right of way.

(C) Inline manholes are the only type permitted within the right of way. The width dimensions shall be no larger than necessary to hold equipment involved and to meet safety standards for maintenance personnel. Outside width, the dimension of the manhole perpendicular to the highway, shall not exceed ten feet, with the length to be held to a reasonable minimum. The outside diameter of the manhole chimney at the ground level shall not exceed 36 inches, except that if the utility demonstrates necessity, the district may, at its discretion, allow an outside diameter of up to 50 inches. The top of the roof of the manhole shall be five feet or more below ground level.

(D) All manhole covers shall be installed flush with the ground or pavement structure. In order to minimize vandalism, manhole covers must weigh at least 175 pounds. Manhole rings and covers must be designed for HS-20 loading.

(E) Manholes shall be straight, inline installations with a minimum overall width necessary to operate and maintain the enclosed equipment. The utility is responsible for any adjustment of the manhole rim that may be needed to meet grade changes.

(4) Installation.

(A) Lines placed beneath any existing highway shall be installed by boring or tunneling. Jacking may not be used unless approved in writing by the district. The district may require encasement of lines installed by boring or jacking. The use of explosives is prohibited. Pipe bursting or fluid/mist jetting may be allowed at the discretion of the department.

(B) For rural, uncurbed highway crossings, all borings shall extend beneath all travel lanes. Unless precluded by right of way limitations, the following clearances are required for rural highway crossings:

(i) 30 feet from all freeway main lanes and other high-speed (exceeding 40 mph) highways except as indicated in clauses (ii) - (iv) of this subparagraph;

(ii) 16 feet for high-speed highways with current average daily traffic volumes of 750 vehicles per day or fewer;

(iii) 16 feet for ramps; or

(iv) ten feet for low-speed (40 mph or less) highways.

(C) Annular voids greater than one inch between the bore hole and carrier line (or casing, if used) shall be filled with a slurry grout or other flowable fill acceptable to the department to prevent settlement of any part of the highway facility over the line or casing.

(D) For curbed highway crossings, all borings shall extend beneath travel and parking lanes and extend beyond the back of curb, plus:

(i) 30 feet from facilities with speed limits of 40 mph or greater; or

(ii) five feet from facilities with speed limits of less than 40 mph or less, plus any additional width necessary to clear an existing sidewalk.

(E) Where circumstances necessitate the excavation of a bore pit or the presence of directional boring equipment closer to the edge of pavement than set forth in paragraphs (2) or (3) of this subsection, approved protective devices shall be installed for protection of the traveling public in accordance with §21.38 of this subchapter. Bore pits shall be located and constructed in such a manner as not to interfere with the highway structure or traffic operations. If necessary, shoring shall be utilized for the protection of the highway, and must be approved by the district.

(F) All traffic control devices, including signs, markings, or barricades used to warn motorists and pedestrians of the construction activity must conform to the TMUTCD.

(G) When trenching longitudinally, backfill or stabilized sand shall be compacted to densities equal to that of the surrounding soil.

(5) Nonmetallic pipe detection. Where nonmetallic pipe is installed, whether longitudinally or at a crossing, a durable metal wire or other district-approved means of detection shall be concurrently installed.

(6) Unsuitable conditions. The following conditions are generally unsuitable or undesirable for pipeline crossings and shall be avoided:

(A) deep cuts;

(B) locations near footings or bridges and retaining walls;

(C) crossing intersections at-grade or ramp terminals;

(D) locations at cross-drains where the flow of water may be obstructed;

(E) locations within basins or underpasses drained by pump if the pipeline carries a liquid or liquefied gas; or

(F) terrain where minimum depth of cover would be difficult to attain.

(7) Clearances. Except as specified in this subchapter, there shall be a minimum of 12 inches vertical and horizontal clearance between a pipeline and an existing utility, unless a greater clearance is required by the district. However, if an installation of another utility or highway feature cannot take place without disturbing an existing utility, the minimum clearance will be 24 inches.

(8) Crossings. A district may require crossings with no longitudinal connections to be encased within the right of way.

(9) Drainage easements. Where it is necessary for pipelines to cross department drainage easements outside of the right of way, the depth of cover shall be as specified for each type of utility. In cases where soil conditions are such that erosion might occur, or where it is not feasible to obtain specified depth, it shall be the responsibility of the utility to install retards, energy dissipators, encasement, or concrete or equivalent slabs/caps over the pipe, as approved by the department. Where grades on the pipelines must be maintained, such as gravity flow sewer lines, each case will be reviewed on an individual basis, keeping in mind that the main purpose of the channel is to carry drainage water and that this flow must not be obstructed. The utility owner is responsible for obtaining any other approvals to occupy the drainage easement.

(10) Existing installations in a highway or transportation project. At the district's discretion, existing longitudinal lines in a highway or transportation project that otherwise meet the requirements of this subchapter may remain in place if the lines:

(A) can be maintained in accordance with §21.37(b)(2) of this subchapter; and

(B) are not located under the pavement structure or shoulder of any proposed or existing highway.

(11) Markers. If a high pressure gas or liquid petroleum line crosses a highway, the utility shall place a readily identifiable, durable, and weatherproof marker over the centerline of the pipe at each right of way line. Readily identifiable, durable, and weatherproof markers shall be placed at a minimum distance of 500 feet or line of sight at the right of way line for pipelines installed longitudinally within the right of way. All markers shall indicate the name, address, emergency telephone number of the owner/operator, and offset from the right of way line. For gas or petroleum pipelines, the pipeline product, operating pressure, and depth of pipe below grade shall also be indicated on the markers. At locations where underground utilities have been allowed to cross at an angle other than 90 degrees to centerline, the district may require additional markers in the medians and outer separations of the highway.

(12) Backfilling. Underground utility installations shall be backfilled with pervious material and outlets for underdrainage.

(13) Underdrainage. Underdrains shall be provided where necessary. No puddling beneath the highway will be permitted.

(b) Gas and liquid petroleum lines.

(1) Low-pressure lines.

(A) Depth of cover for crossings. Depth of cover is the depth to the top of the carrier pipe or casing, as applicable. Where materials and other conditions justify, such as on existing lines remaining in place, the district may require a minimum depth of cover under the pavement structure of 12 inches or one-half the diameter of the pipe, whichever is greater.

(i) For encased low-pressure gas lines, the minimum depth of cover shall be:

(I) 18 inches or one-half the diameter of the pipe, whichever is greater, under pavement structure;

(II) 24 inches outside pavement structure and under ditches (original unsilted flowline); or

(III) 30 inches for unencased sections of encased lines outside of pavement structure.

(ii) For unencased low-pressure gas lines, the minimum depth of cover shall be:

(I) 60 inches under the pavement surface or 18 inches under the pavement structure for paved areas;

(II) 48 inches outside paved areas and under ditches (original unsilted flowline); or

(III) a lesser depth if authorized by the district where a reinforced concrete slab is used to protect the pipeline.

(B) Depth of cover for longitudinal placement. The minimum depth of cover for longitudinal installations shall be 36 inches.

(i) Encasement. Low-pressure gas lines crossing the pavement shall be placed in a steel encasement. The district may waive this encasement requirement if the line is of welded steel construction and is protected from corrosion by cathodic protective measures or cold tar epoxy wrapping, and the utility signs a written agreement that the pavement will not be cut for pipeline repairs at any time in the future.

(ii) Vents. One or more vents shall be provided for each casing or series of casings. For casings longer than 150 feet, vents shall be provided at both ends. On shorter casings, a vent shall be located at the high end with a marker placed at the low end. Vents shall be placed at the right of way line immediately above the pipeline, situated so as not to interfere with highway maintenance or be concealed by vegetation, and shall be no greater than six inches in diameter. The owner's name, address, and emergency telephone number shall be shown on each vent.

(iii) Plastic lines. Plastic lines shall be encased within the right of way on crossings, and must have at least 30 inches of cover.

(iv) Aboveground appurtenances. Except for vents, no above ground utility appurtenances for gas lines shall be permitted within the right of way.

(2) High-pressure lines.

(A) Depth of cover for crossings.

(i) Depth of cover is the depth to the top of the carrier pipe or casing, as applicable. Where materials and other conditions justify, such as on existing lines remaining in place, the district may approve a minimum depth of cover under the pavement structure of 12 inches or one-half the diameter of the pipe, whichever is greater. For encased high-pressure gas or liquid petroleum lines, the minimum depth of cover shall be:

(I) the greater of 18 inches or one-half the diameter of the pipe, under pavement structures;

(II) 30 inches if the line is outside the pavement structure or under a ditch; or

(III) 36 inches for unencased sections of encased lines outside the pavement structure.

(ii) Where a reinforced concrete slab is used to protect the pipeline, the district may authorize a reduction in the depths specified in this section. For unencased high-pressure gas or liquid petroleum lines, the minimum depth of cover is as follows:

(I) 60 inches under the pavement surface or 18 inches under the pavement structure in paved areas; or

(II) 48 inches if the line is placed outside the pavement structure or under a ditch.

(B) Depth of cover for longitudinal placement. The minimum depth of cover shall be 48 inches.

(C) Encasement. Casing shall consist of a vented steel pipe.

(D) Unencasement.

(i) Where encasement is not employed, the utility shall show that the welded steel carrier pipe will provide sufficient strength to withstand the internal design pressure and the dead and live loads of the pavement structure and traffic. Additional protective measures must include:

(I) heavier wall thickness, higher factor of safety in design, or both;

(II) adequate coating and wrapping;

(III) cathodic protection; and

(IV) the use of Barlow's formula regarding maximum allowable operating pressure and wall thickness, as specified in 49 CFR §192.105.

(ii) Shallow anode bed types exceeding 48 inches in width shall not be permitted in the right of way. All others must have a depth of coverage of at least 36 inches. Deep well anode beds of up to 60 inches in diameter are acceptable. Rectifier and meter loop poles shall be placed at or near the right of way line.

(iii) The minimum length of the additional protection shall be the same as that required for an encased crossing.

(iv) The district may allow existing lines under low-volume highways to remain in place without encasement or extension of encasement if they are protected by a reinforced concrete slab or equivalent protection or if they are located at a depth of five feet under the pavement structure and not less than four feet under a highway ditch.

(E) Vents. Vents shall be installed at both ends of a casing, regardless of length, with a marker on at least one end. Vents shall be placed at the right of way line immediately above the pipeline, situated so as not to interfere with highway maintenance or be concealed by vegetation. The owner's name, address, and emergency telephone number shall be shown on each vent marker.

(F) Aboveground appurtenances. Aboveground appurtenances, except vents for gas lines, shall not be permitted within the right of way.

(c) Water lines.

(1) Material type. All material types used for water lines shall conform to American Waterworks Association, applicable local requirements, and 30 TAC §290.44(a).

(2) Depth of cover. The minimum depth of cover shall be 30 inches, but not less than 18 inches below the pavement structure for crossings.

(3) Encasement. Unless another type of encasement is approved by the district, water lines crossing under paved highways must be placed in a steel encasement pipe within the limits of the right of way. At the district's discretion, encasement may be omitted under center medians and outer separations that are more than 76 feet wide. At the district's discretion, encasement under side road entrances may be omitted in consideration of traffic volume, condition of highway, maintenance responsibility, or district practice. Existing water lines 24 inches or greater may be allowed to remain unencased under the pavement of new low volume highways, provided depth and all other requirements of 30 TAC §290.44 are met.

(4) Manholes. The width dimensions shall be no larger than is necessary to hold equipment involved and to meet safety standards for maintenance personnel. The maximum inside diameter of the manhole chimney shall not exceed 48 inches. The outside diameter of the manhole chimney at the ground level shall not exceed 36 inches.

(5) Aboveground appurtenances.

(A) Fire hydrants and valves. When feasible, fire hydrants and blow-off valves are to be located at the right of way line. Fire hydrants shall not be placed in the sidewalk or any closer than five feet from the back of the curb. Valve locations shall be placed so as not to interfere with maintenance of the highway.

(B) Water meters. Individual service meters shall be placed outside the limits of the right of way. Master meters for a point of service connection may be placed in a manhole with a maximum width of 48 inch inside diameter. If additional volume is required, a manhole with a neck of 60-inch depth must be used.

(C) Service lines crossing highway by bore. Lines for customer service that cross the highway may be placed in a high-density polyethylene (HDPE) encasement pipe without joints (rolled pipe).

(d) Nonpotable water control facilities.

(1) Applicability. This subsection applies to agricultural irrigation facilities, water control improvement districts, municipal utility districts, flood control districts, canals, and similar nonpotable water control facilities.

(2) Depth of cover for buried pipe facilities. The minimum depth of cover, regardless of type of pipe used, shall be 30 inches, but not less than 18 inches below any pavement structure.

(3) Encasement for buried pipe facilities. Unless the district approves another type of encasement, all non-potable water control lines crossing under paved highways within the right of way must be placed in a steel encasement pipe. At the district's discretion, encasement may be omitted under center medians and outer separations that are more than 76 feet wide.

(4) Location and design requirements. Open ditch facilities and buried pipe facilities designed and constructed in accordance with this subchapter may be installed across the right of way. Longitudinal buried pipe facilities installed within the right of way must conform with §21.41(c) of this subchapter, consistent with the clearances applicable to all roadside obstacles. Open ditch facilities shall not be installed longitudinally within the right of way, nor will any aboveground appurtenances be permitted within the horizontal clearance.

(5) Levee/ditch travel road location. Coordination with and approval by the district is required where levee/ditch travel roads intersect the highway.

(e) Sanitary sewer lines.

(1) Material type. All material types used for sanitary sewer lines shall conform to 30 TAC §317.2 and applicable local requirements.

(2) Depth of cover. The minimum depth of cover shall be 30 inches, but not less than 18 inches below any pavement structure.

(3) Encasement. Pressurized line crossings under paved highways within the limits of the right of way shall be placed in a steel encasement pipe. Gravity flow lines not conforming to the minimum depth of cover shall be encased in steel or concrete. At the district's discretion, encasement may be omitted under center medians and outer separations that are more than 76 feet wide.

(4) Manholes. Manholes serving sewer lines up to 12 inches shall have a maximum inside diameter of 48 inches. For lines larger than 12 inches, the manhole inside diameter may be increased an equal amount, up to a maximum diameter of 60 inches. Manholes for large interceptor sewers shall be designed to keep the overall dimensions to a minimum. The outside diameter of the manhole chimney at the ground level shall not exceed 36 inches.

(5) Lift stations. Lift stations and pump stations for sanitary sewer lines exceeding 48 inches inside diameter shall be located outside the limits of right of way.

(f) Electric and communication Lines.

(1) Underground electric lines.

(A) Depth of cover. All underground electric lines placed within the right of way may be installed by direct bury at depths according to the voltage of electric lines as required by the National Electrical Safety Code and as shown in the following chart. Figure: 43 TAC §21.40(f)(1)(A)

(B) Encasement. Electric lines crossing the roadway shall be encased in steel or comparable material greater than or equal to that of ductile iron, with satisfactory joints, or materials and designs that will provide equal or better protection of the integrity of the highway system and resistance to damage from corrosive elements to which they may be exposed. The lines shall be buried a minimum of 36 inches under highway ditches, and 60 inches below the pavement structure. Encasement shall be provided as outlined in this section.

(C) Installation. Longitudinal underground electric lines may be placed by plowing or open trench method. All plowing and trenching shall be performed in a uniform alignment with the right of way. If the installation of the facility is found to deviate from the approved location, the district, at its sole discretion, may require the adjustment of the facility to the approved location. The utility facility shall be located as set forth in §21.37(b) of this subchapter.

(D) Aboveground appurtenances.

(i) Aboveground appurtenances installed as part of an underground electric line shall be located at or near the right of way line, and shall not impede highway maintenance or operations.

(ii) Structures that are larger in plan view than single poles may be placed on the right of way if:

(I) the installation will not hinder highway maintenance operations;

(II) the housing will be placed at or near the right of way line;

(III) the installation will not reduce visibility and sight distance of the traveling public;

(IV) the dimensions of the housing are minimized, particularly where the need to allow space for highway improvement or accommodation of other utility lines is apparent;

(V) the outside width, length (longitudinal with respect to the right of way), and height dimensions of the aboveground portion of the housing do not exceed 36 inches, 60 inches, and 54 inches respectively;

(VI) the supporting slab does not project more than three inches above the ground line, nor extend more than 12 inches on either side of the housing structure; and

(VII) the installation will be compatible with adjacent land uses.

(E) Manholes. Manholes serving electric and communication lines shall conform to the requirements of this section.

(F) Abandonment. Underground electric lines may be abandoned in place at the discretion of the district.

(2) Underground communication lines.

(A) Longitudinal. The minimum depth of cover for cable television and copper cable communications lines shall be 24 inches. The minimum depth of cover for fiber optic facilities shall be 42 inches. If the owner/operator of a fiber optic facility waives damages and fully indemnifies the department in a form acceptable to the department, the minimum depth of cover may be reduced to not less than 36 inches.

(B) Crossings.

(i) The minimum depth of cover for cable television and copper cable communication lines shall be 24 inches under ditches or 18 inches beneath the bottom of the pavement structure, whichever is greater.

(ii) The top of the fiber optic facility shall be placed a minimum of 42 inches below the ditch grade or 18 inches below the pavement structure or 60 inches below the top of the pavement surface, whichever is greater. The department may authorize a minimum depth of cover of not less than 36 inches below the ditch grade or 60 inches below the top of the pavement surface, whichever is greater, if the owner/operator waives damages and fully indemnifies the department in a form acceptable to the department.

(iii) The department may require encasement or other suitable protection when necessary to protect the highway facility when the line is located:

(I) at less than minimum depth;

(II) near the footing of a bridge or other highway structure; or

(III) near another hazardous location.

(iv) Unless the line is encased, installation shall be accomplished by boring a hole the same diameter as the line. The annular void between a drilled hole and the line or casing shall be filled with a material approved by the district to prevent settlement of any part of the highway facility over the line or casing.

(C) Installation. Lines may be placed by plowing or open trench method and shall be located on uniform alignment with the right of way and as near as practical to the right of way line to provide space for possible future highway construction and for possible future utility installations.

(D) Multiple conduits.

(i) Shared conduits. When an existing utility rents, leases, or sells conduit usage to another utility, the new utility and the conduit owner must submit a joint Utility Installation Request before placement of a new line within the conduit.

(ii) Additional conduits. No more than two additional empty conduits may be added for every full conduit line, unless otherwise approved by the district.

(E) Aboveground appurtenances.

(i) Aboveground pedestals or other utility appurtenances installed as a part of an underground communication line shall be located at or near the right of way line, so as not to impede highway maintenance or operations.

(ii) Large equipment housings. Structures that are larger in plan view than single poles may be placed on the right of way if:

(I) the installation will not hinder highway maintenance operations;

(II) the housing will be placed at or near the right of way line;

(III) the installation will not reduce visibility and sight distance of the traveling public;

(IV) the dimensions of the housing are minimized, particularly where the need to allow space for highway improvement and accommodation of other utility lines is apparent;

(V) outside width, length (longitudinal), and height dimensions of the aboveground portion of the housing do not exceed 36 inches, 60 inches, and 54 inches respectively;

(VI) the supporting slab does not project further than three inches above ground line, nor extend further than 12 inches on either side of the housing structure; and

(VII) the installation will be compatible with adjacent land uses.

(F) Abandonment. Underground communication lines may be abandoned in place at the discretion of the district.

§21.41. Overhead Electric and Communication Lines.

(a) Type of construction. Longitudinal lines on the right of way shall be limited to single pole construction. Where an existing or proposed utility is supported by "H" frames, the same type structures may be utilized for the crossing provided all other requirements of this subchapter are met.

(b) Vertical clearance. The minimum vertical clearance above the highway shall be 22 feet for electric lines, and 18 feet for communication and cable television lines. These clearances may be greater, as required by the National Electric Safety Code and governing laws.

(c) Horizontal clearances. The following table indicates the design values for horizontal clearances:
Figure: 43 TAC §21.41(c)

(d) Location.

(1) Poles supporting longitudinal lines shall be located within three feet of the right of way line, except that, at the option of the department, this distance may be varied at short breaks in the right of way line. Poles with bases greater than 36 inches in diameter shall not be placed within the right of way. Guy wires placed within the right of way shall be held to a minimum and be in line with the pole line. Other locations may be allowed, but in no case shall the guy wires or poles be located closer than the minimum allowed by the department's horizontal clearance policy, as shown in subsection (c) of this section.

(2) Poles shall not be placed in the center median of any highway. At the department's discretion, poles may be placed in the outer separations or more than three feet inside the right of way where the right of way is greater than 300 feet and where poles can be located in accordance with the department's horizontal clearance policy, as shown in subsection (c) of this section.

(3) Overhead electric, communication, and cable television line crossings at bridges or grade separation structures are prohibited. Overhead lines shall not be located below any bridge structure at any time. If rerouting the line completely around the structure and approaches is not feasible, a minimum horizontal distance of 150 feet from the bridge abutment joint and a minimum vertical clearance of 30 feet above the point of crossing the bridge pavement and retaining walls is required to ensure adequate safety for construction and maintenance operations.

(e) Markers. Utility poles must bear readily identifiable plaques or other approved markers denoting ownership and use, at a distance of approximately one pole per 1,320 feet, as equally spaced as practicable, and at every crossing, in a format acceptable to the department. Each company connecting to a pole shall appropriately identify its use of the pole. There shall be a beginning and end marker for each user of the pole line.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406471
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 12, 2004
For further information, please call: (512) 463-8630

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WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 334. UNDERGROUND AND ABOVEGROUND STORAGE TANKS

SUBCHAPTER A. GENERAL PROVISIONS

30 TAC §334.14

The Texas Commission on Environmental Quality has withdrawn from consideration the proposed amendment to §334.14 which appeared in the April 30, 2004, issue of the *Texas Register* (29 TexReg 4083).

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406465
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Effective date: October 29, 2004
For further information, please call: (512) 239-0348

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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the the rule (Government Code, §2001.036). If a rule is adopted without change to the text as published in the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 28. PHARMACY SERVICES: REIMBURSEMENT

1 TAC §355.8551

The Health and Human Services Commission (HHSC) adopts the amendments to §355.8551, Dispensing Fee, without changes to the proposed text as published in the August 20, 2004, issue of the *Texas Register* (29 TexReg 8055). The text of the rule will not be republished.

The adopted rule includes the following changes to §355.8551: (1) revises the language regarding the provision to pay pharmacists a supplemental amount for providing free delivery to Medicaid recipients by changing the reference to this amount from a fee to an incentive; and (2) it establishes a $0.50 per prescription incentive for pharmacists dispensing generic drugs designated as preferred on HHSC's preferred drug list (PDL). Implementation of this latter provision will serve to increase dispensing fees.

The following comments were received by HHSC during the comment period concerning the proposed rules. The Medical Care Advisory Committee under the authority of the Human Resources Code §32.022, Medical and Hospital Advisory Committee (MCAC), supported the rule if revisions were made to the rule presented to the Committee. The Texas Pharmacy Association supports the adoption of this rule. The Texas Federation of Drug Stores supports the adoption of this rule with reservations. The Pharmaceutical Research and Manufacturers of America (PhRMA), the Generic Pharmaceutical Association, and others oppose the adoption of this rule. Following each comment is the response from HHSC.

Comment: Concerning §355.8551(6)(B), HHSC received comments in opposition from the MCAC, PhRMA, and the Generic Pharmaceutical Association to the proposed rule due to concerns that HHSC had used one set of rules to place brand drugs on the preferred drug list (PDL) and now, in conjunction with the implementation of this proposed rule, plans to use a different set of rules to place generic drugs on the PDL.

Response: House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, as codified in Government Code §531.070, requires the Commission to develop a Preferred Drug List for Medicaid and the Children's Health Insurance Program, which includes the negotiation of supplemental rebate agreements with both generic and brand name drug manufacturers. The Health and Human Services Commission (HHSC) recognizes the economic value that generic products bring to the Medicaid program. The provision of a $0.50 incentive to pharmacies for dispensing generic products for which a manufacturer has agreed to pay a supplemental rebate is consistent with the intent of H.B. 2292. No change was made to the rule in response to this comment.

Comment: Concerning §355.8551(6)(B), HHSC received comments from several persons opposed to HHSC's effort to obtain supplemental rebates from generic manufacturers, given that generic drugs are priced much lower than brand drugs (nationally, brand drugs are $76.29 per prescription while generic drugs are $22.79 per prescription); profit margins are much lower than brand drugs, and generic manufacturers already pay an average 11% Medicaid rebate.

Response: House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, as codified in Government Code §531.070, requires the Commission the develop a Preferred Drug List for Medicaid and the Children's Health Insurance Program, which includes the negotiation of supplemental rebate agreements with both generic and brand name drug manufacturers. These provisions require that all drugs, brand name or generic, must have a rebate agreement to be listed on the preferred drug list. No change was made to the rule in response to this comment.

Comment: Concerning §355.8551(6)(B), HHSC received comments from several persons opposed to the selection of a preferred generic drug from a manufacturer from which the retail pharmacy does not purchase any other generic drugs, as many retail pharmacies purchase primarily from only one generic manufacturer in order to get the best prices by carrying an entire product line.

Response: The purpose of the incentive for dispensing preferred generic drugs is to move Medicaid drug volume to the generic drugs, thereby maximizing the savings to the Medicaid Vendor Drug Program. The alternative of prior authorization for non-preferred generic drugs would have placed a more onerous burden on prescribers and pharmacists. No change was made to the rule in response to this comment.

Comment: Concerning §355.8551(6)(B), HHSC received comments from several persons opposed to the proposed amendments to the rule due to concerns that creating an incentive to move generic drug volume occasioned by the payment of this incentive would interfere in the very competitive generic drug market in Texas and the unintended consequences would be higher costs for the Medicaid Program in the long run.

Response: The provisions of H.B. 2292, 78th Legislature, Regular Session, 2003, as codified in Government Code §531.070, require that all drugs, brand name or generic, must have a rebate agreement to be listed on the preferred drug list. Savings to the Medicaid Vendor Drug Program are maximized as the generic drug volume is moved to preferred generics. HHSC expects that the incentive to dispense preferred generics will move Medicaid volume to the preferred generics, which will result in increased savings. No change was made to the rule in response to this comment.

The amendment is adopted under the Texas Government Code, §531.033, which provides the Commissioner of HHSC with broad rulemaking authority; the Human Resources Code, §32.021, and the Texas Government Code, §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and the Texas Government Code, §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406490
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Effective date: November 21, 2004
Proposal publication date: August 20, 2004
For further information, please call: (512) 424-6900

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER S. WHOLESALE MARKETS

16 TAC §25.501

The Public Utility Commission of Texas (commission) adopts amendments to §25.501, relating to Wholesale Market Design for the Electric Reliability Council of Texas (ERCOT), with changes to the proposed amendments as published in the September 17, 2004, issue of the *Texas Register* (29 TexReg 8982). The amendments modify the requirements for the development and implementation of a nodal market for ERCOT by extending the deadlines for the cost-benefit analysis to December 31, 2004 and the draft protocols and energy load zones to March 18, 2005; requiring that the independent cost-benefit analysis, the draft protocols, and the draft energy load zones be filed for informational purposes rather than for approval; and removing the iterative requirement for the independent cost-benefit analysis. The amendments reflect the commission's current expectations for the process for development and implementation of an improved ERCOT wholesale market design. The amendments are adopted under Project Number 30160.

The commission received comments on the proposed amendments from the DFW Electric Consumer Coalition (DFW), ERCOT, Reliant Energy, Incorporated (Reliant), and TXU Portfolio Management, LP (TXU). TXU supported adoption of the proposed amendments. Reliant, DFW, and ERCOT supported adoption of the proposed amendments with modifications.

TXU stated its appreciation for the commission's willingness to provide for the proper process and amount of time to develop a nodal market.

Reliant supported the modified process set forth in the proposed amendments, and stated that the modified process will provide the commission with much-needed flexibility and the opportunity to gather information to achieve the best policy outcome. Reliant also requested that the deadline to file the cost-benefit analysis be extended to December 31, 2004. Reliant stated its support for the existing October 1, 2006 deadline to implement a nodal market. Reliant stated that any delay in implementation of a nodal market would be detrimental to the State of Texas. It listed numerous benefits of a nodal market, and cited the *2003 State of the Market Report for the ERCOT Wholesale Electricity Markets* (August 2004) prepared by the commission's consultant, Potomac Economics, as support for its position.

Commission's response

The deadline to file the cost-benefit analysis is discussed below in response to ERCOT's comments. The deadline to implement a nodal market is discussed below in response to DFW's comments.

DFW commented that the delay to March 1, 2005 for filing protocols for the new market design is appropriate given the volume of work still needed for their preparation. In particular, DFW noted that the delay provides needed time for consideration of the economists' comments on the draft protocols and for consideration of the cost-benefit analysis required by subsection 25.501(m), prior to ERCOT's filing of the draft protocols. DFW also stated that the commission should not be required to approve the cost-benefit analysis, and agreed that the analysis should not be required to show net benefits from ERCOT's nodal market design; such a requirement would undermine the study's credibility. DFW commended the commission for pushing for prompt resolution of noted inefficiencies in the current market design. However, DFW asserted that the current implementation date of October 1, 2006 for the new market design is unrealistic, and consequently market participants are not taking it seriously, thereby undermining the commission's goal of prompt resolution of noted inefficiencies. Consequently, DFW recommended that the implementation deadline be delayed to October 2007.

Commission's response

The commission agrees with DFW that there should be adequate time for thorough consideration of the economists' comments and the cost-benefit analysis, and that the cost-benefit analysis should be truly independent. Nevertheless, at this juncture, the commission sees no reason why the October 1, 2006 implementation date cannot be met.

ERCOT requested that the deadline to file the cost-benefit analysis be extended to December 31, 2004. ERCOT explained that

the analysis will not be ready by the current deadline of November 1, 2004, because of modeling problems in the Energy Impact Assessment part of the analysis. ERCOT believes that it is imperative that a quality cost-benefit analysis be produced with adequate time for stakeholder review prior to filing with the commission. ERCOT also requested that the deadline for filing the draft energy load zones be extended to coincide with the deadline for filing the draft protocols, because design changes resulting from the economists' comments may result in reconsideration of the current load zone philosophy. ERCOT also requested an extension of the deadline to file the draft protocols to March 18, 2005 to allow time for an interim protocol review to focus particularly on the economists' comments. ERCOT stated that it will closely follow the progress of the overall Texas Nodal Team (TNT) process and the review by the commission to make sure that the overall timeline is maintained. If a material impact to the timeline becomes apparent, ERCOT stated that it will promptly notify the commission.

Commission's response

The commission has changed the deadline to file the cost-benefit analysis as requested by ERCOT, to provide sufficient opportunity for the development of a high quality analysis. The commission has required the cost-benefit analysis in order to ensure that the market designs under consideration will be thoroughly analyzed in an unbiased manner. The independent consultants performing the cost-benefit analysis should fully explain the rationale behind their conclusions and should support their conclusions using actual experience in existing markets and empirical analysis to the extent reasonably possible.

The commission has also changed the deadline for filing the energy load zones to coincide with the deadline for filing the draft protocols, to ensure that they are consistent with the market design underlying the protocols. Finally, the commission has extended the deadline for filing the protocols to March 18, 2005, in order for the economists' comments to be fully considered by TNT. The commission emphasizes the importance of TNT fully considering the economists' comments and reflecting them in the protocols to the extent appropriate.

The amendments are adopted under the Public Utility Regulatory Act, Texas Utilities Code, Title II, §14.002 (Vernon 1998 & Supplement 2005) (PURA), which provides the commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and PURA §39.151, which grants the commission oversight and review authority over independent organizations like ERCOT.

Cross Reference to Statutes: Public Utility Regulatory Act §§14.002, 35.004(e), 39.001(d), and 39.151.

§25.501. Wholesale Market Design for the Electric Reliability Council of Texas.

(a) General. The protocols and other rules and requirements of the Electric Reliability Council of Texas (ERCOT) that implement this section shall be developed with consideration of microeconomic principles and shall promote economic efficiency in the production and consumption of electricity; support wholesale and retail competition; support the reliability of electric service; and reflect the physical realities of the ERCOT electric system. Except as otherwise directed by the commission, ERCOT shall determine the market clearing prices of energy and other ancillary services that it procures through auctions and the congestion rents that it charges or credits, using economic concepts and principles such as: shadow price of a constraint, marginal cost pricing, and maximizing the sum of consumer and producer surplus.

(b) Bilateral markets and default provision of energy and ancillary capacity services. ERCOT shall permit market participants to self-arrange (self-schedule or bilaterally contract for) energy and ancillary capacity services, except to the extent that doing so would adversely impact ERCOT's ability to maintain reliability. To the extent that a market participant does not self-arrange the energy and ancillary capacity services necessary to meet its obligations or to the extent that ERCOT determines that the market participant's self-arranged ancillary services will not be delivered, ERCOT shall procure energy and ancillary capacity services on behalf of the market participant to cover the shortfall and charge the market participant for the services provided.

(c) Day-ahead energy market. ERCOT shall operate a voluntary day-ahead energy market, either directly or through contract.

(d) Adequacy of operational information. ERCOT shall require resource-specific bid curves for energy and ancillary capacity services that it competitively procures in the day-ahead or operating day, and ERCOT shall use these bid curves or ex-ante mitigated bid curves to address market failure, as appropriate, in its operational decisions and financial settlements.

(e) Congestion pricing.

(1) ERCOT shall directly assign all congestion rents to those resources that caused the congestion.

(2) ERCOT shall be considered to have complied with paragraph (1) of this subsection if it complies with this paragraph. ERCOT shall settle each resource imbalance at its nodal locational marginal price (LMP) calculated pursuant to subsection (f) of this section; each load imbalance at its zonal price calculated pursuant to subsection (h) of this section; and congestion rents on each scheduled transaction for a resource and load pair at the difference between the nodal LMP at the resource injection location calculated pursuant to subsection (f) of this section and the zonal price at the load withdrawal location calculated pursuant to subsection (h) of this section.

(f) Nodal energy prices for resources. ERCOT shall use nodal energy prices for resources. Nodal energy prices for resources shall be the locational marginal prices, consistent with subsection (e) of this section, resulting from security-constrained, economic dispatch.

(g) Energy trading hubs. ERCOT shall provide information for energy trading hubs by aggregating nodes and calculating an average price for each aggregation, for each financial settlement interval.

(h) Zonal energy prices for loads. ERCOT shall use zonal energy prices for loads that consist of an aggregation of either the individual load node energy prices within each zone or the individual resource node energy prices within each zone. Individual load node or resource node energy prices shall be the locational marginal prices, consistent with subsection (e) of this section, resulting from security-constrained, economic dispatch. ERCOT shall maintain stable zones and shall notify market participants in advance of zonal boundary changes in order that the market participants will have an appropriate amount of time to adjust to the changes.

(i) Congestion rights. ERCOT shall provide congestion revenue rights (CRRs), but shall not provide physical transmission rights. ERCOT shall auction all CRRs, using a simultaneous combinatorial auction, except as otherwise ordered by the commission for any preassigned CRRs approved by the commission. CRRs shall not be subject to "use-it-or-lose-it" or "schedule-it-or-lose-it" restrictions and shall be tradable.

(j) Pricing safeguards. ERCOT shall apply pricing safeguards to protect against market failure, including market power abuse, consistent with direction provided by the commission.

(k) Simultaneous optimization of ancillary capacity services. For ancillary capacity services that it competitively procures in the day-ahead or operating day, ERCOT shall use simultaneous optimization and shall set prices for each service to the corresponding shadow price.

(l) Multi-settlement system for procuring energy and ancillary capacity services. For any energy and ancillary capacity services that it competitively procures in the day-ahead or operating day, ERCOT shall set a separate market clearing price for each procurement of a particular service.

(m) Development and implementation. ERCOT shall use a stakeholder process to develop a wholesale market design that complies with this section. ERCOT shall also contract for an independent cost-benefit analysis of options. These options may include an option, or options, that would involve modification of the existing ERCOT wholesale market design. For each of the options, the cost-benefit analysis shall include the estimated net benefits of the option in comparison to the current market design. The cost-benefit analysis shall be prepared with sufficient detail to provide the stakeholders and the commission with the necessary information to modify or delete specific items or categories of expenses. The cost-benefit analysis shall be filed by ERCOT by December 31, 2004. ERCOT shall also file with the commission draft protocols that implement an option analyzed in the independent cost-benefit analysis and draft energy load zones that comply with subsection (h) of this section by March 18, 2005. ERCOT shall fully implement the requirements of this section by October 1, 2006.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406481
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Effective date: November 18, 2004
Proposal publication date: September 17, 2004
For further information, please call: (512) 936-7223

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TITLE 22. EXAMINING BOARDS

PART 1. TEXAS BOARD OF ARCHITECTURAL EXAMINERS

CHAPTER 1. ARCHITECTS

SUBCHAPTER A. SCOPE; DEFINITIONS

22 TAC §§1.9 - 1.11, 1.13, 1.14

The Texas Board of Architectural Examiners adopts the repeal of §1.9, pertaining to officers and employees; §1.10, pertaining to committees; §1.11, pertaining to official seal; §1.13, pertaining to Robert's Rules of Order; and §1.14, pertaining to procedure for addressing the board for Title 22, Chapter 1, Subchapter A, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6496). The repeal of these rules is being adopted without changes and will not be republished.

The Board is adopting the repeal of these rules because the Board is simultaneously adopting the creation of other rules that will address the same subjects addressed by these rules in a new Chapter 7 of Title 22 relating to the administration of the agency, procedures relating to the operation of the Board, and the schedule of fees charged for services rendered by the agency.

The repeal of these sections will avoid the duplication of these rules in the proposed Title 22, Chapter 7 and prevent confusion resulting from differences in the repealed rules and the new adopted rules.

The board received no comments pertaining to the proposal to repeal these sections.

The repeal of these sections is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406500
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Effective date: November 21, 2004
Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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SUBCHAPTER E. FEES

22 TAC §1.81

The Texas Board of Architectural Examiners adopts the repeal of §1.81, pertaining to fees for Title 22, Chapter 1, Subchapter E, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6497). The repeal of this rule is being adopted without changes and will not be republished.

The Board is adopting the repeal of this rule because the Board is simultaneously adopting an identical rule within new Chapter 7 which will include rules relating to agency administration and Board procedures.

The repeal of this section will avoid the duplication of this rule in the newly adopted Title 22, Chapter 7 relating to the administration and management of the agency and eliminates the need to publish identical fee rules in three separate chapters relating to the regulation of architecture, landscape architecture, and interior design.

The board received no comments pertaining to the proposal to repeal this section.

The repeal of this section is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200406501
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Effective date: November 21, 2004
Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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CHAPTER 3. LANDSCAPE ARCHITECTS
SUBCHAPTER A. SCOPE; DEFINITIONS

22 TAC §§3.9 - 3.11, 3.13, 3.14

The Texas Board of Architectural Examiners adopts the repeal of §3.9, pertaining to officers and employees; §3.10, pertaining to committees; §3.11, pertaining to official seal; §3.13, pertaining to Robert's Rules of Order; and §3.14, pertaining to procedure for addressing the board for Title 22, Chapter 3, Subchapter A, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6497). The repeal of these rules is being adopted without changes and will not be republished.

The Board is adopting the repeal of these rules because the Board is simultaneously adopting the creation of other rules that will address the same subjects addressed by these rules in a new Chapter 7 of Title 22 relating to the administration of the agency, procedures relating to the operation of the Board, and the schedule of fees charged for services rendered by the agency.

The repeal of these sections will avoid the duplication of these rules in the proposed Title 22, Chapter 7 and prevent confusion resulting from differences in the repealed rules and the new adopted rules.

The board received no comments pertaining to the proposal to repeal these sections.

The repeal of these sections is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Effective date: November 21, 2004
Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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SUBCHAPTER C. EXAMINATION

22 TAC §3.42

The Texas Board of Architectural Examiners adopts an amendment to §3.42, pertaining to the administration and scoring of the landscape architect registration examination for Title 22, Chapter 3, Subchapter C, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6497). The section is being adopted without changes and the text will not be republished.

The amended section conforms the rule to changes made by the examination provider in the scheduling of the examination and the manner in which the examination is to be administered. The rule currently states that the examination will be administered by the Board twice annually. Under the Board's contract with the Council of Landscape Architectural Registration Boards, the organization that sells the examination to the Board, the entire examination will no longer be administered twice per year. Pursuant to the contract, the Board will administer one portion of the examination twice per year and the Council, under contract with the Board, will administer a multiple choice portion of the examination via computer on a separate date at test centers. Under the contract, a candidate will have the option of selecting one of several dates to sit for the multiple choice portion of the examination. The amendment to the rule deletes deadlines applicable to the former procedures for administering the examination. Pursuant to the amendment, the deadline for applying to take a portion of the examination is four months prior to the earliest date upon which the examinee would be able to sit for that portion of the examination. The amendment deletes a requirement that candidates present an identification card that currently is provided to candidates for admission to the examination. The Council will no longer issue the identification cards. The amendment requires the presentation of an official form of identification bearing a recent photograph of the candidate in order for the candidate to gain admission to the examination. The amendment also deletes a provision that allows a candidate to review his or her examination after receiving the results of the examination. Pursuant to the contract with the examination provider, a portion of the examination will be administered on computers. There will be no copy of that portion of the examination on paper that may be reviewed. It is likely that the entire examination will be administered on computer in the future and that no record of the examination will exist on paper that may be reviewed. Therefore, the amendment deletes from the rule the provision for reviewing the examination.

The board received no comments pertaining to the proposal to adopt this section.

The amendment is adopted pursuant to Section 1052.153 of the Tex. Occupations Code Annotated ch. 1052, which requires the Board to prescribe the scope of the examination to receive a certificate of registration as a landscape architect, and to approve the examination, and to administer the examination. The amendment is also adopted pursuant to Section 1051.202 of the Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules to administer laws enforced by the Board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406503

Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Effective date: November 21, 2004
Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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SUBCHAPTER E. FEES

22 TAC §3.81

The Texas Board of Architectural Examiners adopts the repeal of §3.81, pertaining to fees for Title 22, Chapter 3, Subchapter E, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6499). The repeal of this rule is being adopted without changes and will not be republished.

The Board is adopting the repeal of this rule because the Board is simultaneously adopting an identical rule within new Chapter 7 which will include rules relating to agency administration and Board procedures.

The repeal of this section will avoid the duplication of this rule in the newly adopted Title 22, Chapter 7 relating to the administration and management of the agency and eliminates the need to publish identical fee rules in three separate chapters relating to the regulation of architecture, landscape architecture, and interior design.

The board received no comments pertaining to the proposal to repeal this section.

The repeal of this section is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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CHAPTER 5. INTERIOR DESIGNERS

SUBCHAPTER A. SCOPE; DEFINITIONS

22 TAC §§5.9 - 5.11, 5.13, 5.14

The Texas Board of Architectural Examiners adopts the repeal of §5.9, pertaining to officers and employees; §5.10, pertaining to committees; §5.11, pertaining to official seal; §5.13, pertaining to Robert's Rules of Order; and §5.14, pertaining to procedure for addressing the board for Title 22, Chapter 5, Subchapter A, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6499). The repeal of these rules is being adopted without changes and will not be republished.

The Board is adopting the repeal of these rules because the Board is simultaneously adopting the creation of other rules that will address the same subjects addressed by these rules in a new Chapter 7 of Title 22 relating to the administration of the agency, procedures relating to the operation of the Board, and the schedule of fees charged for services rendered by the agency.

The repeal of these sections will avoid the duplication of these rules in the proposed Title 22, Chapter 7 and prevent confusion resulting from differences in the repealed rules and the new adopted rules.

The board received no comments pertaining to the proposal to repeal these sections.

The repeal of these sections is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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SUBCHAPTER E. FEES

22 TAC §5.91

The Texas Board of Architectural Examiners adopts the repeal of §5.91, pertaining to fees for Title 22, Chapter 5, Subchapter E, as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6500). The repeal of this rule is being adopted without changes and will not be republished.

The Board is adopting the repeal of this rule because the Board is simultaneously adopting an identical rule within new Chapter 7 which will include rules relating to agency administration and Board procedures.

The repeal of this section will avoid the duplication of this rule in the newly adopted Title 22, Chapter 7 relating to the administration and management of the agency and eliminates the need to publish identical fee rules in three separate chapters relating to the regulation of architecture, landscape architecture, and interior design.

The board received no comments pertaining to the proposal to repeal this section.

The repeal of this section is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which grants to the Board general authority to adopt rules as needed to administer the laws under the Board's jurisdiction.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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CHAPTER 7. ADMINISTRATION

22 TAC §§7.1 - 7.10

The Texas Board of Architectural Examiners adopts new §§7.1 - 7.10, of Title 22, Chapter 7, pertaining to the administration of Board meetings, agency operations, and the schedule of fees imposed for services rendered by the Board. Sections 7.2, 7.4, 7.8, and 7.10 are being adopted with changes to the text as published in the July 9, 2004, issue of the *Texas Register* (29 TexReg 6500). Sections 7.1, 7.3, 7.5 - 7.7, and 7.9, are being adopted without changes to the text as proposed and will not be republished.

Chapter 7 includes new rules to replace rules that currently appear in Chapter 1, "Architects," Chapter 3, "Landscape Architects," and Chapter 5, "Interior Designers," of Title 22. These rules do not apply directly to the regulation of architecture, landscape architecture, and interior design in that they address agency operations or the conduct of Board meetings. Chapter 7 consolidates the rules and simultaneously repeals them from Chapters 1, 3, and 5. Chapter 7 also includes new rules that currently do not appear in Chapter 1, Chapter 3, or Chapter 5 to implement legislation enacted by the 78th Legislature, Regular Session.

Rule 7.1 restates the statutory requirement that the Chairman of the Board be appointed by the Governor, and that the Board shall elect a Vice-Chairman and a Secretary-Treasurer. Rule 7.1 also requires the Board to employ an Executive Director to hire and manage staff at the Board's office. The rule requires the Board to establish an annual budget and to follow the rules of the Texas Building and Procurement Commission relating to Historically Underutilized Businesses. Rule 7.1 includes the substance of current Rules 1.9, 3.9, and 5.9 which will be repealed.

Rule 7.2 implements a policy to separate the responsibilities of the Board from the responsibilities of the Executive Director and staff of the Board. Rule 7.2 specifies that the Board's policymaking responsibilities include adopting rules, disciplining persons registered by the Board, and exercising other powers delegated by the Legislature. Rule 7.2 lists the management responsibilities of the Executive Director, including the responsibility for employing and managing staff, fulfilling the administrative requirements of agency regulations, issuing subpoenas as part of investigations, and procuring services and materials as required to manage the agency. Rule 7.2 does not include the substance of any pre-existing rule. Changes to new rule 7.2 as proposed add the following to the list of responsibilities of the Board: setting a job description for the Executive Director, and "other responsibilities stipulated by law." The rule as proposed also deletes a reference to the staff of the Board so that the responsibilities listed for the Executive Director are solely those of the Executive Director. The rule was also changed to specify that the Executive Director's responsibilities include those necessary to fulfill duties delegated by the Board or the Chairman to the Executive Director and any other responsibilities that are stipulated by law.

Rule 7.3 allows the Chairman of the Board to appoint committees of the Board necessary to conduct the business of the Board. Rule 7.3 is identical to current Rules 1.10, 3.10, and 5.10 which will be repealed.

Rule 7.4 adopts an official seal of the Board and includes a description the official seal. Rule 7.4 includes the substance of Rules 1.11, 3.11, and 5.11 but also includes a more detailed description of the seal. Rules 1.11, 3.11, and 5.11 will be repealed and replaced by Rule 7. Changes to new rule 7.4 as proposed add a statement that the Board's seal should not be confused with the professional seals to be used by architects, landscape architects, and interior designers. The Board adopted the change out of concern that its registrants may mistake the Board's seal for the seal they are to affix to completed construction documents. In addition, the Board amended the proposed rule to include an image of the official seal of the Board.

Rule 7.5 requires the Board to use Robert's Rules of Order in conducting meetings of the Board, except where the law requires otherwise. Rule 7.5 is identical to current Rules 1.13, 3.13, and 5.13, which will be repealed and replaced by Rule 7.5.

Rule 7.6 specifies procedures for addressing the board. Rule 7.6 requires the Board to include "Public Comment" as a topic on the agenda for each Board meeting. The rule limits each presentation by a member of the public to five minutes unless the Board extends the period for the presentation. The rule limits the Board's responses to, and deliberations upon, inquiries on matters not on the agenda in accordance with the Texas Open Meetings Act. Rule 7.6 is identical to current Rules 1.14, 3.14, and 5.14 which will be repealed and replaced by Rule 7.6.

Rule 7.7 implements procedures for the Board to engage in negotiated rulemaking pursuant to a requirement enacted by the 78th Legislature, Regular Session. Rule 7.7 specifies the procedure for a person to petition the Board to adopt a new rule or to amend an existing Rule. The Rule allows the Board to utilize the methods specified in Chapter 2008, Texas Government Code, for negotiating the substance of a rule. The Rule prohibits the Board from negotiating a rule that is outside the statutory authority of the Board. The substance of Rule 7.7 does not exist in a current rule.

Rule 7.8 implements a policy that encourages the use of alternative dispute resolution procedures for early resolution and settlement of the Board's disciplinary cases and internal personnel disputes, pursuant to a requirement enacted by the 78th Legislature, Regular Session. Rule 7.8 requires the Executive Director to designate at least one employee to serve as the alternative dispute resolution coordinator and specifies the role of the coordinator. Rule 7.8 also allows any party to a dispute to request resolution through any manner specified Chapter 154 of Tex. Civil Practices and Remedies Code Annotated relating to alternative dispute resolution in civil actions. The Rule allows for the allocation of the costs of alternative dispute resolution. Under the Rule, any agreement that purports to bind the Board

would be subject to the approval of the Board at a meeting subject to the Texas Open Meetings Act. The Rule states that any records arising from alternative dispute resolution would be subject to the Texas Public Information Act. Changes to new rule 7.8 as proposed allow parties to alternative dispute resolution to follow guidelines established by the State Office of Administrative Hearings. The proposed rule was also changed to allow the third-party mediator, moderator, arbitrator, or ombudsman to allocate the costs of alternative dispute resolution in the absence of an agreement between the parties regarding cost allocation. The proposed rule was also amended to strike a provision that imposed the cost of the third-party mediator, moderator, arbitrator, or ombudsman upon the party who requested alternative dispute resolution. The stricken language also would have required the party who requested alternative dispute resolution to bear his or her own costs arising from alternative dispute resolution.

Rule 7.9 implements a procedure for contractors and prospective contractors who seek to contract with the agency to protest procurement decisions made by the agency. The Board is required to adopt a procurement protest procedure that is modeled upon the protest procedure adopted by the Texas Building and Procurement Commission, pursuant to Section 2155.076 of Tex. Government Code Annotated ch. 2155. Under the procedure, a protesting contractor or prospective contractor may file a protest with the procurement director, may appeal the procurement director's decision to the Executive Director, and may appeal the Executive Director's determination to the Board. The Board's decision is the final action on the protest. The agency will be required to cease the procurement process upon the timely filing of the protest, unless the Executive Director determines in writing that the procurement without delay is in the best interests of the state. The Rule specifies the deadline for filing the protest, the parties who must be issued notice of the protest, and the contents of the written protest.

Rule 7.10 specifies a schedule of fees for various services rendered by the Board. Rule 7.10 and all the fees listed in the rule are identical to current Rules 1.81, 3.81, and 5.91, which will be repealed and replace by Rule 7.10. Changes to new rule 7.10 as proposed modify the rule to include a warning that failure to pay a registration renewal fee will result in the automatic cancellation of registration by operation of law. A footnote in the schedule of fees was amended to include an explanation that the initial architectural registration fee does not include a $200 professional fee which is imposed upon the renewal of architectural registration. The Board amended the proposed rule to allow for the acceptance of a delivery service receipt of a delivery service other than the U.S. Postal Service as evidence of the timely payment of a fee. The rule was also amended to clarify that "other penalties" as well as late fees accrue when a fee is paid by a check drawn upon a bank that refuses to honor the check. The reference to "other penalties" includes the eventual cancellation of registration pursuant to Section 1051.353(d), Tex. Occupations Code Annotated ch. 1051.

The Board received one comment pertaining to the proposal to adopt rules 7.1 through 7.10. A person objected to a subsection within Rule 7.10 which states that the Board cannot accept cash as payment for any fee. The commentator expressed the opinion that federal law requires the Board to accept cash, noting that currency includes the statement that it is legal tender for "all debts public and private." The substance of the provision that is the subject of the comment has existed in one form or another since at least 1990. The Board declined to modify this provision within the proposed rule. There is a risk to mailing or otherwise delivering cash to the Board. Receipt of payments by check diminishes the risk of theft and creates a verifiable record of payment. Finally, the trust company that maintains the Board's accounts will not accept cash.

New Rule 7.1 is adopted pursuant to Section 1051.107 of Tex. Occupations Code Annotated ch. 1051, which provides that the Governor shall designate a member of the Board to serve as the presiding officer and that the Board shall elect an assistant presiding officer and a secretary-treasurer; Section 6(a) of Article 8930 of Tex. Civil Statutes Annotated which requires the Board to adopt an annual budget; and Section 2161.003 of Tex. Government Code Annotated which requires the agency to adopt the rules of the Texas Building and Procurement Commission regarding Historically Underutilized Businesses as its own rules. New Rule 7.2 is adopted pursuant to Section 1051.153 of Tex. Occupations Code Annotated ch. 1051 which requires the Board to develop and implement a policy separating the policymaking functions of the Board from the management functions of the Board's staff. New Rule 7.3 is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 which provides the Board with general authority to adopt rules necessary to the administration of its statutory responsibilities. New Rule 7.4 is adopted pursuant to Section 1051.206 of Tex. Occupations Code Annotated ch. 1051 which requires the Board to adopt an official seal for use on official documents and specifies certain mandatory details of the seal. New Rule 7.5 is adopted pursuant to Section 1051.202 of Tex. Occupations Code Annotated ch. 1051 with provides the Board with general authority to adopt rules necessary to the administration of its statutory duties. New Rule 7.6 is adopted pursuant to Section 1051.254 of Tex. Occupations Code Annotated ch. 1051, which requires the Board to develop and implement policies that provide the public a reasonable opportunity to appear before the Board and speak on any issue under the Board's jurisdiction; and under Section 551.042 of Tex. Government Code Annotated ch. 551, which allows a person to petition the Board for the adoption of rules. New Rule 7.7 is adopted pursuant to Section 1051.211(a)(1) of Tex. Occupations Code Annotated ch. 1051, which requires the Board to implement a policy to encourage the use of negotiated rulemaking in the adoption of Board rules. New Rule 7.8 is adopted pursuant to Section 1051.211(a)(2), (b), and (c) of Tex. Occupations Code Annotated ch. 1051, which requires the Board to implement a policy to encourage the use of alternative dispute resolution procedures to assist in the resolution of internal and external disputes under the Board's jurisdiction; to conform to the extent possible to certain guidelines; and to appoint an alternative dispute resolution coordinator. New Rule 7.9 is adopted pursuant to Section 2155.076 of Tex. Government Code Annotated ch. 2155, which requires the Board to adopt procedures for contractors and other interested parties to protest a procurement decision made by the Board. New Rule 7.10 is adopted pursuant to Sections 1051.351, 1051.354, 1051.355, 1051.357, 1051.403, 1051.651, 1051.652, 1052.054, 1052.0541, 1053.052, and 1053.0521 of Tex. Occupations Code Annotated ch. 1051, ch. 1052, and ch. 1053, which allows the Board to charge a fee for the annual renewal of registrations of architects, landscape architects, and interior designers; provides an exemption from the fee for military personnel on active duty; allows the Board to charge an annual renewal fee for a registration on inactive status and an administrative fee to reactivate an inactive registration; allows the Board to charge a fee to architects whose registration is on emeritus status; allows the Board to charge a fee for reinstatement of registration after its denial,

revocation, or suspension; allows the Board to charge a fee to architects to fund architectural examination fee scholarships; and allows the Board to set a fee for a Board action involving an administrative expense in an amount that is reasonable and necessary to cover the cost of the administrative expense. The new rules are also adopted pursuant to Section [1051.202] of Tex. Occupations Code Annotated ch. [1051], which provides the Board with general authority to promulgate rules necessary to the administration of its statutory responsibilities.

§7.2. Division of Responsibilities.

(a) It is the Board's policy to maintain separation between the policymaking responsibilities of the Board and the management responsibilities of the executive director and the staff of the Board.

(b) The Board has the duty to exercise the legal authority delegated to it by the Legislature. The Board's responsibilities are:

(1) the adoption of rules interpreting and implementing the Board's enabling legislation and other statutes that vests legislative authority in the Board;

(2) disciplining Registrants according to statute;

(3) imposing administrative penalties on unregistered persons pursuant to law;

(4) bringing an action to enjoin a violation of the laws and rules enforced by the Board or to enforce a subpoena issued by the executive director;

(5) addressing issues that relate to regulation of the professions under the Board's jurisdiction;

(6) employing an executive director, evaluating the performance of the executive director, and setting a job description and compensation for the executive director; and

(7) such other responsibilities stipulated by law.

(c) The executive director is responsible for carrying out the business of the Board and the ministerial functions in implementing and enforcing the law. The responsibilities of the executive director are:

(1) employing, directing, evaluating the performance of, and setting compensation for the staff;

(2) directing the administrative functions in regulating the professions under the Board's jurisdiction, including the processing of applications for registration by the Board, monitoring of continuing education of Registrants, investigating alleged violations of the law enforced by the Board, recommending enforcement action to the Board, receiving and accounting for administrative fees and penalties, and all other management responsibilities;

(3) issuing subpoenas to compel the production of information relevant to the investigation of an alleged violation of the laws enforced by the Board;

(4) contracting for services and materials necessary to fulfill the requirements of the law as implemented by the Board;

(5) providing administrative support and information to the Board as required for the Board to fulfill its policymaking responsibilities;

(6) such other responsibilities that are necessary to fulfill duties delegated by the Board or the Chairman; and

(7) such other responsibilities stipulated by law.

§7.4. Official Seal.

The Board's official seal includes a border of two concentric circles around a five-pointed star, the outer circle resembling a rope and the inner circle resembling a chain. The words "Texas Board of Architectural Examiners" shall appear within the border between the two circles. This seal should not be confused with the seal to be affixed to documents by an architect, landscape architect, and an interior designer pursuant to §1.101, §3.101, and §5.111, respectively. The following is the official seal of the Board:
Figure: 22 TAC §7.4

§7.8. Alternative Dispute Resolution.

(a) It is the Board's policy to encourage the resolution and early settlement of all disputed matters, internal and external, through voluntary settlement procedures.

(b) The executive director shall designate at least one employee of the Board to serve as the Board's alternative dispute resolution coordinator to:

(1) coordinate the implementation of the Board's alternative dispute resolution policies;

(2) serve as a resource for any training needed to implement the procedures for negotiated rule-making or alternative dispute resolution; and

(3) collect data concerning the effectiveness of these procedures, as implemented by the Board.

(c) The Board, a respondent, the executive director, or any other party involved in an internal or external disputed matter may request that the matter be resolved through any manner of alternative dispute resolution specified in Chapter 154, Civil Practice and Remedies Code, including mediation, arbitration, and moderated settlement conferences, or through the appointment of an ombudsman. The parties may agree to follow the guidelines established by the State Office of Administrative Hearings relating to alternative dispute resolution, to the extent possible.

(d) The allocation of the costs of alternative dispute resolution is subject to negotiation and agreement between the parties. In the absence of an agreement, the costs of alternative dispute resolution shall be allocated by the third-party mediator, moderator, arbitrator, or ombudsman.

(e) Any resolution reached as a result of an alternative dispute resolution procedure is intended to be through the voluntary agreement of the parties. Any resolution that purports to bind the Board must be approved by the Board at a meeting subject to the Texas Open Meetings Act, Chapter 551, Government Code.

(f) The Board is subject to the Texas Public Information Act, Chapter 552, Government Code. Any written record, communication, or other material is confidential only to the extent provided by law and subject to the exemptions provided in that Act.

§7.10. Fees--General.

(a) FAILURE TO TIMELY PAY A REGISTRATION RENEWAL WILL RESULT IN THE AUTOMATIC CANCELLATION OF REGISTRATION BY OPERATION OF LAW.

(b) In addition to any fees established elsewhere in these rules, by the Act, or by another provision of Texas law, the following fees shall apply to services provided by the Board:
Figure: 22 TAC §7.10(b)

(c) The Board cannot accept cash as payment for any fee.

(d) An official postmark from the U.S. Postal Service or other delivery service receipt may be presented to the Board to demonstrate the timely payment of any fee.

(e) If a check is submitted to the Board to pay a fee and the bank upon which the check is drawn refuses to pay the check, the fee shall be considered unpaid and any applicable late fees or other penalties accrue. The Board shall impose a processing fee for any check that is returned unpaid by the bank upon which the check is drawn.

(f) A Registrant who is in Good Standing or was in Good Standing at the time the Registrant entered into military service shall be exempt from the payment of any fee during any period of active duty service in the U. S. military. The exemption under this subsection shall continue through the remainder of the fiscal year during which the Registrant's active duty status expires.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406499
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Effective date: November 21, 2004
Proposal publication date: July 9, 2004
For further information, please call: (512) 305-8535

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PART 4. TEXAS COSMETOLOGY COMMISSION

CHAPTER 89. GENERAL RULES AND REGULATIONS

22 TAC §89.76

The Texas Cosmetology Commission adopts the repeal of §89.76, concerning minimum requirements for cosmetology school separate facilities as was published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7861).

No comments were received.

The repeal is adopted under Texas Occupations Code, Chapter 1602, §1602.151, which provides the Commission with the authority to "adopt rules consistent with this chapter", to protect the public's health and safety. There are no other statutes affected by this rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406485
Antoinette Humphrey
Executive Director
Texas Cosmetology Commission
Effective date: November 18, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 380-7606

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PART 30. TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS

CHAPTER 681. PROFESSIONAL COUNSELORS

The Texas State Board of Examiners of Professional Counselors (board) adopts amendments to §§681.2, 681.14, 681.41 - 681.42, 681.45, 681.72, 681.83, 681.91, 681.93, 681.101, 681.121, 681.125, 681.141 - 681.142, 681.147, 681.165, and 681.168 and new §681.171, concerning the licensing and regulation of professional counselors. Section 681.147 is adopted with changes to the proposed text as published in the August 6, 2004, issue of the *Texas Register* (29 TexReg 7637). Sections 681.2, 681.14, 681.41 - 681.42, 681.45, 681.72, 681.83, 681.91, 681.93, 681.101, 681.121, 681.125, 681.141 - 681.142, 681.165, 681.168 and 681.171 are adopted without changes, and the sections will not be republished.

Specifically, the amendments cover definitions, additional fees collected, dual relationships, application requirements, examination time frame, bi-annual renewals, and emergency suspension. The new §§681.168 covers the surrendering of a license. The new §681.171 covers Senate Bill 161, 78th Legislature, 2003, which amends Occupations Code, Chapter 503, relating to emergency suspensions and administrative penalties.

The amendments are necessary to implement House Bill 2985, 78th Legislature, 2003, which requires the Texas State Board of Examiners of Professional Counselors to assess and collect fees to fund the Office of Patient Protection within the Texas Health Professions Council, and Senate Bill 1152, 78th Legislature, Regular Session, which amends Government Code, Chapter 2054, directing all Department of State Health Services administered licensing programs to participate in Texas Online. The licensing fee amendments are required as a result of revisions to the Health and Safety Code, §§12.0111 and 12.0112, pursuant to House Bill 2292, 78th Legislature, 2003.

One comment was received during the public comment period.

The commenter commended the board for establishing a rule that defined a non-counseling related field, §681.2(9). The commenter feels that in absence of statutory change, this amendment is an important improvement in determining what can be accepted as being counseling related.

The board agrees. No change was made as a result of the comment.

The commenter also commended the board for the amendment to board rule §681.42 on clarifying what is not considered a defense associated with sexual misconduct.

The board agrees. No change was made as a result of the comment.

The board made the following changes to correct punctuation due to the deletion of a statement.

Change: Concerning §681.147(4), the word "and" was added at the end of the paragraph. Also, a "semicolon" and the word "and" was deleted and a "period" was added at the end of §681.147(5).

SUBCHAPTER A. THE BOARD

22 TAC §681.2, §681.14

The amendments are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406561
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER C. CODE OF ETHICS

22 TAC §§681.41, 681.42, 681.45

The amendments are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200406562
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER D. APPLICATION PROCEDURES

22 TAC §681.72

The amendment is adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406563
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER E. ACADEMIC REQUIREMENTS FOR EXAMINATION AND LICENSURE

22 TAC §681.83

The amendment is adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200406564
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER F. EXPERIENCE REQUIREMENTS FOR EXAMINATION AND LICENSURE

22 TAC §681.91, §681.93

The amendments are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER G. LICENSURE EXAMINATIONS

22 TAC §681.101

The amendment is adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200406566
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER I. REGULAR LICENSE RENEWAL; INACTIVE AND RETIREMENT STATUS

22 TAC §681.121, §681.125

The amendments are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406567
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER J. CONTINUING EDUCATION REQUIREMENTS

22 TAC §§681.141, 681.142, 681.147

The amendments are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

§681.147. Activities Unacceptable as Continuing Education.

The board will not give continuing education credit to a licensee for:

(1) education incidental to the regular professional activities of a counselor such as learning occurring from experience or research;

(2) organizational activity such as serving on committees or councils or as an officer in a professional organization;

(3) meetings and activities not related to the practice of professional counseling which are required as a part of one's job;

(4) teaching or consultation which is part of one's employment; and

(5) an experience which does not fit the types of acceptable continuing education in §681.142 of this title (relating to Types of Acceptable Continuing Education).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406568
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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SUBCHAPTER K. COMPLAINTS AND VIOLATIONS

22 TAC §§681.165, 681.168, 681.171

The amendments and new section are adopted under Texas Occupations Code, Chapter 503, which provides the Texas State

Board of Examiners of Professional Counselors with the authority to adopt rules concerning the regulation of licensure of professional counselors that are reasonably necessary to properly perform its duties under this Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406569
Judith Powell
Chairperson
Texas State Board of Examiners of Professional Counselors
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 458-7236

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 111. CONTROL OF AIR POLLUTION FROM VISIBLE EMISSIONS AND PARTICULATE MATTER

SUBCHAPTER B. OUTDOOR BURNING

30 TAC §111.209

Texas Commission on Environmental Quality (commission) adopts the amendment to §111.209. Section 111.209 is adopted *without change* to the proposed text as published in the May 28, 2004 issue of the *Texas Register* (29 TexReg 5276) and will not be republished.

The amendment is being adopted as a revision to the Texas state implementation plan, which will be submitted to the United States Environmental Protection Agency (EPA).

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULE

A bill from the 77th Legislature, 2001 amended Texas Occupations Code, §801.361, Disposal of Animal Remains and allowed the burning of animal remains if the burning occurred in a county with a population of less than 10,000, on property owned by the veterinarian, and the veterinarian did not charge for disposal. This bill did not allow the burning of associated medical waste.

This rulemaking implements a subsequent amendment to Texas Occupations Code, §801.361. Senate Bill (SB) 216, 78th Legislature, 2003, amended Texas Occupations Code, §801.361, by allowing veterinarians to burn animal remains and associated medical waste. Associated medical waste includes: animal waste, blood, gloves, sleeves, newspapers, and plastic bags, but does not include sharps. SB 216 also changes the conditions under which a veterinarian may burn waste. The adopted amendment revises paragraph (3) by replacing the current language with a reference to amended Texas Occupations Code, §801.361. This provides an exception to the prohibition of outdoor burning by veterinarians in accordance with Texas Occupations Code, §801.361.

In compliance with House Bill 3061, 78th Legislature, 2003, this rule was developed in cooperation with and was approved by the Texas Animal Health Commission on May 25, 2004. The commission simultaneously adopts in this issue of the *Texas Register* an amendment to 30 TAC §330.4, Permit Required.

SECTION DISCUSSION

The amendment to §111.209, Exception for Disposal Fires, is necessary to make commission rules consistent with the burning revisions provided by SB 216. The amendment revises paragraph (3) by removing the current language and replacing it with a reference to amended Texas Occupations Code, §801.361. This amendment modifies the exception to the prohibition of outdoor burning relating to burning by veterinarians to make it consistent with Texas Occupations Code, §801.361.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. The amendment to §111.209 is only intended to make existing commission rules consistent with the new legislative changes made to the Texas Occupations Code, and the adopted rule does not adversely affect in a material way the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. Therefore, the adopted amendment does not qualify as a "major environmental rule." Furthermore, the analysis required by Texas Government Code, §2001.0225(c) does not apply because the rule does not meet any of the four applicable requirements of a major environmental rule. The rule does not exceed a standard set by federal law, exceed an express requirement of state law, exceed a requirement of a delegation agreement, or adopt a rule solely under the general powers of the agency. The rule is adopted specifically to make commission rules consistent with SB 216 and does not exceed the requirements of that bill.

TAKINGS IMPACT ASSESSMENT

The commission evaluated the rule and performed an assessment of whether the rule constitutes a takings under Texas Government Code, Chapter 2007. The specific purpose of the adopted rule is to make existing commission rules consistent with the new legislative changes made to the Texas Occupations Code by SB 216. The rule substantially advances this purpose by replacing existing language with a reference to the Texas Occupations Code as amended by SB 216. Promulgation and enforcement of the adopted rule is neither a statutory nor a constitutional taking of private real property. Specifically, the rule does not affect private real property rights because it does not burden, restrict, or limit an owner's property rights that would otherwise exist in the absence of the regulation. The rule actually expands the allowable uses of a veterinarian's private real property except those veterinarians in a municipality that is within a county of 10,000 or fewer people. The adopted rule does not meet the definition of a takings under Texas Government Code, §2007.002(5).

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the rulemaking and found that the adopted rule is subject to the Texas Coastal Management Program (CMP) in accordance with the Coastal Coordination Act, Texas Natural Resources Code, §§33.201 *et seq.*, and, therefore, must be consistent with all applicable CMP goals and policies. The commission conducted a consistency determination for the adopted rule in accordance with Coastal Coordination Act Implementation Rules, 31 TAC §505.22 and found that the rulemaking is consistent with the applicable CMP goals and policies.

The CMP goals applicable to the rule include: to protect, preserve, restore, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas; to ensure sound management of all coastal resources by allowing for compatible economic development and multiple human uses of the coastal zone; to ensure and enhance planned public access to and enjoyment of the coastal zone in a manner that is compatible with private property rights and other uses of the coastal zone; and to balance these competing interests.

CMP policy applicable to the rule is 31 TAC §501.14(q), which states that commission rules under Texas Health and Safety Code, Chapter 382, governing emissions of air pollutants, shall comply with regulations in Code of Federal Regulations, Title 40, adopted in accordance with Clean Air Act, 42 United States Code Annotated, §§7401, *et seq.*, to protect and enhance air quality in the coastal area so as to protect coastal natural resources areas and promote the public health, safety, and welfare.

Promulgation and enforcement of the rule does not violate or exceed any standards identified in the applicable CMP goals and policies. The adopted rule is consistent with these CMP goals and policies. The rule does not create or have a direct or significant adverse effect on any coastal natural resource areas.

PUBLIC COMMENT

The commission conducted a public hearing on the rulemaking on June 24, 2004, in Austin. The Texas Veterinary Medical Association (TVMA) commented at the hearing. During the public comment period, which closed on June 28, 2004, the commission received written comments from TVMA, EPA, and Senator Judith Zaffirini. EPA stated no objection to the proposed amendment to §111.209, TVMA stated support of the changes to Chapter 111, while Senator Zaffirini only commented on the amendment to §330.4.

RESPONSE TO COMMENTS

Comment

TVMA stated support of the changes to Chapter 111. EPA stated no objection to the amendment to §111.209 as a revision to the SIP and noted that the revisions in this rulemaking reference Texas Occupational Code, §801.361, which will be included by reference in the SIP revision.

Response

The commission appreciates these comments.

STATUTORY AUTHORITY

The amendment is adopted under Texas Health and Safety Code, Texas Clean Air Act (TCAA), §382.011, which authorizes the commission to administer the requirements of the TCAA; §382.012, which provides the commission the authority to develop a comprehensive plan for the state's air; §382.017, which authorizes the commission to adopt rules consistent with the policy and purposes of the TCAA; §382.018, which authorizes the commission to control outdoor burning; and §382.085, which prohibits unauthorized air emissions; and Texas Water Code, §5.103, which authorizes the commission to adopt rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406487
Stephanie Bergeron Perdue
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: November 18, 2004
Proposal publication date: May 28, 2004
For further information, please call: (512) 239-6087

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CHAPTER 114. CONTROL OF AIR POLLUTION FROM MOTOR VEHICLES
SUBCHAPTER I. NON-ROAD ENGINES
DIVISION 6. LAWN SERVICE EQUIPMENT OPERATING RESTRICTIONS

30 TAC §114.452, §114.459

The Texas Commission on Environmental Quality (commission) adopts the repeal of §114.452 and §114.459. Sections 114.452 and 114.459 are adopted *without changes* as published in the June 11, 2004 issue of the *Texas Register* (29 TexReg 5736).

Repealed §114.452 and §114.459 and the corresponding revisions to the state implementation plan (SIP) will be submitted to the United States Environmental Protection Agency (EPA) as a revision to the SIP.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED REPEALS

The Houston/Galveston/Brazoria (HGB) ozone nonattainment area is classified as Severe-17 under the Federal Clean Air Act Amendments of 1990 (42 United States Code (USC), §§7401 *et seq.*), and therefore, is required to attain the one-hour ozone standard of 0.12 parts per million by November 15, 2007. The HGB area, defined by Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties, has developed a demonstration of attainment in accordance with 42 USC, §7410. The most relative HGB SIP revisions to date are the December 2000 one-hour ozone standard attainment demonstration, the September 2001 follow-up revision, and the December 2002 nitrogen oxides (NO_x)/highly-reactive volatile organic compound (HRVOC) revision.

This process has proven to be challenging due to the magnitude of reductions needed for attainment. The emission reduction requirements included as part of the December 2000 SIP revision represent substantial, intensive efforts on the part of stakeholder coalitions in the HGB area to address ozone. These coalitions, which include local governmental entities, elected officials, environmental groups, industry, consultants, and the public, worked diligently with EPA and the commission to identify and quantify

control strategy measures for the HGB attainment demonstration.

December 2000

The December 2000 SIP revision contains rules and photochemical modeling analyses in support of the HGB area ozone attainment demonstration. The majority of the emissions reductions identified in this revision were from a 90% reduction in point source NO_x. The modeling analysis also indicated a shortfall in necessary NO_x emissions, such that an additional 91 tons per day (tpd) of NO_x reductions were necessary for an approvable attainment demonstration. In addition, the revision contained post-1999 rate of progress (ROP) plans for the milestone years 2002 and 2005 and for the attainment year 2007, and transportation conformity motor vehicle emission budgets (MVEBs) for NO_x and volatile organic compounds (VOC). The SIP also contained enforceable commitments to implement further measures in support of the HGB area attainment demonstration, as well as a commitment to perform and submit a midcourse review.

September 2001

The September 2001 SIP revision for the HGB ozone nonattainment area included the following elements: 1) corrections to the ROP table/budget for the years 2002, 2005, and 2007 due to a mathematical inconsistency; 2) incorporation of a change to the idling restriction control strategy clarifying that the operator of a rented or leased vehicle is responsible for compliance with the requirements in situations where the operator of a leased or rented vehicle is not employed by the owner of the vehicle (The commission committed to making this change when the rule was adopted in December 2000.); 3) incorporation of revisions to the clean diesel fuel rules to provide greater flexibility in complying with the requirements of the rule while preserving the emission reductions necessary to demonstrate attainment in the HGB area; 4) incorporation of a stationary diesel engine rule that was developed as a result of the state's analysis of EPA's reasonably available control measures; 5) incorporation of revisions to the point source NO_x rules; 6) incorporation of revisions to the emissions cap and trade rules; 7) the removal of the construction equipment operating restriction and the accelerated purchase requirement for Tier 2/3 heavy duty equipment; 8) the replacement of the Tier 2/3 rules with the Texas Emission Reduction Plan (TERP) program; 9) the layout of the midcourse review process, which details how the state will fulfill the commitment to obtain the additional emission reductions necessary to demonstrate attainment of the one-hour ozone standard in the HGB area; and 10) replacement of 2007 ROP MVEBs to be consistent with the attainment MVEBs.

As was discussed in the December 2000 revision, the modeling resulted in a 141 parts per billion peak ozone level correlating to a shortfall calculation of 91 tpd NO_x equivalent. An additional five tpd was added to the shortfall because the state could not take credit for the NO_x reductions associated with the diesel pull-ahead strategy. The excess emissions from this strategy were not included in the original emissions inventory. The gap control measures adopted in December 2000, along with the stationary diesel engine rules included in the September revision, resulted in NO_x reductions of 40 tpd, which left a total remaining shortfall of 56 tpd. The state committed to address this shortfall through the midcourse review process.

December 2002

In January 2001, the Business Coalition for Clean Air - Appeal Group (BCCA-AG) and several regulated companies challenged the December 2000 HGB SIP and some of the associated rules. Specifically, the BCCA-AG challenged the 90% NO_x reduction requirement from stationary sources in the HGB area. In May 2001, the parties agreed to a stay in the case, and Judge Margaret Cooper, Travis County District Court, signed a Consent Order, effective June 8, 2001, requiring the commission to perform an independent, thorough analysis of the causes of rapid ozone formation events and identify potential mitigating measures not yet identified in the HGB area attainment demonstration, according to the milestones and procedures in Exhibit C (Scientific Evaluation) of the Order.

In compliance with the Consent Order, the commission conducted a scientific evaluation based in large part on aircraft data collected by the Texas 2000 Air Quality Study (TexAQS). The TexAQS, a comprehensive research project conducted in August and September 2000 involving more than 40 research organizations and over 200 scientists, studied ground-level ozone air pollution in the HGB area and East Texas regions. One conclusion of the study was that the ambient concentrations of NO_x and VOC were not consistent with the industrial emissions estimates. Specifically, the ratio of NO_x to VOC did not correlate to the ambient ratio of NO_x to VOC. Because of the greater certainty associated with NO_x emissions estimates, it can be concluded that industrial VOC emissions were likely significantly understated in earlier emissions inventories.

To address these findings and to fulfill obligations in the Consent Order, the commission adopted a SIP revision in December 2002 that focused on replacing the most stringent 10% industrial NO_x reductions with VOC controls. In light of the TexAQS study, the commission conducted further modeling analysis of ambient VOC data. The results of photochemical grid modeling and analysis indicated that it is possible to achieve the same level of air quality benefits with reductions in industrial VOC emissions, combined with an overall 80% reduction in NO_x emissions from industrial sources, as would be realized with a 90% reduction in industrial NO_x emissions. Studies have suggested that the HGB area's high ozone events can be attributed to the presence of significant reactivity in the airshed. An analysis of automated gas chromatograph data revealed that four compounds were frequently responsible for high reactivity days: ethylene, propylene, 1,3-butadiene, and butenes, as such these compounds were selected as the best candidates for the first round of HRVOC emission controls.

The commission adopted revisions to the industrial source control requirements, one of the control strategies within the existing federally approved SIP. The December 2002 SIP revision contains new rules that will better quantify and reduce emissions of HRVOCs from four key industrial sources: fugitives, flares, process vents, and cooling towers. The adopted rules target HRVOC emissions while maintaining the integrity of the SIP. Analysis showed that limiting emissions of ethylene, propylene, 1,3-butadiene, and butenes in conjunction with an 80% reduction in NO_x is equivalent to or better in terms of air quality benefit to that resulting from a 90% point source NO_x reduction requirement alone. As such, the HRVOC rules are performance-based, emphasizing monitoring, recordkeeping, reporting, and enforcement rather than establishing individual unit emission rates.

The technical support documentation accompanying the SIP revision contains the supporting analysis from ongoing analysis examining whether reductions in HRVOC emissions could replace the last 10% of industrial NO_x controls, while ensuring that the

air quality specified in the approved December 2000 HGB area SIP is met.

Current Revision

As mentioned previously, the commission committed to perform a midcourse review to ensure attainment of the one-hour ozone standard. The midcourse review process provides the ability to update emissions inventory data, utilize current modeling tools, such as MOBILE6, and enhance the photochemical grid modeling. The data gathered from the TexAQS continues to improve photochemical modeling of the HGB area. The collection of these technical improvements gives a more comprehensive understanding of the ozone challenge in Houston, which is necessary for developing a plan to reach attainment. In early 2003, the commission was preparing to move forward with the midcourse review, and EPA announced its plans to begin implementation of the eight-hour ozone standard. The EPA published rules for implementation of the eight-hour ozone standard in the June 2, 2003 issue of the *Federal Register* (68 FR 32802). In the same time frame, EPA also formalized its intentions to designate areas for the eight-hour ozone standard by April 15, 2004, meaning states would need to reassess their efforts and control strategies to address this new standard by 2007. Recognizing that existing one-hour nonattainment areas would soon be subject to the eight- hour ozone standard, and in an effort to efficiently manage the state's limited resources, the commission developed an approach that addresses the outstanding obligations under the one-hour ozone standard while beginning to analyze eight-hour ozone issues.

The commission's one-hour ozone SIP commitments include: 1) completing a one-hour ozone MCR; 2) performing modeling; 3) adopting measures sufficient to fill the NO_x shortfall; 4) adopting measures sufficient to demonstrate attainment; and 5) revising the MVEB using MOBILE6.

Results from the TexAQS and recent photochemical modeling indicate that additional HRVOC reductions will be the most beneficial measure in reducing ozone in the HGB area. The commission is proposing to reduce HRVOC emissions to reach attainment of the one-hour ozone standard. The photochemical modeling of the August - September 2000 episode coupled with a weight-of-evidence argument demonstrates attainment of the one-hour ozone standard. To achieve the necessary HRVOC reductions, the commission is proposing a two-pronged approach that would address short-term emission events through a not-to-exceed limit, and would address steady state and routine emissions through an annual cap. The annual HRVOC cap would be reduced from the existing HRVOC cap in order to support the attainment demonstration modeling.

The HGB SIP no longer relies as heavily on NO_x-based strategies. A combination of point source HRVOC controls and NO_x reductions appears to be the most effective means of reducing ozone in the HGB area, and there is no longer a NO_x shortfall in the HGB SIP. The commission also evaluated a number of the existing control strategies that were put in place in the December 2000 revision. The photochemical modeling shows that some of these strategies are no longer necessary to attain the one-hour ozone standard. This SIP revision repeals the commercial lawn and garden equipment operating restrictions, the heavy-duty vehicle idling restrictions, and removes the motor vehicle inspection and maintenance (I/M) program requirements from Chambers, Liberty, and Waller Counties. In addition, this SIP revision includes changes to the environmental speed limit strategy. In September 2002, the commission revised the existing speed limit strategy to suspend the 55 mile per hour (mph) speed limit until May 1, 2005, and, where posted speeds were 65 mph or higher before May 1, 2002, to increase speeds to five mph below what was posted. The 78th Legislature, 2003, removed the commission's authority to determine speed limits for environmental purposes; therefore, this adoption removes the reinstatement of the 55 mph speed limit on May 1, 2005, and maintains the currently posted speed limits at five mph below the posted speed limit before May 1, 2002. Also, as part of this SIP revision, the commission is adopting new statewide portable fuel container rules. Historically, the commission has expressed a preference to implement technology-based strategies over behavior-altering strategies, and these changes embody that philosophy.

Through this revision, the commission is fulfilling its outstanding one-hour ozone SIP obligations and beginning to plan for the upcoming eight-hour ozone standard. This proposal demonstrates attainment of the one-hour ozone standard in the HGB area in 2007 and provides a preliminary analysis of the HGB area in terms of the eight-hour ozone standard in 2007 and 2010. EPA's eight-hour implementation rules provide flexibility to the states in transitioning from the one-hour to the eight- hour ozone standard, and the commission believes that the steps taken in this adoption and the technical work performed to date will be invaluable through the transition period. Upon EPA's finalization of the eight-hour implementation rules, the commission expects to begin developing eight-hour ozone SIPs.

Sections 114.452 and 114.459 were originally adopted on December 6, 2000, as part of the SIP control strategy for the HGB ozone nonattainment area to achieve attainment with the NAAQS for ozone. The purpose of the rules was to establish a restriction on the use of commercial lawn and garden equipment (non-road, spark-ignition equipment rated at 25 horsepower (hp) and less) as an air pollution control strategy to delay the emissions of NO_x, a key ozone precursor, until later in the day, thus limiting ozone formation. By delaying the hours of operation during the effective time period, the NO_x emissions will not mix in the atmosphere with other ozone- causing compounds until later in the day. The critical time for the mixing (chemical reactions) of NO_x and VOCs is early in the day; thus, higher ozone levels occur most frequently on hot summer afternoons. By delaying the operation of the affected equipment, the NO_x emissions are less likely to mix in the atmosphere with other ozone-forming compounds until after the critical mixing time has passed. Therefore, production of ozone will be stalled until later in the day when optimum ozone formation conditions no longer exist, ultimately minimizing the peak level of ozone produced.

Historically, the commission expressed a preference to implement technology-based strategies over behavior-altering strategies such as the lawn and garden equipment operating restrictions. The commission delayed the implementation of these rules until 2005 in order to research other methods of achieving the same amount of NO_x and VOC reductions. The commission reevaluated a number of the existing control strategies, including lawn and garden equipment operating restrictions, that were put in place in the December 2000 revision. Results from the TexAQS and recent photochemical modeling indicate that additional HRVOC reductions will be the most beneficial measure in reducing ozone in the HGB area and that this strategy is no longer necessary to attain the one-hour ozone standard. Therefore, the commission is adopting the repeal of Chapter 114, Subchapter I, Division 6. The proposal

for this rulemaking inadvertently listed the repeals in Subchapter I, Division 2, rather than Division 6. The repeals are adopted in Subchapter I, Division 6.

SECTION BY SECTION DISCUSSION

Sections 114.452 and 114.459 are repealed because the commission determined that this strategy is no longer necessary to attain the one-hour ozone standard.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the adopted rulemaking action in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking action does not meet the definition of a "major environmental rule" as defined in that statute. A "major environmental rule" is a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

The adopted revisions to Chapter 114 and the SIP repeal operating restrictions on commercial lawn and garden equipment operators. The repeals are not expected to adversely affect in a material way the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

The repeals do not meet any of the four applicability criteria of a "major environmental rule" as defined in the Texas Government Code. Section 2001.0225 applies only to a major environmental rule the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law.

The repeals implement requirements of 42 USC. Under 42 USC, §§7410, *et seq.,* states are required to adopt a SIP which provides for "implementation, maintenance, and enforcement" of the primary NAAQS in each air quality control region of the state. While 42 USC, §§7410, *et seq.,* does not require specific programs, methods, or reductions in order to meet the standard, SIPs must include "enforceable emission limitations and other control measures, means or techniques (including economic incentives such as fees, marketable permits, and auctions of emissions rights), as well as schedules and timetables for compliance as may be necessary or appropriate to meet the applicable requirements of this chapter," (meaning Chapter 85, Air Pollution Prevention and Control). It is true that 42 USC does require some specific measures for SIP purposes, such as the I/M program, but those programs are the exception, not the rule, in the SIP structure of 42 USC. The provisions of 42 USC recognize that states are in the best position to determine what programs and controls are necessary or appropriate in order to meet the NAAQS. This flexibility allows states, affected industry, and the public, to collaborate on the best methods for attaining the NAAQS for the specific regions in the state. Even though 42 USC allows states to develop their own programs, this flexibility does not relieve a state from developing a program that meets the requirements of §§7410, *et seq*. Thus, while specific measures are not generally required, the emission reductions are required. States are not free to ignore the requirements of §§7410, *et seq.*, and must develop programs to assure that the nonattainment areas of the state will be brought into attainment on schedule.

The requirement to provide a fiscal analysis of proposed regulations in the Texas Government Code was amended by Senate Bill (SB) 633 during the 75th legislative session. The intent of SB 633 was to require agencies to conduct a regulatory impact analysis (RIA) of extraordinary rules. These are identified in the statutory language as major environmental rules that will have a material adverse impact and will exceed a requirement of state law, federal law, or a delegated federal program, or are adopted solely under the general powers of the agency. With the understanding that this requirement would seldom apply, the commission provided a cost estimate for SB 633 that concluded "based on an assessment of rules adopted by the agency in the past, it is not anticipated that the bill will have significant fiscal implications for the agency due to its limited application." The commission also noted that the number of rules that would require assessment under the provisions of the bill was not large. This conclusion was based, in part, on the criteria set forth in the bill that exempted proposed rules from the full analysis unless the rule was a major environmental rule that exceeds a federal law. As discussed earlier in this preamble, 42 USC does not require specific programs, methods, or reductions in order to meet the NAAQS; thus, states must develop programs for each nonattainment area to ensure that the area will meet the attainment deadlines. Because of the ongoing need to address nonattainment issues, the commission routinely proposes and adopts SIP rules. The legislature is presumed to understand this federal scheme. If each rule proposed for inclusion in the SIP was considered to be a major environmental rule that exceeds federal law, then every SIP rule would require the full RIA contemplated by SB 633. This conclusion is inconsistent with the conclusions reached by the commission in its cost estimate and by the Legislative Budget Board (LBB) in its fiscal notes. Because the legislature is presumed to understand the fiscal impacts of the bills it passes, and that presumption is based on information provided by state agencies and the LBB, the commission believes that the intent of SB 633 was only to require the full RIA for rules that are extraordinary in nature. While the SIP rules will have a broad impact, that impact is no greater than is necessary or appropriate to meet the requirements of 42 USC. For these reasons, rules adopted for inclusion in the SIP fall under the exception in Texas Government Code, §2001.0225(a), because they are specifically required by federal law.

In addition, 42 USC, §7502(a)(2), requires attainment as expeditiously as practicable, and §7511(a)(d) requires states to submit ozone attainment demonstration SIPs for severe ozone nonattainment areas such as the HGB area. The adopted repeal will remove operating restrictions on commercial lawn and garden equipment operators in the Houston nonattainment area. Historically, the commission expressed a preference to implement technology-based strategies over behavior-altering strategies and the adopted repeals embody that philosophy. The commission also evaluated a number of the existing control strategies, including lawn and garden equipment operating restrictions, that were put in place in the December 2000 revision. The photochemical modeling shows that this strategy is no longer necessary to attain the one-hour ozone standard and therefore, the commission is adopting the repeal of Chapter 114, Subchapter I, Division 6. Therefore, the adopted repeal is consistent with the ozone attainment demonstration SIP for the HGB area, required by 42 USC, §§7410, *et seq*.

The commission consistently applied this construction to its rules since this statute was enacted in 1997. Since that time, the legislature revised the Texas Government Code but left this provision substantially unamended. It is presumed that "when an agency interpretation is in effect at the time the legislature amends the laws without making substantial change in the statute, the legislature is deemed to have accepted the agency's interpretation." *Central Power & Light Co. v. Sharp*, 919 S.W.2d 485, 489 (Tex. App. Austin 1995), *writ denied with per curiam opinion respecting another issue*, 960 S.W.2d 617 (Tex. 1997); *Bullock v. Marathon Oil Co.*, 798 S.W.2d 353, 357 (Tex. App. Austin 1990, no writ). *Cf. Humble Oil & Refining Co. v. Calvert*, 414 S.W.2d 172 (Tex. 1967); *Dudney v. State Farm Mut. Auto Ins. Co.*, 9 S.W.3d 884 (Tex. App. Austin 2000); *Southwestern Life Ins. Co. v. Montemayor*, 24 S.W.3d 581 (Tex. App.--Austin 2000, *pet. denied*); and *Coastal Indust. Water Auth. v. Trinity Portland Cement Div.*, 563 S.W.2d 916 (Tex. 1978).

As discussed earlier in this preamble, this rulemaking implements the requirements of 42 USC. There is no contract or delegation agreement that covers the topic that is the subject of this rulemaking. Therefore, the adopted repeals do not exceed a standard set by federal law, exceed an express requirement of state law, exceed a requirement of a delegation agreement, nor are the repeals adopted solely under the general powers of the agency. In addition, the repeals are adopted under Texas Health and Safety Code (also known as the Texas Clean Air Act), §§382.011, 382.012, 382.017, and 382.019. The commission invited public comment on this determination; no comments were received.

TAKINGS IMPACT ASSESSMENT

The commission completed a takings impact assessment for the rulemaking action under Texas Government Code, §2007.043. The specific purpose of these revisions is to repeal operating restrictions on commercial lawn and garden equipment operators.

Texas Government Code, §2007.003(b)(4), provides that Chapter 2007 does not apply to this adopted rulemaking action, because it is reasonably taken to fulfill an obligation mandated by federal law. States are primarily responsible for ensuring attainment and maintenance of NAAQS once the EPA has established them. Under 42 USC, §§7410, *et seq.*, and related provisions, states must submit, for approval by the EPA, SIPs that provide for the attainment and maintenance of NAAQS through control programs directed to sources of the pollutants involved. The commercial lawn and garden operating restriction was submitted in the HGB December 2000 SIP revision as a control strategy to reduce NO_x in order to meet the ozone NAAQS set by the EPA under 42 USC, §7409. However, the commission adopts the repeal of commercial lawn and garden operating restrictions because photochemical modeling shows that this strategy is no longer necessary to attain the one-hour ozone standard and the combination of point source HRVOC controls and NO_x reductions appears to be the most effective means of reducing ozone in the HGB area. Therefore, the overall goal of this rulemaking action is to meet the air quality standards established under federal law as NAAQS.

In addition, Texas Government Code, §2007.003(b)(13), states that Chapter 2007 does not apply to an action that: 1) is taken in response to a real and substantial threat to public health and safety; 2) is designed to significantly advance the health and safety purpose; and 3) does not impose a greater burden than is necessary to achieve the health and safety purpose. Although the repeals do not directly prevent a nuisance or prevent an immediate threat to life or property, they do prevent a real and substantial threat to public health and safety and significantly advance the health and safety purpose. This action is taken in response to the HGB area exceeding the federal ozone NAAQS, which adversely affects public health, primarily through irritation of the lungs. The commercial lawn and garden operating restriction was submitted as a control strategy in the HGB December 2000 SIP revision. Historically, the commission expressed a preference to implement technology-based strategies over behavior-altering strategies such as the lawn/garden operating restrictions and the adopted repeal embodies that philosophy. The commission reexamined this strategy and photochemical modeling shows that this strategy is no longer necessary to attain the one-hour ozone standard and therefore, the commission is adopting the repeal of Chapter 114, Subchapter I, Division 6. The action does not specifically advance the health and safety purpose by reducing ozone levels in the HGB nonattainment area. However, the repeal of this control strategy is part of a larger scheme to reduce ozone in the HGB area through the most effective means and strategies determined by the commission. Consequently, these adopted repeals meet the exemption in §2007.003(b)(13). This rulemaking action, therefore, meets the requirements of Texas Government Code, §2007.003(b)(4) and (13). For these reasons, the adopted repeals do not constitute a takings under Chapter 2007.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the adopted rulemaking and found that the adoption is an action identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11, or will affect an action/authorization identified in 31 TAC §505.11, and therefore required that applicable goals and policies of the Texas Coastal Management Program (CMP) be considered during the rulemaking process.

The commission prepared a consistency determination for the adopted repeals under 31 TAC §505.22 and found that the rulemaking is consistent with the applicable CMP goals and policies. The CMP goal applicable to this rulemaking is the goal to protect, preserve, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas (31 TAC §501.12(1)). The CMP policy applicable to this rulemaking action is the policy that commission rules comply with regulations in 40 Code of Federal Regulations, adopted in accordance with the Federal Clean Air Act, 42 USC, §§7401, *et seq.*, to protect and enhance air quality in the coastal area so as to protect coastal natural resource areas and promote public health, safety, and welfare (31 TAC §501.14(q)). This rulemaking complies with 40 Code of Federal Regulations, adopted in accordance with the Federal Clean Air Act. Therefore, in compliance with 31 TAC §505.22(e), this rulemaking is consistent with CMP goals and policies. The commission invited public comment on this determination; no comments were received.

PUBLIC COMMENTS

Public hearings on this proposal were held in Houston on August 2, 2004; Beaumont on August 3, 2004; and Austin on August 5, 2004. The comment period closed on August 9, 2004. Written comments were submitted by EPA; Environmental Defense; Galveston-Houston Association for Smog Prevention (GHASP); Sierra Club, Houston Regional Group (Sierra Club); Houston-Galveston Area Council (HGAC); the Honorable Bill

White, Mayor, City of Houston, the Honorable Robert Eckels, County Judge, Harris County, provided joint comments (Houston/Harris County); and three individuals. Environmental Defense, GHASP, Sierra Club, HGAC, Houston/Harris County, and one individual generally supported the repeal of these rules. Two individuals and EPA neither supported nor opposed the rules, but commented on the rules. EPA requested that the commission provide a detailed, substantive analysis of how these measures will advance attainment.

RESPONSE TO COMMENTS

Environmental Defense, GHASP, Houston/Harris County, HGAC, Sierra Club, and one individual commented that they approved of the repeal of the lawn and garden restrictions.

The commission appreciates the support of the repeal of these rules.

One individual commented that gasoline-powered leaf blowers should be permanently banned.

The commission responds that it does not have plans at this time to ban all gasoline- powered leaf blowers. However, the EPA is in the process of phasing in more stringent emission standards for small spark-ignition engines like the ones used in leaf blowers, mowers, and trimmers. New technology should dramatically reduce emissions from this type of engine.

One individual commented that the fumes and noise from lawn equipment are disturbing. The commenter also asked why this rule was adopted and is now being repealed.

The commission responds that existing engines used in lawn and garden operations may emit large amounts of emissions, particularly when not maintained properly. However, new standards by the EPA will ensure that new engines purchased in the future will be cleaner than older models. Noise is outside the commission's jurisdiction and is not addressed in this rulemaking. The reason this rule was adopted and is now being repealed is because the commission has discovered more effective and less burdensome means of reducing harmful emissions in the HGB ozone nonattainment area.

EPA commented that "necessary to attain" is not the reasonably available control measures (RACM) standard; instead it is whether the rules would advance the attainment date. EPA asked that the commission provide a RACM analysis that includes "a detailed, substantive consideration of whether these measures {are} reasonable and would advance attainment."

The commission recognizes that a RACM analysis is a SIP requirement and will document SIP requirements in the accompanying one-hour attainment demonstration scheduled for consideration on December 1, 2004. The commercial lawn and garden time restrictions would reduce NO_x by approximately 4.6 tpd. On June 23, 2004, the commission proposed a one- hour ozone midcourse review attainment demonstration for the HGB area. The recently proposed SIP addresses emissions of both NO_x and HRVOCs. The current proposal models six of ten days below 125 ppb, using a weight-of-evidence analysis. Additional enhancements to the modeling since the SIP was proposed in June replicate peak ozone at or below 125 ppb on eight of ten days. The inclusion of the commercial lawn and garden time restriction rule does not significantly impact modeled peak ozone concentrations.

Given the minimal emission reductions and the development of a more robust attainment demonstration, this measure will not advance the one-hour ozone attainment date of the HGB area, and therefore, is not RACM. No changes were made to the rules in response to this comment.

STATUTORY AUTHORITY

The repeals are adopted under Texas Water Code (TWC), §5.102, which provides the commission with the general powers to carry out its duties under TWC; §5.103, which authorizes the commission to adopt any rules necessary to carry out the powers and the duties under the provisions of TWC and other laws of this state; and §5.105, which authorizes the commission by rule to establish and approve all general policy of the commission. These repeals are also adopted under Texas Health and Safety Code, Texas Clean Air Act (TCAA), §382.017, which authorizes the commission to adopt rules consistent with the policy and purposes of the TCAA; §382.011, which authorizes the commission to establish the level of quality to be maintained in the state's air and to control the quality of the state's air; §382.012, which authorizes the commission to prepare and develop a general, comprehensive plan for the control of the state's air; and §382.019, which provides the commission the authority to adopt rules to control and reduce emissions from engines used to propel land vehicles.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

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Texas Commission on Environmental Quality
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For further information, please call: (512) 239-5017

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CHAPTER 115. CONTROL OF AIR POLLUTION FROM VOLATILE ORGANIC COMPOUNDS

SUBCHAPTER G. CONSUMER-RELATED SOURCES

DIVISION 2. PORTABLE FUEL CONTAINERS

30 TAC §§115.620 - 115.622, 115.626, 115.627, 115.629

The Texas Commission on Environmental Quality (commission) adopts new §§115.620 - 115.622, 115.626, 115.627, and 115.629; and corresponding revisions to the state implementation plan (SIP). The commission adopts new §§115.620, 115.622, 115.626, 115.627, and 115.629 *with changes* to the proposed text as published in the June 11, 2004, issue of the *Texas Register* (29 TexReg 5747). The commission adopts new §115.621 *without change* to the proposed text and will not be republished.

The adopted new rules and revised SIP narrative will be submitted to the United States Environmental Protection Agency (EPA) as revisions to the SIP.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULES

The Houston/Galveston/Brazoria (HGB) ozone nonattainment area is classified as Severe-17 under the Federal Clean Air Act Amendments of 1990 (42 United States Code (USC), §§7401 *et seq.*), and therefore, is required to attain the one-hour ozone standard of 0.12 parts per million by November 15, 2007. The HGB area, defined by Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties, has developed a demonstration of attainment in accordance with 42 USC, §7410. The most relative HGB SIP revisions to date are the December 2000 one-hour ozone standard attainment demonstration, the September 2001 follow-up revision, and the December 2002 nitrogen oxides (NO_x)/highly-reactive volatile organic compound (HRVOC) revision.

This process has proven to be challenging due to the magnitude of reductions needed for attainment. The emission reduction requirements included as part of the December 2000 SIP revision represent substantial, intensive efforts on the part of stakeholder coalitions in the HGB area to address ozone. These coalitions, which include local governmental entities, elected officials, environmental groups, industry, consultants, and the public, worked diligently with EPA and the commission to identify and quantify control strategy measures for the HGB attainment demonstration.

December 2000

The December 2000 SIP revision contains rules and photochemical modeling analyses in support of the HGB area ozone attainment demonstration. The majority of the emissions reductions identified in this revision were from a 90% reduction in point source NO_x. The modeling analysis also indicated a shortfall in necessary NO_x emissions, such that an additional 91 tons per day (tpd) of NO_x reductions were necessary for an approvable attainment demonstration. In addition, the revision contained post-1999 rate of progress (ROP) plans for the milestone years 2002 and 2005 and for the attainment year 2007, and transportation conformity motor vehicle emission budgets (MVEBs) for NO_x and volatile organic compounds (VOC). The SIP also contained enforceable commitments to implement further measures in support of the HGB area attainment demonstration, as well as a commitment to perform and submit a midcourse review.

September 2001

The September 2001 SIP revision for the HGB ozone nonattainment area included the following elements: 1) corrections to the ROP table/budget for the years 2002, 2005, and 2007 due to a mathematical inconsistency; 2) incorporation of a change to the idling restriction control strategy clarifying that the operator of a rented or leased vehicle is responsible for compliance with the requirements in situations where the operator of a leased or rented vehicle is not employed by the owner of the vehicle (The commission committed to making this change when the rule was adopted in December 2000.); 3) incorporation of revisions to the clean diesel fuel rules to provide greater flexibility in complying with the requirements of the rule while preserving the emission reductions necessary to demonstrate attainment in the HGB area; 4) incorporation of a stationary diesel engine rule that was developed as a result of the state's analysis of EPA's reasonably available control measures; 5) incorporation of revisions to the point source NO_x rules; 6) incorporation of revisions to the emissions cap and trade rules; 7) the removal of the construction equipment operating restriction and the accelerated purchase requirement for Tier 2/3 heavy duty equipment; 8) the replacement of the Tier 2/3 rules with the Texas Emission Reduction Plan (TERP) program; 9) the layout of the midcourse review process, which details how the state will fulfill the commitment to obtain the additional emission reductions necessary to demonstrate attainment of the one-hour ozone standard in the HGB area; and 10) replacement of 2007 ROP MVEBs to be consistent with the attainment MVEBs.

As was discussed in the December 2000 revision, the modeling resulted in a 141 parts per billion peak ozone level correlating to a shortfall calculation of 91 tpd NO_x equivalent. An additional five tpd was added to the shortfall because the state could not take credit for the NO_x reductions associated with the diesel pull-ahead strategy. The excess emissions from this strategy were not included in the original emissions inventory. The gap control measures adopted in December 2000, along with the stationary diesel engine rules included in the September revision, resulted in NO_x reductions of 40 tpd, which left a total remaining shortfall of 56 tpd. The state committed to address this shortfall through the midcourse review process.

December 2002

In January 2001, the Business Coalition for Clean Air - Appeal Group (BCCA-AG) and several regulated companies challenged the December 2000 HGB SIP and some of the associated rules. Specifically, the BCCA-AG challenged the 90% NO_x reduction requirement from stationary sources in the HGB area. In May 2001, the parties agreed to a stay in the case, and Judge Margaret Cooper, Travis County District Court, signed a Consent Order, effective June 8, 2001, requiring the commission to perform an independent, thorough analysis of the causes of rapid ozone formation events and identify potential mitigating measures not yet identified in the HGB area attainment demonstration, according to the milestones and procedures in Exhibit C (Scientific Evaluation) of the Order.

In compliance with the Consent Order, the commission conducted a scientific evaluation based in large part on aircraft data collected by the Texas 2000 Air Quality Study (TexAQS). The TexAQS, a comprehensive research project conducted in August and September 2000 involving more than 40 research organizations and over 200 scientists, studied ground-level ozone air pollution in the HGB area and East Texas regions. One conclusion of the study was that the ambient concentrations of NO_x and VOC were not consistent with the industrial emissions estimates. Specifically, the ratio of NO_x to VOC did not correlate to the ambient ratio of NO_x to VOC. Because of the greater certainty associated with NO_x emissions estimates, it can be concluded that industrial VOC emissions were likely significantly understated in earlier emissions inventories.

To address these findings and to fulfill obligations in the Consent Order, the commission adopted a SIP revision in December 2002 that focused on replacing the most stringent 10% industrial NO_x reductions with VOC controls. In light of the TexAQS study, the commission conducted further modeling analysis of ambient VOC data. The results of photochemical grid modeling and analysis indicated that it is possible to achieve the same level of air quality benefits with reductions in industrial VOC emissions, combined with an overall 80% reduction in NO_x emissions from industrial sources, as would be realized with a 90% reduction in industrial NO_x emissions. Studies have suggested that the HGB area's high ozone events can be attributed to the presence of significant reactivity in the airshed. An analysis of automated

gas chromatograph data revealed that four compounds were frequently responsible for high reactivity days: ethylene, propylene, 1,3-butadiene, and butenes, as such these compounds were selected as the best candidates for the first round of HRVOC emission controls.

The commission adopted revisions to the industrial source control requirements, one of the control strategies within the existing federally approved SIP. The December 2002 SIP revision contains new rules that will better quantify and reduce emissions of HRVOCs from four key industrial sources: fugitives, flares, process vents, and cooling towers. The adopted rules target HRVOC emissions while maintaining the integrity of the SIP. Analysis showed that limiting emissions of ethylene, propylene, 1,3-butadiene, and butenes in conjunction with an 80% reduction in NO_x is equivalent to or better in terms of air quality benefit to that resulting from a 90% point source NO_x reduction requirement alone. As such, the HRVOC rules are performance-based, emphasizing monitoring, recordkeeping, reporting, and enforcement rather than establishing individual unit emission rates.

The technical support documentation accompanying the SIP revision contains the supporting analysis from ongoing analysis examining whether reductions in HRVOC emissions could replace the last 10% of industrial NO_x controls, while ensuring that the air quality specified in the approved December 2000 HGB area SIP is met.

Current Revision

As mentioned previously, the commission committed to perform a midcourse review to ensure attainment of the one-hour ozone standard. The midcourse review process provides the ability to update emissions inventory data, utilize current modeling tools, such as MOBILE6, and enhance the photochemical grid modeling. The data gathered from the TexAQS continues to improve photochemical modeling of the HGB area. The collection of these technical improvements gives a more comprehensive understanding of the ozone challenge in Houston, which is necessary for developing a plan to reach attainment. In early 2003, the commission was preparing to move forward with the midcourse review, and EPA announced its plans to begin implementation of the eight-hour ozone standard. The EPA published rules for implementation of the eight-hour ozone standard in the June 2, 2003 issue of the *Federal Register* (68 FR 32802). In the same time frame, EPA also formalized its intentions to designate areas for the eight-hour ozone standard by April 15, 2004, meaning states would need to reassess their efforts and control strategies to address this new standard by 2007. Recognizing that existing one-hour nonattainment areas would soon be subject to the eight-hour ozone standard, and in an effort to efficiently manage the state's limited resources, the commission developed an approach that addresses the outstanding obligations under the one-hour ozone standard while beginning to analyze eight-hour ozone issues.

The commission's one-hour ozone SIP commitments include: 1) completing a one-hour ozone MCR; 2) performing modeling; 3) adopting measures sufficient to fill the NO_x shortfall; 4) adopting measures sufficient to demonstrate attainment; and 5) revising the MVEB using MOBILE6.

Results from the TexAQS and recent photochemical modeling indicate that additional HRVOC reductions will be the most beneficial measure in reducing ozone in the HGB area. The commission proposed to reduce HRVOC emissions to reach attainment of the one-hour ozone standard. The photochemical modeling of the August - September 2000 episode coupled with a weight-of-evidence argument demonstrates attainment of the one-hour ozone standard. To achieve the necessary HRVOC reductions, the commission proposed a two-pronged approach that would address short-term emission events through a not-to-exceed limit, and would address steady state and routine emissions through an annual cap. The annual HRVOC cap is reduced from the existing HRVOC cap in order to support the attainment demonstration modeling.

The HGB SIP no longer relies solely on NO_x based strategies. A combination of point source HRVOC controls and NO_x reductions appears to be the most effective means of reducing ozone in the HGB area and there is no longer a NO_x shortfall in the HGB SIP. As a result, the commission also evaluated a number of the existing control strategies that were put in place in the December 2000 revision. The photochemical modeling shows that some of these strategies are no longer necessary to attain the one-hour ozone standard. This SIP revision included the repeal of the commercial lawn and garden equipment restrictions, the repeal of the heavy-duty vehicle idling restrictions, and the removal of the motor vehicle inspection and maintenance program requirements from Chambers, Liberty, and Waller Counties. In addition, this SIP proposal included revisions to the environmental speed limit strategy. In September 2002, the commission revised the existing speed limit strategy to suspend the 55 mile per hour (mph) speed limit until May 1, 2005, and, where posted speeds were 65 mph or higher before May 1, 2002, to increase speeds to five mph below what was posted. The 78th Legislature, 2003, removed the commission's authority to determine speed limits for environmental purposes; therefore, this rulemaking removes the reinstatement of the 55 mph speed limit on May 1, 2005, and maintains the currently posted speed limits at five mph below the posted limit before May 1, 2002. Also, as part of this SIP revision, the commission adopts new statewide portable fuel container rules. Historically, the commission has expressed a preference to implement technology-based strategies over behavior-altering strategies, and these changes embody that philosophy.

Through this revision, the commission is fulfilling its outstanding one-hour ozone SIP obligations and beginning to plan for the upcoming eight-hour ozone standard. This rulemaking demonstrates attainment of the one-hour ozone standard in the HGB area in 2007 and provides a preliminary analysis of the HGB area in terms of the eight-hour ozone standard in 2007 and 2010. EPA's proposed eight-hour implementation rules provide flexibility to the states in transitioning from the one-hour to the eight-hour ozone standard, and the commission believes that the steps taken in this rulemaking and the technical work performed to date will be invaluable through the transition period. Upon EPA's finalization of the eight-hour implementation and the transportation conformity rules, the commission expects to begin developing eight-hour ozone SIPs.

Adopted new Division 2 establishes new requirements relating to the design criteria for portable fuel containers and portable fuel container spouts. The adoption is in response to an October 31, 2001 petition for rulemaking from Fluoro-Seal and to the directive from the commission on December 5, 2001, to initiate rulemaking on these issues. The new rules establish design criteria for "no-spill" portable gas cans based in large part on the California Air Resources Board (CARB) standards. The most significant difference with the CARB standards is that these regulations do not require the control of permeations rates through the walls of portable fuel containers. This provision is not included in the

Texas regulations because the cost of compliance is expected to be large and the reduction in emissions small, relative to other provisions.

Effective December 31, 2005, these new rules will limit the type of portable fuel containers and portable fuel container spouts sold, offered for sale, manufactured, and/or distributed in the State of Texas. Fuel released into the environment leads to the contamination of both the state's air and water. These rules ensure that portable fuel containers manufactured under these standards will release fewer amounts of fuel as the result of spillage and evaporation. According to the most conservative estimates by commission staff, the reduction in spills and evaporation will reduce emissions from portable fuel containers by 45%. Staff estimates that the reductions statewide will amount to at least 12.5 tpd. The great majority of these reductions are to air emissions, but contamination of surface water and groundwater will also be reduced. Staff does not have adequate studies to estimate the reduction of water contamination. Factors such as distance from surface water in which spills occur and the time after a spill before rain occurs would impact the spread of contamination of surface water. One situation that will directly reduce releases to surface water will be the reduction of spills when refueling powered water craft with portable fuel containers. Contamination reaching groundwater would be affected by the type of surface or soil on which a spill occurs, the depth to groundwater, and annual average rainfall amounts in the area. The small size of spills that could occur from a portable fuel container would generally lead to greater evaporation of the fuel rather than transport to water.

SECTION BY SECTION DISCUSSION

Adopted new §115.620, Definitions, establishes the meaning of the terms "Nominal capacity," "Portable fuel container," "Portable fuel container spout," and "Target fuel tank." At adoption, the definition of portable fuel container is amended to remove a citation to federal Consumer Product Safety Commission regulations to make the rule easier to read. The citation was added to exclude containers that are sold to consumers already filled with fuel and that are not intended for reuse. This issue is addressed by adding a new exclusion at adoption.

Adopted new §115.621, Applicability, establishes the persons that this rule applies to. That is, unless exempted under §115.627, anyone who sells, offers for sale, supplies, distributes, or manufactures portable fuel containers and portable fuel container spouts in Texas is subject to these rules.

Adopted new §115.622, Performance Standards and Testing Requirements, establishes that, notwithstanding the exemptions provided in §115.627, no person shall sell, supply, offer for sale, distribute, or manufacture in Texas any portable fuel container or portable fuel container spout that was manufactured on or after December 31, 2005, unless it complies with the standards described in this section. Based on public comment, the compliance date was changed at adoption from January 1, 2006, to December 31, 2005, as discussed in the RESPONSE TO COMMENTS section of this preamble.

Adopted new §115.622(1) explains that each portable fuel container may only have one hole in the vessel. This standard has been included in the rule as a means of reducing emissions that occur when vent holes (a small second hole in the vessel that is used to expedite the flow of fuel out of the portable fuel container) are left open, leading to evaporative emissions and possibly spillage of fuel.

Adopted new §115.622(2) describes the standards required for portable fuel container spouts. Each portable fuel container spout will be required to have an automatic shutoff device to prevent over filling in accordance with CARB Test Method 510; automatically close and seal when removed from the fuel tank in accordance with CARB Test Method 511; seal without leakage when affixed to the portable fuel container vessel; and meet fuel flow rate and cut off level standards. The portable fuel container spout must provide a fuel flow rate in accordance with CARB Test Method 512, which specifies a flow rate of not less than 1/2 gallon per minute when attached to a portable fuel container that holds 1.5 gallons or less; one gallon per minute when attached to a portable fuel container that holds more than 1.5 gallons but less than or equal to 2.5 gallons; or two gallons per minute when attached to a portable fuel container that holds more than 2.5 gallons. Cut off fuel flow levels are set so as to eliminate the overfilling of a target fuel tank. Cut off fuel flow levels are one inch from the top of the target fuel tank for tanks that have a nominal capacity of 1.5 gallons or less. If the target fuel tank can hold more than 1.5 gallons, the cut-off level is 1.25 inches from the top of the fuel tank.

Adopted new §115.626, Labeling, states that portable fuel containers and portable fuel container spouts subject to this rule must display a label indicating that the system was designed in accordance with the rule as specified. Labels must also list the date when the device was manufactured and show prominently the word "spill-proof." Finally, the label must specify with which portable fuel containers the portable fuel container spout must be used. This final requirement will ensure that consumers match the proper spout to their vessel (or vice versa) in those cases when the devices are purchased separately. At adoption, a sentence is added to this section to state that other state and federal labeling requirements for portable fuel containers also apply. The addition of this sentence is intended to make it clear that there are other labeling requirements outside the scope of this rulemaking that pertain to portable fuel containers and that these rules do not affect those requirements.

Adopted new §115.627, Exemptions, states that all portable fuel containers and portable fuel container spouts manufactured prior to December 31, 2005, and all portable fuel containers with a nominal capacity of less than or equal to one quart, or greater than ten gallons are exempted from the requirements of this new rule. Based on public comment, the commission changed at adoption the compliance date from January 1, 2006, to December 31, 2005, as discussed in the RESPONSE TO COMMENTS section. The exemption allowing persons to sell, supply, offer for sale, or distribute portable fuel containers and portable fuel container spouts manufactured prior to December 31, 2005, allows companies to liquidize any stock of noncompliant portable fuel containers that otherwise would have become unsaleable in the state after the implementation date of this new rule. This section exempts from the rule any portable fuel container or portable fuel container spout that is sold, supplied, or offered for sale outside of Texas. This section also exempts portable fuel containers and portable fuel container spouts used in officially sanctioned racing competitions if the spill-proof spouts would cause problems with the race by increasing time needed to refuel during the race and if the spout and receiving tank are equipped with a spill-proof mechanism. Based on public comment, the commission adds at adoption an exemption for safety cans when their use is required by the federal Occupational Safety and Health Administration under 29 Code of Federal Regulations Part §1926.155(l), as discussed in the RESPONSE TO COMMENTS section. Also based

on public comment, the commission adds an exemption for containers that are filled with fuel by the manufacturer prior to sale to consumers and that are not intended for reuse as portable fuel containers, as discussed in the RESPONSE TO COMMENTS section.

Adopted new §115.629, Affected Counties and Compliance Schedules, states that all affected persons in all counties within the State of Texas must comply with this rulemaking action as soon as practicable, but not later than December 31, 2005. Based on public comment, the commission changed at adoption the compliance date from January 1, 2006 to December 31, 2005, as discussed in the RESPONSE TO COMMENTS section.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the rulemaking action in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking action does not meet the definition of a "major environmental rule" as defined in that statute. A "major environmental rule" is a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

This rulemaking and revisions to the SIP will reduce emissions of VOCs throughout Texas by regulating the type of portable fuel containers that can be manufactured or imported for sale in Texas on or after December 31, 2005. Specifically, the new rules will require that new portable fuel containers have devices to prevent spills and overfilling of the receiving tanks. The new rules are not expected to adversely affect in a material way the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

The new rules do not meet any of the four applicability criteria of a "major environmental rule" as defined in the Texas Government Code. Texas Government Code, §2001.0225 applies only to a major environmental rule the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law.

The new rules implement requirements of 42 USC. Under 42 USC, §7410, states are required to adopt a SIP which provides for "implementation, maintenance, and enforcement" of the primary NAAQS in each air quality control region of the state. While 42 USC, §7410 does not require specific programs, methods, or reductions in order to meet the standard, SIPs must include "enforceable emission limitations and other control measures, means or techniques (including economic incentives such as fees, marketable permits, and auctions of emissions rights), as well as schedules and timetables for compliance as may be necessary or appropriate to meet the applicable requirements of this chapter," (meaning Chapter 85, Air Pollution Prevention and Control). It is true that 42 USC does require some specific measures for SIP purposes, such as the inspection and maintenance program, but those programs are the exception, not the rule, in the SIP structure of 42 USC. The provisions of 42 USC recognize that states are in the best position to determine what programs and controls are necessary or appropriate in order to meet the ozone standard. This flexibility allows states, affected industry, and the public to collaborate on the best methods for attaining the NAAQS for the specific regions in the state. Even though 42 USC allows states to develop their own programs, this flexibility does not relieve a state from developing a program that meets the requirements of 42 USC, §7410. Thus, while specific measures are not generally required, the emission reductions are required. States are not free to ignore the requirements of 42 USC, §7410, and must develop programs to assure that the nonattainment areas of the state will be brought into attainment on schedule.

The requirement to provide a fiscal analysis of regulations in the Texas Government Code was amended by Senate Bill (SB) 633 during the 75th Legislature, 1997. The intent of SB 633 was to require agencies to conduct a regulatory impact analysis (RIA) of extraordinary rules. These are identified in the statutory language as major environmental rules that will have a material adverse impact and will exceed a requirement of state law, federal law, or a delegated federal program, or are adopted solely under the general powers of the agency. With the understanding that this requirement would seldom apply, the commission provided a cost estimate for SB 633 that concluded "based on an assessment of rules adopted by the commission in the past, it is not anticipated that the bill would not have significant fiscal implications for the agency due to its limited application." The commission also noted that the number of rules that would require assessment under the provisions of the bill was not large. This conclusion was based, in part, on the criteria set forth in the bill that exempted rules from the full analysis unless the rule was a major environmental rule that exceeds a federal law. As discussed earlier in this preamble, 42 USC does not require specific programs, methods, or reductions in order to meet the NAAQs for ozone; thus, states must develop programs for each nonattainment area to ensure that each area will meet the attainment deadlines. Because of the ongoing need to address nonattainment issues, the commission routinely adopts SIP rules. The legislature is presumed to understand this federal scheme. If each rule included in the SIP was considered to be a major environmental rule that exceeds federal law, then every SIP rule would require the full RIA contemplated by SB 633. This conclusion is inconsistent with the conclusions reached by the commission in its cost estimate and by the Legislative Budget Board in its fiscal notes. Because the legislature is presumed to understand the fiscal impacts of the bills it passes, and that presumption is based on information provided by state agencies and the Legislative Budget Board, the commission believes that the intent of SB 633 was only to require the full regulatory impact analysis for rules that are extraordinary in nature. While the SIP rules will have a broad impact, that impact is no greater than is necessary or appropriate to meet the requirements of 42 USC. For these reasons, rules adopted for inclusion in the SIP fall under the exception in Texas Government Code, §2001.0225(a), because they are specifically required by federal law.

In addition, 42 USC, §7502(a)(2), requires attainment as expeditiously as practicable, and 42 USC, §7511a(d) requires states to submit ozone attainment demonstration SIPs for severe ozone nonattainment areas such as the HGB area. The rules will reduce VOC emissions statewide, including in the HGB area. The control of VOCs in the HGB area will assist with achieving attainment of the NAAQS for ozone for that area. Therefore, the new rules are necessary components of and consistent with the

ozone attainment demonstration SIP for the HGB area, required by 42 USC, §7410.

The commission has consistently applied this construction to its rules since this statute was enacted in 1997. Since that time, the legislature has revised the Texas Government Code, but left this provision substantially unamended. The commission presumes that "when an agency interpretation is in effect at the time the legislature amends the laws without making substantial change in the statute, the legislature is deemed to have accepted the agency's interpretation." *Central Power & Light Co. v. Sharp*, 919 S.W.2d 485, 489 (Tex. App. Austin 1995), *writ denied with per curiam opinion respecting another issue*, 960 S.W.2d 617 (Tex. 1997); *Bullock v. Marathon Oil Co.*, 798 S.W.2d 353, 357 (Tex. App. Austin 1990), *no writ*. *Cf. Humble Oil & Refining Co. v. Calvert*, 414 S.W.2d 172 (Tex. 1967); *Dudney v. State Farm Mut. Auto Ins. Co.*, 9 S.W.3d 884, 893 (Tex. App. Austin 2000); *Southwestern Life Ins. Co. v. Montemayor*, 24 S.W.3d 581 (Tex. App. Austin 2000), *pet. denied*; and *Coastal Indust. Water Auth. v. Trinity Portland Cement Div.*, 563 S.W.2d 916 (Tex. 1978).

As discussed earlier in this preamble, this rulemaking implements requirements of 42 USC. There is no contract or delegation agreement that covers the topic that is the subject of this rulemaking action. Therefore, the new rules do not exceed a standard set by federal law, exceed an express requirement of state law, exceed a requirement of a delegation agreement, or are adopted solely under the general powers of the agency. In addition, the rules are adopted under Texas Health and Safety Code, §§382.002, 382.011, 382.012, and 382.017.

TAKINGS IMPACT ASSESSMENT

The commission completed a takings impact analysis for the rulemaking action under Texas Government Code, §2007.043. The specific purpose of these new rules is to reduce the emissions of VOCs caused by leaks and spills from portable fuel containers.

Texas Government Code, §2007.003(b)(4), provides that Chapter 2007 does not apply to this rulemaking action, because it is reasonably taken to fulfill an obligation mandated by federal law. The control requirements within this rulemaking action were developed in order to meet the ozone NAAQS set by the EPA under 42 USC, §7409. States are primarily responsible for ensuring attainment and maintenance of NAAQS once the EPA has established them. Under 42 USC, §7410, and related provisions, states must submit for EPA approval SIPs that provide for the attainment and maintenance of the applicable ozone standard through control programs directed to sources of the ozone. Therefore, one purpose of this rulemaking action is to meet the air quality standards established under federal law, identifiable as the NAAQS. Any VOC reductions resulting from the current rulemaking are no greater than what scientific research indicates is necessary to achieve the desired ozone levels. However, this rulemaking is only one step among many necessary for attaining the ozone standard.

In addition, Texas Government Code, §2007.003(b)(13), states that Chapter 2007 does not apply to an action that: 1) is taken in response to a real and substantial threat to public health and safety; 2) is designed to significantly advance the health and safety purpose; and 3) does not impose a greater burden than is necessary to achieve the health and safety purpose. Although the new rules do not directly prevent a nuisance or prevent an immediate threat to life or property, they do prevent a real and substantial threat to public health and safety and significantly advance the health and safety purpose. This action is taken in response to the finding that the HGB area exceeds the federal ozone standard, and may consequently affect public health in an adverse manner, primarily through irritation of the lungs. The action significantly advances the health and safety purpose by reducing ozone levels in the HGB nonattainment area. Consequently, these rules meet the exemption in Texas Government Code, §2007.003(b)(13). This rulemaking action therefore meets the requirements of Texas Government Code, §2007.003(b)(4) and (13). For these reasons, the new rules do not constitute a takings under Texas Government Code, Chapter 2007.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the rulemaking action and found that the proposal is an action identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11, or will affect an action/authorization identified in §505.11, and therefore will require that applicable goals and policies of the Coastal Management Program be considered during the rulemaking process.

The commission prepared a consistency determination for the rules under 31 TAC §505.22 and found that the rulemaking action is consistent with the applicable CMP goals and policies. The CMP goal applicable to this rulemaking action is the goal to protect, preserve, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas (31 TAC §501.12(1)). No new sources of air contaminants will be authorized and ozone levels will be reduced as a result of these new rules. The CMP policy applicable to this rulemaking action is the policy that commission rules comply with regulations in 40 CFR, to protect and enhance air quality in the coastal area (31 TAC §501.14(q)). This rulemaking action complies with 40 CFR. Therefore, in compliance with 31 TAC §505.22(e), this rulemaking action is consistent with CMP goals and policies.

EFFECT ON SITES SUBJECT TO THE FEDERAL OPERATING PERMIT PROGRAM

Chapter 115 is an applicable requirement under 30 TAC Chapter 122; therefore, owners or operators subject to the federal operating permit program must, consistent with the revision process in Chapter 122, revise their operating permits to include the revised Chapter 115 requirements for each emission unit affected by the revisions to Chapter 115 at their sites.

PUBLIC COMMENT

Public hearings were held in Houston on August 2, 2004, in Beaumont on August 3, 2004, and in Austin on August 5, 2004, but no oral comments were received concerning the portable fuel container rules. The public comment period ended at 5:00 p.m. on August 9, 2004. Written comments were submitted by the Central Texas EAC Task Force (EAC); Ms. Joni Brown, Air Quality Program Coordinator, representing the City of Victoria (Victoria); Environmental Defense; the Galveston-Houston Association for Smog Prevention (GHASP), sending two letters; the Houston-Galveston Area Council (HGAC); the Sierra Club, Houston Regional Group (Sierra Club); the commission's Office of Public Interest Counsel (OPIC); the Honorable Bill White, Mayor, City of Houston, and the Honorable Robert Eckels, County Judge, Harris County, providing joint comments (Houston/Harris County); the Greater Houston Partnership (GAP); and the Transportation Policy Council (TPC). GHASP, Victoria, OPIC, HGAC, EAC, Sierra Club, Houston/Harris County, GAP,

and TPC indicated that they supported the rulemaking. Environmental Defense did not indicate whether it is for or against the adoption of the rules but provided specific comments on the rules.

RESPONSE TO COMMENTS

Comment

OPIC, GHASP, Sierra Club, Victoria, TPC, EAC, Houston/Harris County, GAP, and HGAC issued their support of the proposed portable fuel container rulemaking.

Response

The commission acknowledges the comments and appreciates the support of the rules.

Comment

OPIC commented that the proposed fuel container rule does not adopt the exact language used in the CARB rule and adds conditions that limit its applicability.

Response

The proposed rule, as written, is limited in applicability only to the extent that it imposes standards upon portable fuel containers and spouts which are sold, supplied, offered for sale, or distributed in the State of Texas. As noted, the proposed rule is not written with the exact language of the CARB rule. For example, unlike the CARB rule, the proposed rule does not include a permeation standard for portable fuel containers because very few emission reductions would be achieved via this strategy, and the cost for manufacturers to include impermeable coatings to portable fuel containers would be high. Furthermore, according to the CARB's portable fuel container Web page it was, and still is, in the process of amending its portable fuel container rule. No changes were made in response to this comment.

Comment

OPIC recommended adding a definition of "motor fuel" to the rule.

Response

OPIC's recommended definition of "motor fuel" is not included in the proposed rule because it would unnecessarily limit the portable fuel container rule. The definitions of "motor fuel" cited by OPIC do not capture the entire universe of fuels that could be contained in these types of containers and used for the operation of internal combustion engines and/or motors. No changes were made in response to this comment.

Comment

OPIC recommended that the definition of "Portable fuel container" be revised so as to delete the language "for use in internal combustion engines, and that is subject to 16 CFR §1500.83(a)(14)" and insert an applicability requirement that the container be designed to be used "in a manner that does not involve permanent attachment to any motorized equipment or vehicle."

Response

The definition of portable fuel containers was not revised as OPIC suggested. The phrase "for use in internal combustion engines" is necessary in order to specify the use for the universe of fuels that could be contained in regulated containers. The reference to 16 CFR §1500.83(a)(14) was used in the proposed rule to differentiate portable fuel containers, which are sold empty, from containers of fuels that are sold full, if the containers are not intended to be reused as portable fuel containers. The citation is to the Federal Consumer Product Safety Commission regulation concerning the labeling required for portable fuel containers. However, based on this comment which demonstrated that the reference was not clear, the commission is amending at adoption the definition by removing the citation and adding at adoption a new exclusion to exempt these types of containers from the rule. If this differentiation is lost, containers of emergency fuels would have to comply with the rules even though those containers are sealed until used and are not intended for reuse. These cans are designed to be carried in a vehicle for filling automobile gas tanks in emergency situations where a motorist runs out of gas. Additionally, the language OPIC suggested would apply to all fuel containers like those on motor boats that have gas tanks which are not permanently attached to the engine but can be disconnected to be refilled or stored. The substitution language is not needed because the definitions of "Portable fuel container" and "Portable fuel container spout" limit applicability of the rules to containers used to fill tanks that are attached to internal combustion engines, rather than to the receiving tanks also.

Comment

OPIC recommended an exemption be added to the portable fuel container rule to exempt "safety cans" as defined in 29 CFR §1926.155(l).

Response

The federal Occupational Safety and Health Administration (OSHA) regulation requires the use of safety cans in certain areas. These cans do not conform with the portable fuel container rules because the safety cans are designed to avoid fire hazards rather than curb air emissions. Since the OSHA regulations preempt the commission's rules in areas under OSHA's jurisdiction, the suggested change adds clarity to the rule. Therefore, the commission has amended the rule by adding at adoption the exemption as §115.627(5).

Comment

EAC commented that the commission should change the implementation date of the proposed rule from January 1, 2006 to December 31, 2005 because this change will comply with the terms of the Early Action Compact agreement and avoid unnecessary risk to the Clean Air Action Plan (CAAP).

Response

To comply with the rule as proposed, manufacturers must implement the rule through modification of their production processes prior to January 1, 2006. However, the date change requested should not present an unreasonable burden. The emission reductions from the proposed rules are needed to ensure a successful CAAP for the EAC region, as well as to fulfill nonattainment emission reduction commitments. The terms of the early action compact agreement stipulate that all emission reduction measures must be implemented no later than December 31, 2005. Therefore, the commission is amending §§115.622, 115.627(1), and 115.629 to make the cut-off date for manufacturing noncompliant portable fuel containers December 31, 2005, rather than January 1, 2006.

Comment

Environmental Defense commented that the proposed fuel container rule significantly underestimates emissions reductions.

Response

The commission utilized the 2002a version of the NONROAD model for 2007 to calculate realistic and conservative statewide emission reductions. Although the use of evidence from other studies/models might show greater potential emission reductions, the commission would not be able to demonstrate to EPA that the portable fuel container rule would achieve emission reductions greater than the amount presently asserted. No changes were made in response to this comment.

Comment

Environmental Defense commented that modest cost increases associated with the proposed fuel container rule will be significantly offset with fuel savings resulting from consumers losing less fuel over the lifetime of the proposed fuel containers.

Response

Upon implementation of the proposed fuel container rule, the commission realizes that less fuel will be lost to spillage and evaporation. However, the commission is not able to precisely quantify those savings to factor fuel cost savings into the cost benefit estimation. To the degree possible, the commission adequately calculated the estimated cost of compliance. No changes were made in response to this comment.

Comment

Environmental Defense commented that the commission should consider the need for additional labeling if containers are not suitable for refueling on-road motor vehicles.

Response

The commission did not include a labeling requirement stating whether or not a portable fuel container is suitable for refueling on-road motor vehicles. California did require such labeling in its no-spill portable fuel container rule since very few portable fuel containers that were "spill-proof" could service an on-road vehicle. However, today most manufacturers of portable fuel containers are now producing cans that can service on-road motor vehicles. Therefore, the commission believes that market forces should dictate this aspect of labeling rather than regulation. No changes were made in response to this comment.

Comment

Environmental Defense commented that the commission should review California's portable fuel rule experience with respect to consumer issues.

Response

The CARB is amending its no-spill portable fuel container rule to address consumer issues and to change its requisite test methods. In order for Texas to meet the deadlines for the midcourse review of the SIP, the commission could not wait for the CARB rules to be adopted. In the future the commission may amend its portable fuel container rule to correspond to the CARB rule, to align the commission's test methods with those presently under CARB's consideration. No changes were made in response to this comment.

Comment

Environmental Defense commented that the commission should reconsider whether it is sensible to include California's permeability standards.

Response

Unlike CARB, the commission did not include a permeation standard for portable fuel containers. First, the commission found that very few emissions resulted from permeation. Second, the cost for manufacturers to include impermeable coatings to portable fuel containers was considerable. Third, CARB, by virtue of the size of the California market, and other states that have adopted no-spill gas can rules have created a de facto national standard for impermeable no-spill portable fuel containers. Therefore, it is expected that most manufacturers of no-spill portable fuel containers will comply with the more stringent CARB standards when selling to retailers in Texas rather than have a separate product line for the Texas market. Fourth, the coating that renders plastic portable fuel containers impermeable fades with time and eventually becomes useless after only a few months. Since these reasons indicate that there would be few additional emission reductions from this factor, the commission chose not to adopt the permeability standards. No changes were made in response to this comment.

Comment

Environmental Defense commented that the commission should consider the overall cost effectiveness of the proposed fuel container rule rather than the incremental cost of any individual element of the regulation.

Response

The overall cost effectiveness of this rule has been calculated accurately. Best estimates of variables such as costs to consumers and the expected savings from reduced fuel loss were factored into the final cost analysis. The commission does not anticipate significant fiscal implications for manufacturers of portable fuel containers due to implementation of the proposed new rules. There are no known manufacturers in Texas that will be directly affected by the new requirements. CARB estimated that any manufacturing costs required to produce the upgraded portable fuel containers would likely be passed along to consumers buying and businesses selling the new portable fuel containers. Retailers who sell portable fuel containers may be impacted if the potential increase in costs of the products reduces demand; however, the commission does not anticipate this will occur. The price increase, estimated between $6.00 and $11 per portable fuel container, is not anticipated to drastically alter consumer/business purchases of these products.

The cost rulemaking elements were considered in developing the proposed fuel container rule. The commission considered the permeation limits of the CARB rule in drafting its rule, but determined it was the least cost-effective reduction that could be achieved and it did not achieve the maximum reductions possible. The CARB rule permeation standard allows approximately ten times the permeation rate that is found in metal fuel containers, but to achieve the prescribed rate, manufacturers of plastic containers must use proprietary processes that are under the control of a limited number of manufacturers. In order to avoid giving preference to a limited number of manufacturers, the commission did not include the permeation standard. However, since most manufacturers produce fuel containers for a national market and because it is unlikely that they will develop a separate product line for the Texas market, it is not expected that this omission will have a significant impact on the emission reductions. No changes were made in response to this comment.

Comment

Environmental Defense commented that the commission should consider outreach and incentive programs to accelerate the turnover of the state's gas cans.

Response

The commission believes that the turnover rate for portable fuel containers is rapid enough that emission reductions will result soon after implementation of the rule. There will be an announcement about the upcoming standards on the commission's Web site. The commission does not immediately plan to create an incentive and outreach program to accelerate turnover rate; however, it is also possible that other agencies at the state and local levels will offer such programs. No changes were made in response to this comment.

STATUTORY AUTHORITY

The new rules are adopted under Texas Water Code, §5.102, concerning General Powers, §5.103, concerning Rules, and §5.105, concerning General Policy, which provide the commission with the general powers to carry out its duties and authorize the commission to adopt rules necessary to carry out its powers and duties under the Texas Water Code; §26.003, concerning Policy; §26.011, concerning In General, which provide the commission with the authority to maintain and control the quality of water in the state; and under Texas Health and Safety Code, §382.017, concerning Rules, which authorizes the commission to adopt rules consistent with the policy and purposes of Texas Health and Safety Code, Chapter 382 (also known as the Texas Clean Air Act). The new rules are also adopted under Texas Health and Safety Code, §382.002, concerning Policy and Purpose, which establishes the commission's purpose to safeguard the state's air resources, consistent with the protection of public health, general welfare, and physical property; §382.011, concerning General Powers and Duties, which authorizes the commission to control the quality of the state's air; and §382.012, concerning State Air Control Plan, which authorizes the commission to prepare and develop a general, comprehensive plan for the control of the state's air. The new rules are adopted under federal mandates contained in 42 USC, §7410, that requires states to introduce pollution control measures in order to reach specific air quality standards in particular areas of the state.

§115.620. Definitions.

The following words and terms, when used in this division, have the following meanings, unless the context clearly indicates otherwise. Additional definitions for terms used in this division are found in §§3.2, 101.1, and 115.10 of this title (relating to Definitions).

(1) Nominal capacity--The volume indicated by a portable fuel container manufacturer that represents the maximum recommended filling level.

(2) Portable fuel container--Any vessel that is designed to be used in combination with a portable fuel container spout and that is designed or used primarily to receive, transport, store, or dispense fuel for use in internal combustion engines.

(3) Portable fuel container spout--Any device that is designed or manufactured to be attached to a portable fuel container for the purpose of dispensing fuel into a target fuel tank leading to an internal combustion engine.

(4) Target fuel tank--Any receptacle that receives fuel from a portable fuel container.

§115.622. Performance Standards and Testing Requirements.

Except as provided in §115.627 of this title (relating to Exemptions), no person shall sell, supply, offer for sale, distribute, or manufacture any portable fuel container or portable fuel container spout which was manufactured on or after December 31, 2005, that does not comply with the following performance standards.

(1) Portable fuel containers must have only one opening in the vessel.

(2) Portable fuel container spouts must:

(A) contain an automatic shutoff device that stops the flow of fuel before the target fuel tank overflows, in accordance with California Air Resources Board (CARB) Test Method 510 (July 6, 2000);

(B) automatically close and seal when removed from the target fuel tank, and remain completely closed when not dispensing fuel, in accordance with CARB Test Method 511 (July 6, 2000);

(C) seal without leakage to the portable fuel container to which it is affixed;

(D) provide a fuel flow rate, in accordance with CARB Test Method 512 (July 6, 2000), of not less than:

(i) 1/2 gallon per minute when attached to a portable fuel container with a nominal capacity of 1.5 gallons or less;

(ii) one gallon per minute when attached to a portable fuel container with a nominal capacity greater than 1.5 gallons but less than or equal to 2.5 gallons; or

(iii) two gallons per minute when attached to a portable fuel container with a nominal capacity of greater than 2.5 gallons; and

(E) cut off fuel flow when the fuel level in the target fuel tank reaches:

(i) one inch from the top of a target fuel tank with a nominal capacity of 1.5 gallons or less; or

(ii) 1.25 inches from the top of a target fuel tank with a nominal capacity greater than 1.5 gallons.

§115.626. Labeling.

Portable fuel containers and portable fuel container spouts subject to the requirements of §115.622 of this title (relating to Performance Standards and Testing Requirements) must be labeled so as to indicate compliance with the requirements of §115.622 of this title. The label must also list the date the device was manufactured and must prominently include the word "spill-proof." The label must also specify with which portable fuel containers the portable fuel container spout must be used. These labeling requirements are in addition to any other federal or state labeling requirements that apply to portable fuel containers.

§115.627. Exemptions.

This division (relating to Portable Fuel Containers) does not apply to:

(1) portable fuel containers or portable fuel container spouts manufactured prior to December 31, 2005;

(2) portable fuel containers with a nominal capacity less than or equal to one quart, or greater than ten gallons;

(3) portable fuel containers or portable fuel container spouts that are sold, supplied, or offered for sale outside of Texas;

(4) portable fuel containers and portable fuel container spouts used in officially sanctioned racing competitions when the minimum flow rates provided in §115.622(2)(D) of this title (relating

to Performance Standards and Testing Requirements) would interfere with the competition by requiring too long to refuel vehicles during the race, if both the portable fuel container spout and the receiving tank have compatible spill-proof mechanisms to avoid spills when transferring fuel;

(5) safety cans when their use is required by the federal Occupational Safety and Health Administration under 29 Code of Federal Regulations §1926.155(l); and

(6) containers that are filled with fuel by the manufacturer prior to sale to consumers and that are not intended for reuse as portable fuel containers.

§115.629. Affected Counties and Compliance Schedules.

All affected persons in all counties within the State of Texas shall be in compliance with the provisions of this division as soon as practicable, but no later than December 31, 2005.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

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Stephanie Bergeron Perdue
Director, Environmental Law Division
Texas Commission on Environmental Quality
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Proposal publication date: June 11, 2004
For further information, please call: (512) 239-6087

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CHAPTER 330. MUNICIPAL SOLID WASTE
SUBCHAPTER A. GENERAL INFORMATION

30 TAC §330.4

Texas Commission on Environmental Quality (TCEQ or commission) adopts the amendment to §330.4. Section 330.4 is adopted *without change* to the proposed text as published in the May 28, 2004, issue of the *Texas Register* (29 TexReg 5278) and will not be republished.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULE

A bill from the 77th Legislature, 2001, amended Texas Occupations Code, §801.361, Disposal of Animal Remains. This bill allowed the burning or burying of animal remains if the disposal occurred in a county with a population of less than 10,000, the burning or burying occurred on property owned by the veterinarian, and the veterinarian did not charge for disposal. This bill did not allow the burning or burying of medical waste associated with animal remains.

This rulemaking implements Senate Bill (SB) 216, 78th Legislature, 2003. This bill amended Texas Occupations Code, §801.361, and took effect September 1, 2003. Texas Occupations Code, §801.361 now allows a veterinarian to dispose of animal remains and medical waste associated with the animal by burial or burning if certain conditions are met. The veterinarian must conduct these activities on property owned by the veterinarian that is outside the corporate boundaries of a municipality or within the corporate boundaries of a municipality as a result of an annexation that occurs on or after September 1, 2003. Further, SB 216 stipulates that Texas Occupations Code, §801.361 prevails over any other law that authorizes a government entity to prohibit or restrict outdoor burning or abate a public nuisance.

In compliance with House Bill 3061, 78th Legislature, 2003, this rule was developed in cooperation with and was approved by the Texas Animal Health Commission on May 25, 2004. The commission simultaneously adopts in this issue of the *Texas Register* the amendment to 30 TAC §111.209, Exception for Disposal Fires.

SECTION DISCUSSION

The commission amends §330.4(c), (g), and (x) in order to conform with current formatting standards. In subsection (c) "MSWLF" is revised to "MSW landfill facility." In subsection (g) the titles of §§330.150 - 330.159 are listed individually and the title of the subchapter in which these sections are contained, "Operational Standards for Solid Waste Processing and Experimental Sites" is removed. The amendment to subsection (x) replaces "RCRA" with "The Resource Conservation and Recovery Act."

The commission revises §330.4(y) to refer to amended Texas Occupations Code, §801.361. Texas Occupations Code, §801.361 allows a veterinarian to burn or bury the remains of an animal and medical waste associated with the animal on property owned by the veterinarian without having to seek approval from the TCEQ for this activity. The veterinarian-owned property must now be outside the corporate boundaries of any municipality or within the corporate boundaries of a municipality as a result of an annexation that occurs on or after September 1, 2003. Existing language in §330.4(y) that conflicts with amended Texas Occupations Code, §801.361, is removed. Additionally, new language is added to §330.4(y) that stipulates that veterinarians who dispose by burning under this section must comply only with §111.209(3). Paragraphs (1) - (9) of this subsection are removed.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute. Furthermore, it does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a).

A "major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. This rulemaking amends §330.4(y) by removing existing language that conflicts with amended Texas Occupations Code, §801.61 and by adding language that stipulates that veterinarians burning under Texas Occupations Code, §801.361 must comply only with §111.209(3). This adopted rule does not qualify as a major environmental rule because it does not have as its specific intent the protection of the environment or the reduction of risk to human health from environmental exposure. The specific intent of this amendment is to incorporate the changes made by SB 216 into the municipal solid waste permitting exemption for the disposal

of animal remains and associated medical waste by veterinarians.

In addition, a regulatory impact assessment is not required because the rule does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). The rule does not exceed a standard set by federal law because there is no corresponding federal standard. The rule does not exceed an express requirement of state law because it is in direct response to SB 216, and does not exceed the requirements of this bill. This rule does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program. This rule does not adopt a rule solely under the general powers of the agency, but rather under specific state law, namely Texas Health and Safety Code, §361.011 and §361.024.

TAKINGS IMPACT ASSESSMENT

The commission performed an assessment of this rule in accordance with Texas Government Code, §2007.043. The specific purpose of the adopted rule is to implement SB 216. The rule implements the provisions of SB 216, which modified the requirements applicable to veterinarians who wish to dispose of animal remains and associated medical waste by burying or burning without obtaining a TCEQ permit or registration. The rule substantially advances this stated purpose by modifying §330.4 to conform to the statute. The rule does not affect real property because it refers to a statute that specifies the conditions under which a veterinarian may dispose of animal remains and associated medical waste without TCEQ authorization. Therefore, the adopted rule does not constitute a taking under Texas Government Code, Chapter 2007.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the rulemaking and found that the rule is neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11, nor does it affect any action/authorization identified in §505.11. Therefore, the adopted rule is not subject to the Texas Coastal Management Program.

PUBLIC COMMENT

The commission conducted a public hearing on the rulemaking on June 24, 2004, in Austin. The Texas Veterinary Medical Association (TVMA) commented at the hearing. During the public comment period, which closed on June 28, 2004, the commission received written comments from TVMA, EPA, and Senator Judith Zaffirini. EPA stated neither support nor objection to the amendment to Chapter 330, while TVMA and Senator Zaffirini expressed opposition to the amendment to §330.4.

RESPONSE TO COMMENTS

Comment

TVMA and Senator Zaffirini commented that the net effect of the rule will be to preclude the burying of carcasses by veterinarians.

Response

It is the agency's position that the adopted rule conforms to the intent of SB 216 and does not prohibit or restrict the activities authorized by the bill. This rule amendment refers directly to Texas Occupations Code, §801.361 as amended by SB 216.

Comment

TVMA and Senator Zaffirini commented that the majority of veterinarians using SB 216 would rather burn carcasses than bury them. However, TVMA further stated, that sometimes weather conditions don't permit burning. In this case the veterinarian has a few options including burial, transport to a landfill, or sending the carcass home with the owner so that the owner may dispose of the carcass. TVMA pointed out that there may be public and animal health issues with the transport of carcasses and the disposal of carcasses by individual animal owners who often just dump the carcass in a pasture. TVMA stated that under the proposed rule veterinarians who want to bury carcasses must deed record, which requires that veterinarians survey their land, record it in the county, send a copy to the TCEQ, and let the TCEQ know when they have closed the burial pit. TVMA stated that these deed recordation requirements will prevent veterinarians from using SB 216 to bury at all, which will mean sending carcasses home with the owners. TVMA and Senator Zaffirini stated that it is financially burdensome for veterinarians to survey their land and deed record in order to dispose of animals by burial. TVMA and Senator Zaffirini commented that veterinarians are highly trained and educated on proper disposal of animal remains. TVMA asked that the commission not adopt the rule as written and consider a rule that excepts veterinarians from deed recordation requirements.

Response

The amendment does not mention deed recordation, nor does the amendment modify the deed recordation requirements for municipal solid waste. Existing 30 TAC §330.7, Deed Recordation, requires a person burying municipal solid waste, including dead animals, to deed record. This rulemaking does not open or modify §330.7, but rather it amends §330.4, Permit Required, by referencing Texas Occupations Code, §801.361.

The requirement to deed record does not prohibit conduct authorized by SB 216.

The commission agrees that veterinarians are highly trained professionals who will decide to burn or bury diseased animals based on best management practices that are protective of public and animal health. Some diseased animal carcasses are best disposed of by burial because disease could be spread if carcasses with certain kinds of disease are disposed of by burning. Veterinarians have access to information that will help them decide the most protective method by which to dispose of diseased animal carcasses.

Comment

TVMA and Senator Zaffirini stated that the amended rule will hold veterinarians to the same standards as other entities that are disposing of municipal solid waste.

Response

The amendment to §330.4 does not require veterinarians to comply with all of the requirements for municipal solid waste landfills. Specifically, the amendment to §330.4 modifies the current provisions regarding disposal of the remains of an animal that dies in the care of a veterinarian. It does this by referring directly to Texas Occupations Code, §801.361.

STATUTORY AUTHORITY

The amendment is adopted under Texas Water Code (TWC), §5.013, which establishes the general jurisdiction of the commission; TWC, §5.102, which establishes the commission's general

authority to carry out its jurisdiction; and TWC, §5.103, which requires the commission to adopt any rule necessary to carry out its powers and duties under this code and other laws of this state. The commission also takes this action under Texas Health and Safety Code, §361.011 and §361.024, which provide the commission with the authority to adopt rules necessary to carry out its powers and duties under the Texas Solid Waste Disposal Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 334. UNDERGROUND AND ABOVEGROUND STORAGE TANKS

The Texas Commission on Environmental Quality (agency, commission, or TCEQ) adopts amendments to §§334.2, 334.5, 334.7 - 334.10, 334.12, 334.46, 334.50, 334.55, 334.56, 334.302, 334.306 - 334.310, 334.313 - 334.315, 334.322, 334.530 - 334.535, and 334.560. Sections 334.2, 334.10, 334.50, 334.302, 334.306, 334.309, 334.313, 334.531, 334.533 - 334.535, and 334.560 are adopted *with changes* to the proposed text as published in the April 30, 2004 issue of the *Texas Register* (29 TexReg 4083). Sections 334.5, 334.7 - 334.9, 334.12, 334.46, 334.55, 334.56, 334.307, 334.308, 334.310, 334.314, 334.315, 334.322, 334.530, and 334.532 are adopted *without changes* to the proposed text and will not be republished. Section 334.14 is withdrawn.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULES

To better ensure that all payable reimbursement claims can be paid before the Petroleum Storage Tank Remediation (PSTR) Account sunsets in 2006, given limited agency resources, the standard for the reimbursement of eligible cleanup expenses related to leaking petroleum storage tank (LPST) sites is revised to move away from an "actual cost" -based system. Reimbursement will instead be based on the lower of either line-item amounts listed in Subchapter M of this chapter or line-item amounts listed in invoices submitted with the claim, with limited updates to those Subchapter M line-item amounts proposed in this rulemaking. In addition, better accountability provisions are proposed to be added in the reimbursement rules as a result of the agency's experiences with petroleum storage tank (PST) audit cases over the last few years.

Throughout this rulemaking package, administrative changes have been made in accordance with *Texas Register* requirements and to be consistent with other commission rules (e.g., references to the Texas Natural Resource Conservation Commission or TNRCC have been updated to Texas Commission on Environmental Quality, TCEQ, or agency, as appropriate).

The commission specifically solicited comments and suggested alternatives with regard to each of the following issues in this rulemaking: 1) considering the language in §334.309(c) - should the agency continue to utilize an actual cost analysis and if so, how should actual cost be defined; 2) does the language overly limit the agency's audit authority as described in §334.309(d) and §334.533; and 3) considering the language in §334.306(f) - what method(s) could be used to address concerns that have been expressed regarding the ability of the agency to ensure that subcontractors receive payment for work performed as part of the PST reimbursement program.

SECTION BY SECTION DISCUSSION

Subchapter A - General Provisions

Regulatory reform changes are adopted to provide clarification of existing regulatory requirements concerning tank labeling and the definition of action level; to insert a definition of petroleum storage tank since the term was inadvertently omitted in a previous rulemaking and is used in this chapter; to add flexibility concerning certification of certain environmental professionals; to expand the "seller's disclosure" to include aboveground storage tanks (ASTs) as well as underground storage tanks (USTs); to delete outdated language concerning temporarily out-of-service tanks; and to correct an administrative error from a recent PST rulemaking.

Adopted §334.2 adds paragraph (6) to insert a definition of action level. The term is moved from the definitions section in Subchapter H because the term is used in other subchapters in this chapter, and is updated to remove language that is covered more thoroughly in Subchapters D and G of this chapter (see discussion of §334.322 in this preamble). Subsequent definitions are renumbered accordingly. The definition of corrosion technician is renumbered as paragraph (28) and the word "is" inserted into the last line to improve readability; the phrase "has been" is deleted from subparagraph (A) to improve readability; the word "is" is deleted from subparagraph (B) to improve readability; and subparagraph (C) is amended to allow the Steel Tank Institute as an additional entity from which certification of a cathodic protection tester will be accepted, as long as the manner of certification under the rule meets the agency's satisfaction. The definition of free product is renumbered as paragraph (41), with the parenthetical clarified to match the definitions in Subchapter M of this chapter. A definition of petroleum storage tank is added as paragraph (80), because the term was inadvertently omitted in a previous rulemaking and is used in this chapter. This definition tracks the statutory definition in Texas Water Code (TWC), Chapter 26, Subchapter I, §26.342(12). The definition of petroleum substance is renumbered as paragraph (81) and amended by adding "e.g.," as a precedent to each set of examples enclosed in parentheticals to specify that they are examples and not a restricted list. The definition of professional geoscientist is added, from proposal, as new paragraph (88) to recognize this professional licensure. Subsequent definitions are renumbered accordingly. The definition of spill is renumbered as paragraph (100) and amended by adding reference to ASTs as a correction. Throughout the section, the acronyms "AST" and "UST" are spelled out to be consistent with other commission rules.

Adopted §334.5(b)(1)(C) reflects the current name of the agency.

Adopted §334.7(d)(1)(A)(i) and (ii), concerning tank registration updates, is reinserted after accidental deletion in an administrative error in a recent PST rulemaking.

Adopted §334.8(c)(5)(C) inserts the phrase "or within 30 days of a subsequent tank installation," into the first sentence to clarify the existing requirement in §334.7(d)(4) of this subchapter. The change reiterates, in this section, that the tank-labeling requirement is applicable to tanks installed after the promulgation of the compliance self-certification regulations, in addition to tanks already installed at that time. Section 334.8(c)(5)(A)(i) - (iii), (B)(i) and (iii), and (D)(i) reflects the current name of the agency.

Adopted §334.9 is expanded to include ASTs as well as USTs, to ensure that purchasers of both types of regulated tanks are notified in writing of applicable requirements. The benefits of increased compliance with applicable regulations, previously realized for USTs, will also be realized for ASTs under the change. Parallel provisions for ASTs are inserted in the introductory language and in paragraphs (2) and (5). Subsection (4) adds the phrase "as to USTs" to make the paragraph specific to USTs, adds the phrase "and other" before the word "requirements" to reference other Texas Administrative Code requirements, and replaces "Texas Natural Resource Conservation Commission" with "Texas Commission on Environmental Quality" to reflect the current name of the agency. Paragraph (5) is added to provide language similar to paragraph (4), but altered to be specific to ASTs.

Adopted §334.10(a)(6) is deleted as an outdated provision, because such extensions of time are no longer allowable under 30 TAC §334.54. The subsequent paragraphs are renumbered accordingly. New language is added, from proposal, to §334.10(a)(10) to specify that when agency requirements specify documents that must be prepared by, or prepared under, the supervision of a duly licensed professional engineer, a duly licensed professional geoscientist, or a duly licensed professional surveyor, those documents must be prepared in accordance with all requirements of statute and rule applicable to that respective professional.

Adopted §334.12(a) reflects the current name of the agency.

Subchapter C - Technical Standards

Regulatory reform changes are made to reflect agency experience with certain systems since the rules were written, to make corrections, and to delete outdated provisions.

Adopted §334.46 is amended to prevent double-walled tanks that are shipped by the manufacturer with a vacuum on the interstice from having to be needlessly air tested if that vacuum is still within manufacturer's specifications when the tank arrives at a site where it will be installed. Section 334.46(d)(1) deletes the sentence "New tanks shall be air tested before they are installed." to allow some flexibility in the overall requirement. Section 334.46(f)(2)(B) changes the word "and" to the word "or" to allow a choice in allowable procedure.

Adopted §334.50(a)(1)(C)(ii)(V) deletes the phrase "and (B)(i)(III)" because that referenced subclause does not exist and by changing the word "subsections" to "subsection." Section 334.50(d)(6)(B) corrects the spelling of the word "course" to "coarse." Also, the word "subsection" has been replaced with the word "subparagraph" in §334.50(d)(2)(C)(i)(II), as a correction from proposal, to conform with Texas Register requirements.

Adopted §334.55(a)(6)(B)(i) removes an erroneous reference to §334.50(d)(9), relating to "Statistical inventory reconciliation (SIR) and inventory control" as an external release monitoring and detection method, and an unnecessary reference to §334.50(d)(10), relating to "Alternative release detection method" as an external release monitoring and detection method.

Adopted §334.56(b)(1)(A) removes an erroneous reference to §334.50(d)(9), relating to "Statistical inventory reconciliation (SIR) and inventory control" as an external release monitoring and detection method, and an unnecessary reference to §334.50(d)(10), relating to "Alternative release detection method" as an external release monitoring and detection method. Section 334.56(c)(2) replaces "Texas Natural Resource Conservation Commission" and "TNRCC" with "Texas Commission on Environmental Quality" and "TCEQ" to reflect the current name of the agency.

Subchapter H - Reimbursement Program

To increase the agency's ability to process and pay all payable reimbursement claims before the PSTR Account sunsets in 2006, given limited agency resources, the standard for the reimbursement of eligible cleanup expenses related to LPST sites is revised to move away from an "actual cost"-based system. Reimbursement will instead be based on the lower of either line-item amounts listed in Subchapter M or line-items amounts listed in invoices submitted with the claim. In addition, better accountability provisions were are added in the reimbursement rules to better fulfill the stewardship role the agency has for the PSTR Account under TWC, §26.3573(h). These changes are based on experience the agency has gained in conducting numerous PST reimbursement audits over the last several years. In addition to these changes, the rules concerning assignment of reimbursement rights, including associated paperwork requirements, are simplified and clarified. This will increase the predictability of the process by which an eligible owner or operator seeks to transfer reimbursement rights to another. Greater clarity in this process also reduces the agency's liability to suit based on an allegation that reimbursement funds were sent to a person other than the person authorized by the owner or operator. This rulemaking package also updates and clarifies existing program rules, and makes corrections to rule language to improve rule consistency.

Adopted §334.302 changes the title of the section by the addition of the word "Assignments" at the end, to make clear that the rules regarding the assignment of reimbursement rights are contained in this section. Section 334.302(c)(2) changes the word "one" to "$1" to conform with *Texas Register* formatting. Section 334.302(c)(6) deletes the word "or" and moves it to paragraph (7) to reflect that another item is added to this list of regulations. Section 334.302(c)(7) adds the phrase "any expenses" to clarify the requirement and improve readability. A new §334.302(c)(8) is added to the list of items for which reimbursement will not be made, that being markup of amounts paid to subcontractors by owners/operators who act as their own prime contractor or consultant. Cross-references to similar provisions proposed in Subchapter M are also included in the new language.

Adopted §334.302(d)(1) replaces the term "his duly authorized representative" with the term "his/her agent" to clarify the term. The phrase "through an assignment" is added to §334.302(d)(4) to clarify the nature of the authorization by which an owner or operator may ask the agency to pay his/her reimbursement money directly to another party. The phrase "agents or" is deleted from §334.302(i) and (j) to clarify that an assignment of reimbursement rights under these regulations is needed for the agency to pay anyone other than the owner or operator in a reimbursement situation. Also in §334.302(i) the language "except as provided by §334.306(f) of this title (relating to Form and Contents of Application)" is added, from proposal, so that subcontractors who

meet the requirements of §334.306(f) can be paid directly without obtaining an assignment. In §334.302(h), the word "fund" is replaced with the word "account" as a correction. In §334.302(j), the word "agent" is replaced with the word "assignee" to clarify and reiterate that an assignment of reimbursement rights under these regulations is needed for the agency to pay anyone other than the owner or operator in a reimbursement situation, and the words "insuring" and "insure" are replaced with the words "ensuring" and "ensure" to correct spelling errors.

Adopted §334.302(k) adds the word "eligible" before the phrase "owner or operator" to reiterate that owners or operators must be otherwise eligible before they are in a position to make an assignment of their reimbursement rights under the rule, and to make a cross-reference to the term "eligible owner or operator" in §334.310. Section 334.302(k)(1) is amended to read "the person assigned the right to accept payment on behalf of an eligible owner or operator. Such assignees are limited to the following:" to make it clear that an assignment under the rule is the authorizing mechanism, and that assignments can only be made as listed in the subsequent subparagraphs. The phrase "a purchaser of the property where the release occurred and on which the claim for payment is based" in §334.302(k)(1)(A) is deleted because an owner of contaminated property may already receive reimbursement as an "eligible owner or operator" as provided in §334.310(a)(1)(C) once appropriate corrective action activities are performed. New language for §334.302(k)(1)(A) is added which reads "a Prime Corrective Action Specialist, properly registered under Subchapter J of this chapter (relating to Leaking Petroleum Storage Tank Corrective Action Specialist Registration and Project Manager Licensing), hired by the owner or operator to perform corrective action activities at the leaking petroleum storage tank site in question who also holds a lienhold interest on the real estate or fixture that is attached to the real estate where the release occurred and on which the claim for payment is based; or" to better describe the scenario where an owner or operator assigns his/her reimbursement directly to the prime contractor who is responsible for the performance of corrective action at the site, as opposed to the description currently found in §334.302(k)(1)(B), which is deleted because an amended version of the existing language has been incorporated into the new §334.302(k)(1)(A). Current language in §334.302(k)(1)(C) is relettered as §334.302(k)(1)(B) to reflect the deletion of the current §334.302(k)(1)(B). Section 334.302(k)(1)(D) is relettered as §334.302(k)(1)(C) to reflect the deletion of current §334.302(k)(1)(B).

Adopted §334.302(k)(2) provides reference corrections due to other changes to this subsection. Section 334.302(l) is deleted as part of simplifying the assignment process by no longer requiring a contract of subrogation to be submitted by the claimant.

Adopted §334.306(b)(6) replaces the phrase "legible copies of invoices providing a description of:" with the phrase "legible copies of contractor and subcontractor invoices and any other documents required by the executive director to provide a description of:" to clarify the type of invoices required and to clarify the point, made throughout this subchapter and Subchapter M, that invoices are just one of the types of documents that may be necessary to demonstrate that applicable requirements have been met. The phrase ", using the same break-down of individual activities as are listed in this subchapter and Subchapter M of this chapter" is added at the end of the sentence in §334.306(b)(6)(E). This is intended to simplify the reimbursement review process by increasing continuity and consistency in reimbursement applications and to prevent "cost bundling," whereby an applicant lumps many activities together such that it becomes difficult to separate out the individual activities for proper agency review. This adopted rule should speed up agency processing of applications. In §334.306(b)(6)(F), the phrase "the total amount paid, or ensured to be paid through the posting of a payment bond" is added to provide clarification and to provide continuity with language in §334.306(b)(7), and to address the commission's specific concern regarding subcontractors who are not getting paid.

Current rules do not adequately require prime contractors to show that they have "paid costs in full" to subcontractors. This is true even though owners or operators, when receiving reimbursement monies from the agency, must make such a demonstration as to their prime contractors. To ensure equal treatment of all categories of reimbursement claimants and to prevent unjust enrichment from the PSTR Account as part of the agency's statutory duty to be a good steward of the Account, the rules would compel the same type of showing of §334.302(i) - (k) assignees that owners or operators have to make when they receive reimbursements directly. The change would likely encourage subcontractors to stay in the business of performing corrective action in reimbursement situations. Therefore, §334.306(b)(7) is amended to read "certification on the designated agency form, either that the amounts described in §334.309(c) of this title (relating to Reimbursable Costs) have been paid in full by the claimant or have been ensured to be paid in full through the posting of a payment bond in the amount not yet paid in full by the claimant. The certification must include:" to require a specific certification, as opposed to other demonstrations of proof at the claim review stage, that the claimant has either made the payment or has been ensured to be paid in full through the posting of a payment bond in the amount not yet paid in full by the claimant. Section 334.306(b)(7)(A) provides details of what is being certified in situations where the claimant is either an eligible owner or operator or an insurer under §334.302(k)(1)(B). Section 334.306(b)(7)(B) provides details of what is being certified in situations where the claimant is an assignee contractor under §334.302(k)(1)(A). Language is deleted from §334.306(b)(7)(A) and (B) that would no longer be relevant in the change from a "proof" demonstration to a certification. Section 334.306(b)(7)(C), (D), and (E) is deleted as no longer relevant in the change from a "proof" demonstration to a certification.

Current language in §334.306(b)(8) is deleted as an outdated and unnecessary requirement. New language is added for the paragraph, which reiterates the requirement that before the agency can honor an otherwise proper request by an owner or operator to send a reimbursement check to an entity other than the owner or operator, the required assignment documents must be filled out completely and accurately. Adopted new §334.306(b)(9) states that if any combination of the owner or operator and the legal "persons" performing corrective action activities at the LPST site are "related parties," as defined in the new definition in §334.322, this information would have to be disclosed in the reimbursement application. It is important for the agency to have this information, because some reimbursement line-item amounts (e.g., allowable prime contractor markup on subcontractor expenses) are based on the idea that the two parties are indeed separate entities. The language will help prevent unjust enrichment from the PSTR Account, and will be part of fulfilling the agency's statutory duty of good stewardship of that account under TWC, §26.3573(h). The existing §334.306(b)(9) is renumbered as §334.306(b)(10).

Section 334.306(f) has been changed from proposal. The new language states that a subcontractor may submit information to the agency to assert a claim that the subcontractor has performed pre-approved work and has not been fully paid for the work. The new language also states that a subcontractor may be considered for direct reimbursement by the commission if all of the following requirements are met: 1) the subcontractor requesting to be directly reimbursed by the agency shall have performed work for a person eligible for reimbursement in accordance with §334.310 and performed such work as a subcontractor to a prime corrective action specialist retained by the eligible owner or operator; 2) a Fund Payment Report that contains the charges for which the subcontractor has not been paid has been issued in accordance with §334.314; 3) the prime corrective action specialist has failed to pay the subcontractor, due to insolvency subject to the limitations of 11 United States Code, §365(e)(1), the amount reflected on the Fund Payment Report; 4) the commission has not paid for the work performed in the Fund Payment Report or the commission has successfully recovered the money paid for the work performed in the Fund Payment Report in accordance with 30 TAC §334.318 and TWC, §26.355; and 5) the subcontractor has filed within 120 days of the effective date of this subchapter (Subchapter H) written notice to the agency of the amounts owed on each specific Fund Payment Report that the prime corrective action specialist has failed to pay and an affidavit by the subcontractor stating that the prime corrective action specialist has failed to pay the amount being requested by the subcontractor. The existing §334.306(f) is relettered as §334.306(g). Filings by subcontractors directly to the agency for reimbursement is limited to within 120 days of the effective date of the rule because new rule language in §334.306, requiring either proof of payment to subcontractors or posting of a payment bond in the amount not yet paid to the subcontractors, will help subcontractors get paid by their prime contractors in the future and thereby alleviate the need for the agency to directly reimburse the subcontractors. The 120-day time period provides an opportunity for subcontractors who, under the prior rules, had not been paid by the contractor and had no recourse within the scope of the prior rules to be paid directly by the TCEQ for work performed.

Adopted §334.307(a)(3) replaces the word "which" with the word "what" to improve readability. Section 334.307(b) adds the word "may" and the phrase "allow for proper application" and deletes "the application" to provide clarification and to improve readability.

Adopted §334.308(a) replaces the word "which" with the word "that" to improve readability and replaces the word "section" with the word "chapter" to clarify the scope of the subsection. Section 334.308(b) replaces the phrase "which arise directly from" with the phrase "directly required for" and replaces the phrase "the requirements of the agency, subject to the limitations prescribed by this section" with the phrase "commission rules" to make the language simpler, provide clarification, and improve readability. Section 334.308(c)(14) inserts the phrase "under this paragraph" at three different places, and deletes "of tank removals," "removed," and "of removal" to provide clarification and improve readability. Section 334.308(c)(18) and (19) changes the word "guidelines" to the word "specifications" to reflect the new title of Subchapter M. Section 334.308(f) adds the phrase "of any substance listed in §334.301(a) of this title (relating to Applicability of this Subchapter)" to clarify the applicability of the subsection. Section 334.308(g)(12) adds the word "product" after the word "petroleum" to clarify what category of substances the paragraph is referencing. Section 334.308(g)(20)(B) replaces the word "which" with the word "that" to improve readability. Section 334.308(g)(22) is added to explicitly state that when a corrective action activity is not done correctly the first time, the claimant will be able to recover costs only if the work is correctly redone. Section 334.308(g)(23) is added to explicitly state that no reimbursements are allowed in instances where fraud is shown.

Adopted §334.309(a) changes the word "guidelines" to the word "specifications" to reflect the proposed new title of Subchapter M.

Adopted §334.309(c) states: "For reimbursements appropriate to be made under this subchapter, the amount reimbursed will be the lower of the invoiced amount or the line-item amount (adjusted for scope of work) for that activity specified in Subchapter M of this chapter (relating to Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program). An exception to this subsection is made for items under Subchapter M of this chapter requiring bidding, where reimbursement requests are processed as described in Subchapter M of this chapter. For those activities that require pre-approval under §334.310(f) of this title (relating to Requirements for Eligibility), the agency may also, at its discretion, limit the amount reimbursed to the pre-approved amount." This will cause the standard for the reimbursement of eligible cleanup expenses related to LPST sites to move away from an "actual cost" -based system. Reimbursement will instead be based on the lower of either line-item amounts listed in Subchapter M or line-item amounts listed in invoices submitted with the claim.

Under current PST program rules, agency staff are performing two separate reviews of each reimbursement claim. The first involves determining the activities that were pre-approved and the cost pre-approved for each activity, documenting that the activities were actually done as pre-approved, then adjusting for changes in scope of work (e.g., a pre-approval is initially given for the installation of three monitoring wells but, with agency concurrence for a "field change," the contractor only drills two). The second review of the claim is an "actual cost review." This involves a detailed evaluation of applicable invoices, receipts, cancelled checks, certified public accountant certifications, promissory notes, etc., whereby the applicant demonstrates what the pre-approved work actually cost to perform. Following these reviews, under current rules, the agency reimburses the lower of the amounts calculated in the two reviews for each claim. "Actual cost" reviews are very time consuming. Also, since statute (TWC, §26.35731(c)) requires that within 90 days after the date on which the commission receives a completed application for reimbursement from an owner or operator of a PST system that is seeking reimbursement, the commission shall send a fund payment report to that owner or operator, available staff must, therefore, be dedicated to the processing of new applications. In addition, questions have been raised about the consistency of agency actual cost reviews under the current rules.

The agency adopts changes in to the rules to eliminate actual cost reviews, and to use the concurrent resource savings to further ensure that all eligible valid claims are paid before the PSTR Account sunset. This will also allow the payment of as many eligible valid non-pre-approved claims as possible before PSTR Account sunset, as statute (TWC, §26.35731(b)) provides that

non-pre-approved claims for reimbursement cannot be considered, processed, or paid until all pre-approved claims have been completed.

Another benefit to these particular rule changes is that they would constitute a significant simplification of the application process, both in terms of the work required by applicants to prepare and submit applications and the work required by agency staff to review them. This simplification is expected to result in reduction in the number of associated protests that are filed, saving time for both applicants and agency staff.

Adopted new §334.309(d) is changed from proposal to state: "A cost is not reimbursable if a contractor fails to pay its subcontractors for subcontracted work, or if there is a failure to perform the work claimed as technically required. The audit of reimbursable costs is addressed in §§334.530 - 334.535 of this title (relating to Purpose and Applicability of the Subchapter, Cooperation with Audit; False Submittals, Payments, Audits, Notice of Overpayment, and Objections to the Notice of Overpayment and Formal Petition for Hearing)." Agency audit staff may review claims based on actual cost as defined in §§334.530 - 334.535. Agency audit staff need the ability to review costs within invoices to properly determine if those costs are actual amounts paid for actual work performed. A review of actual costs within the invoices would then need to be compared to fair market rates for those costs (e.g., RCS line-item amounts in Subchapter M or agency PST State Lead Remediation rates) to ensure that only reasonable costs are being invoiced.

Adopted §334.310(c) adds the phrase "Agency eligibility determinations must" and deletes the phrase "The agency may determine other persons to be eligible owners or operators" to better express the limitations of the referenced statutory provision. Section 334.310(f) adds the sentence "Pre-approval of proposed corrective action activities and costs does not create an entitlement to reimbursement for any corrective action task, at the amount pre-approved or a different amount." to provide a more specific restatement in this section of existing language found in §334.302(h).

Adopted §334.313(a)(1)(A)(ii) deletes the phrase "be accompanied by"; deletes the phrase "of invoices (contractor and subcontractor)"; deletes the existing reference to §334.306(b)(6); adds the phrase "as required under §334.306(b)(6) of this title" to eliminate redundant language, to clarify the clause, and to make included references more specific; and adds the phrase "by certification of" before the word "proof" to reflect new language in §334.306(b)(7). Section 334.313(a)(1)(A)(iii) deletes the phrase "be accompanied by" to eliminate redundant language. Section 334.313(a)(1)(A)(iv) deletes the phrase "the completion of" to eliminate unnecessary language. Existing language in §334.313(a)(1)(B) - (D) is deleted because the agency's treatment of incomplete applications is consolidated and clarified in a new §334.313(b). Existing language in §334.313(a)(1)(E) is relettered as §334.313(a)(1)(B), with the phrase "in a fund payment report that those costs" added and the phrase "and the application" deleted to clarify that a fund payment report will be the mechanism of notification; the words "completes" and "of" are added to provide clarification; and the existing reference to §334.313(f) is changed to reference §334.313(d) to reflect the relettering of this subsection. Existing language in §334.313(a)(1)(F) is relettered as §334.313(a)(1)(C) and is amended by deleting and adding language to simply state: "if it has been determined that an otherwise complete application contains costs for a corrective action activity which the agency determines to have been performed improperly, the applicant will be notified in a fund payment report that those costs are denied as not allowable under §334.308(g)(22) of this title (relating to Allowable Costs and Restrictions on Allowable Costs)." Existing language in §334.313(a)(1)(G) is amended to delete an unnecessary reference and relettered as §334.313(a)(1)(D). Existing language in §334.313(b) and (c) is deleted because the agency's treatment of incomplete applications is proposed to be consolidated and clarified in new subsection (b). Existing rule language in these subsections could be read to require the agency to send back all applications for even the smallest deficiency. Existing language in §334.313(d) is relettered as §334.313(b) and amended to provide a consolidated statement of the agency's treatment of incomplete claims. Under the requirements, the agency has the flexibility to issue a fund payment report that classifies appropriate parts of a claim as payable, denies appropriate parts of a claim, and categorizes the deficient parts of the claim as "withheld" until such time as the deficiency is cured. Under this option, large payable amounts will not be held back for a small deficiency in another part of the claim. In §334.313(b), changes are adopted to delete references to different stages of the review process, so that the listed options are available to the agency whenever a deficiency is found, as well as to improve readability. Adopted §334.313(b)(2) is amended to more accurately reflect that payment for portions of a claim may be withheld, as opposed to characterizing the entire claim that way under the existing option. The phrase "of those portions of the claim for which additional information has been requested" replaces the phrase "for insufficiently documented costs or insufficiently documented corrective action activity" to ensure that all types of deficiencies under this subchapter are encompassed. Section 334.313(e) is relettered as §334.313(c) and §334.313(f) is relettered as §334.313(d) to reflect changes adopted earlier in this section that require the reformatting.

Adopted §334.314(b)(1) deletes the phrase ", provided a signed subrogation contract is submitted, when required" as an outdated provision. Section 334.314(d) deletes the phrase ", which may include the submission of a signed subrogation contract, when required" as an outdated provision. Eliminating this requirement is part of streamlining the application and review process.

Adopted §334.315(b)(2) reflects the current name of the agency.

Adopted §334.322(1) amends the definition of action level to provide simplification and clarification and moves the definition to Subchapter A because the term "action" level is also used in other subchapters in this chapter (see §334.2 previously discussed in this preamble). Subsequent definitions are renumbered accordingly. The definition of contract of subrogation in §334.322(6) is deleted as outdated, since the regulations which use the term "contract of subrogation" are deleted as part of the agency's streamlining of the application and review process (see §334.314 previously discussed in this preamble). Subsequent definitions are renumbered accordingly. A new definition of related parties is added as §334.322(16) to support the new rule language in §334.306(b)(9) (see §334.306 previously discussed in this preamble). Subsequent definitions are renumbered accordingly. The definition of tank removal is renumbered as §334.322(18) and is clarified by the insertion of more precise terms for the tanks covered by the definition and for the material referenced. Subsequent definitions are renumbered accordingly.

Subchapter L - Overpayment Prevention

One of the motivations in initiating this rulemaking package was for the agency to incorporate the lessons learned in the last several years of conducting PST reimbursement audits. These experiences indicate that better accountability provisions are needed in this chapter, and that certain clarifications are needed in this subchapter. A main point detailed in these amendments is clearly stating which parties will now be subject to a Notice of Overpayment (seeking disgorgement of monies reimbursed) versus which parties must cooperate with an audit.

Adopted §334.530(a) and (b) changed the word "Fund" to the word "Account" as a correction.

The title of adopted §334.531 is changed to "Cooperation with Audit; False Submittals" to better reflect the section's contents with the adopted changes. Section 334.531(a) defines the parties who must cooperate with an audit of a claim(s) and explicitly states that the agency is not to be charged for copies of required documents. Section 334.531(b) more clearly states that a disgorgement proceeding will ensue when the documents necessary to support a claim are not timely provided to the agency by the party(s) listed in subsection (a); while existing language on this point in subsection (c) is deleted and existing subsection (d) is relettered as subsection (c).

Adopted §334.532(a) changes the word "Fund" to the word "Account" as a correction.

Adopted §334.533 reletters current language as subsection (a) to allow insertion of a new subsection (b). The phrase "of claims and associated documents" is added as a clarification of what is being audited. Section 334.533(1) adds the phrase "eligible to be paid as provided by TWC, §26.3573" from proposal to add reference to the TWC, and clarify the meaning of the word "allowable." Existing paragraphs (2) and (3) are deleted as unnecessary given that the new language cross-references the subject matter of an audit. Paragraph (4) is renumbered as paragraph (2), with the clarifying phrase "Subchapter H of this chapter" added to cross-reference the meaning of the term "reimbursable" in the existing language and a date is corrected in two places to provide continuity with Subchapter H language. A new paragraph (3) is added from proposal to state that actual cost is the actual amount paid for actual work performed, net of any discounts, offsets, or other reduction to the amount paid and that actual cost includes associated overhead and reasonable profit. Subsection (b) is added as a clarification of what information is subject to review during an audit and to clarify that any amounts included in a Notice of Overpayment represents amounts not actually paid, rather than amounts represented by only a promise to pay.

Adopted §334.534(a) deletes the phrase "necessary, allowable, or reimbursable cost of corrective action" and replaces it with the phrase "amount provided for under this chapter" to more clearly reference the various regulatory standards that must be met and adds language to allow the executive director to include in a notice of overpayment a charge for the claimant to pay interest when the overpayment was the result of incorrect, incomplete, or inaccurate documentation submitted by the claimant. Also the word "reimbursement" is changed from proposal to the word "payment" in the first sentence of subsection (a). Section 334.534(b) replaces the phrase "person who received money from the Petroleum Storage Tank Remediation (PSTR) Fund or to persons who were paid by the person who received money from the PSTR fund" with the phrase "claimant (either the party who contracted directly with the TCEQ for corrective action work, the eligible owner or operator, or the party assigned the reimbursement right under §334.302(i) - (k) of this title (relating to General Conditions and Limitations Regarding Reimbursement; Assignments)" to establish that a disgorgement action will only be initiated against a reimbursement claimant. Section 334.534(c) reflects the current name of the agency. Section 334.534(d) changes the word "Fund" to the word "Account" as a correction. Section 334.534(e) is deleted and an amended version of the original language of this subsection is moved to subsection (a).

Adopted §334.535(a) replaces the phrase "the party" with the phrase "any person" to better express the entity covered by this subsection. Section 334.535(b) more clearly references the various regulatory standards at issue and matches adopted language in §334.533 and §334.534. Section 334.535(b) adds the sentence, "At hearing, the petitioner must prove that the audited claims or portions of claims were for amounts appropriately paid under the requirements of this chapter" to reiterate the requirements at issue and to overtly state that the burden of proof has always been with the petitioner.

Subchapter M - Reimbursable Cost Guidelines for the Petroleum Storage Tank Reimbursement Program

Though a comprehensive, exhaustive revisiting of all the Reimbursable Cost Guideline dollar line-item amounts would not be prudent given the limited time before the PSTR Account sunset and the time a rulemaking takes to complete, this rulemaking does include adjustments to these line-item amounts that were arrived at following discussions with a stakeholder group concerning changes in the marketplace since the last amendments to this subchapter. There are limitations, besides time considerations, to the changes that can be made in this subchapter in this rulemaking. During the 2001 session of the Texas Legislature, the agency was asked for a projection concerning the burden on the PSTR Account between that time and the Account sunset date. Based on that projection, as part of House Bill 2687, amendments were made to TWC, Chapter 26, Subchapter I, which changed the fee schedule (for the fee which supplies the Account) and extended the Account sunset date to 2006. The line-item dollar amounts that the agency will reimburse for various eligible remedial activities are contained in this subchapter. Current changes to these line-item amounts include increases in some areas and decreases in others to reflect applicable changes in market pricing and costs of services. Because the agency needs to adhere to the PSTR Account Burden projections given to the legislature during the drafting of House Bill 2687, the agency seeks to assure that these line-item increases and decreases remain within the limits of the projected income to the Account established by the House Bill 2687 fee schedule to address remaining eligible LPST sites, statewide. This has limited the number of "marketplace" updates that can be made.

The title of this subchapter is changed to "Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program." In addition, this subchapter is revised to remove internal inconsistencies, add flexibility to improve efficiency, expand the use of bidding while simultaneously clarifying how the agency handles bidding situations, and reduce some of the paperwork burden on applicants for reimbursement. The rulemaking also removes most language associated with "actual cost" reviews (see §334.309 previously discussed in this preamble).

Also, language for this subchapter is adopted to match similar language adopted in Subchapter H of this chapter to ensure that owners or operators for LPST sites do not profit from the pollution

for which they have a legal liability (see §334.302(c)(8) previously discussed in this preamble).

Adopted §334.560 amends the title of this section by changing the word "Guidelines" to "Specifications" because the word "Guidelines" is misleading given that these are rules and not guidelines. This section merely contains language adopting "Figure: 30 TAC §334.560." The language adopting the figure is also amended to state: "The following Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program are in effect as of November 18, 2004." The referenced separate figure comprises the actual Reimbursable Cost Specifications (RCSs) and is amended as follows.

On the cover page of the figure, the title is changed to "Reimbursable Cost Specifications" because the word "Guidelines" could be misleading given that these are rules and not guidelines; the word "Division" is changed to "Reimbursement Program" to reflect current agency alignment; and "Texas Natural Resource Conservation Commission" is changed to "Texas Commission on Environmental Quality" to reflect the agency's recent name change. The first item addressed in the Table of Contents is changed to read "Introductory Requirements" to reflect the new title of that item; the page numbers are renumbered to correspond with changes in the document; and a new "Part 11: Allowable Reimbursable Costs for the Risk Evaluation of Individual Exposure Pathways" is adopted as an addition to the document in Section 2, Appendix A.

The "Introduction" section of the RCSs is renamed as "Introductory Requirements" to better reflect its purpose and new language. Changes are adopted throughout the Introductory Requirements to reflect the change from "Guidelines" to "Specifications" in the title, as well as to change "TNRCC" to "agency" to be consistent with the remainder of this chapter and with the definitions in 30 TAC Chapter 3. In the second paragraph, the phrase "the costs of corrective action" is added as clarifying language. The phrase "in all but extraordinary cases" is deleted because the only appropriate areas for discretion in reimbursement amounts are expressed within the subchapter and in cross-referenced regulations elsewhere in the chapter. The sentence, "All requests for reimbursement must meet the requirements stated herein and in Subchapter H of this chapter" is adopted to provide a cross-reference to Subchapter H. The language: "For bid items, the agency requires a specific description of the items, including the item's exact type, model, age, history of previous usage, history of previous ownership, warranty information, and verification that all bids are at arm's length. The agency will only reimburse up to pre-approved bid amounts for pre-approved bid items. For bid items, at least three bids will be required, unless otherwise specified herein. When three bids are required, the agency may accept less than three bids for those situations where it is demonstrated to the satisfaction of the agency that three bids cannot be reasonably obtained (to be handled on a case-by-case basis)" is added to state specific requirements related to bid items. The language: "For non-bid items, the agency will reimburse either the invoiced amount or the RCSs line-item amount for that activity, whichever is lower. For those activities that require pre-approval under §334.310(f) of this title (relating to Requirements for Eligibility), the agency may also, at its discretion, limit the amount reimbursed to the pre-approved amount" is added to reflect the adopted language in §334.309(c) (see §334.309(c) previously discussed in this preamble). The last sentence of the second paragraph is deleted as unnecessary, given the language provided by additions which precede it. A new third paragraph is added to require prime contractors for LPST sites to submit a Site Closure Schedule to help ensure that there will be an ongoing dialogue between the contractor, owner/operator, and the agency coordinator concerning where the site is on the path to closure. The report will help the agency fulfill its statutory mandate to make sure that all LPST sites are progressing in a timely and proper manner toward ultimate closure. The paragraph goes on to state requirements for the submission of the schedule, and what will happen if the schedule is not properly and timely submitted and updated. The following paragraph, beginning with "The Reimbursement Cost Guidelines will be utilized. . . ," is deleted as unnecessary, given the new language for paragraph two. The paragraph that begins with "The format of this document. . ." is deleted as unnecessary language. A new paragraph is added to explicitly state that records of applicable quantities associated with reimbursement claims must be kept, and examples are given of different types of quantities. These records will better allow the agency under the new reimbursement scheme, at the initial review and the audit stages, to evaluate reimbursement claims to see if the regulatory requirements have been met. Another new paragraph is added to ensure appropriate use of PSTR Account funds in the reimbursement of capital equipment item costs. This paragraph contains language specifying that the agency may require methods of identification such as serial numbers for capital equipment items in order to track the purchase, use, and condition of these items, and contains language stating that the agency may restrict reimbursable amounts for capital equipment items to prorated amounts, which consider usage.

Section 1: Activities, is amended. In the first paragraph, the term "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. In the second paragraph, the workplan/cost proposal amount is changed in this section and throughout the RCSs from $115 to $195, which allows for one additional hour for a Project Manager (PM) billed at $80 per hour and reflects the additional effort necessary to prepare adequate and complete cost proposals for submittal to the agency; the requirement for the submission of an Exit Criteria Flow Chart and Site Closure Schedule with the cost proposal is to provide the agency additional information as to the current site status to conduct a more thorough appraisal of cost proposals; and "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

ACTIVITY 00: TANK REMOVAL. In the third paragraph, the term "table below" is changed to "following table" to improve clarity. In the fourth paragraph, the acronym "USTs" is substituted for the term "underground storage tanks" for consistency. In Notes 1 and 2, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter; "TNRCC Region inspector"and "Region inspector" are changed to "agency Regional Inspector" to provide consistency in terminology; and "the TNRCC Central Office Project Coordinator" and "the Central Office Project Coordinator" are changed to "your agency Site Coordinator" to simplify the terms and provide consistency in terminology.

ACTIVITY 01: INITIAL ABATEMENT. "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter; "TNRCC Central Office Project Coordinator" is changed to "agency Site Coordinator" to simplify the term and provide consistency in terminology; "TNRCC Region inspector" is changed to "agency Regional Inspector" to provide consistency in terminology; the use of capitalization for the term "Initial Abatement" is eliminated as a correction; and the term "Reasonable Cost

Guidelines" is changed to "Reasonable Cost Specifications" to reflect the new title of the RCSs.

ACTIVITY 02: PHASE-SEPARATED HYDROCARBON (PSH) RECOVERY. The use of capitalization for the term "Initial Abatement" is eliminated as a correction; language addressing pre-approval and referencing §334.310(f) is clarified by adding the phrase "written agency approval for"; the term "TNRCC Central Office Project Coordinator" is changed to "agency Site Coordinator" to simplify the term and provide consistency in terminology; and the term "TNRCC Region inspector" is changed to "agency Regional Inspector" to provide consistency in terminology. Additional language is adopted, requiring submission of an Interim Corrective Action Plan (ICAP) with a Release Report for the approved continued recovery of free product in emergency situations, while existing language requiring the preparation of an ICAP for non-emergency situations is eliminated and replaced with the term "next phase of work." The Note block at the end of the paragraph adds the term "MDPE" to reference the definition of this technology as it has been added to the RCSs.

In the worksheet for this activity the word "Manual" in the title block is removed as this activity now refers to other work activities besides manual work associated with PSH removal.

In Activity 02, Part A, Personnel Costs, the following changes are adopted.

Activity 02, Part A, Section 1

The agency recognizes that alternative PSH removal technologies exist and it has been approving costs for these remedial activities on a case-by-case basis. Since the agency recognizes the value of these newer technologies, new line items are introduced into this activity to reimburse for costs associated with new PSH removal technologies. These technologies are categorized as Mobile Dual Phase Extraction (MDPE) technologies. The reimbursement for all work associated with this task is placed under this activity. The Section 1 title is changed to add the term "/MDPE CAP" to reflect the addition of these technologies to the section, and a new lump sum line item cost of $2,865 for preparation and submission of an MDPE CAP is adopted for this item. This will apply in cases where extensive site alterations would be required to perform an MDPE event(s). (Site changes envisioned will include trenching, construction of fencing, and possibly waste disposal and will apply to MDPE events lasting 14 days or more.) The existing cumulative Total for Section 1 ($1,825) is deleted as no longer applicable.

In Activity 02, Part A, Section 2: Office Costs, costs to allow a Registered Corrective Action Specialist (RCAS) to prepare and submit reports following MDPE events are included and a differentiation is made between MDPE and non-MDPE report preparation. The section title adds the term "Non-MDPE Events" to specify the expanded intent of the section. In the first item, the terms "FAR" and "or System O&M" are removed as unnecessary and the term "Report Preparation" is added to provide clarity. The term "Project Manager" is deleted and the term "/Data Review" is added to "Report Preparation & Submission" in the activity description for "PSH Recovery" to clarify that time required for analysis and reduction of field data is included in the report preparation costs. The term "PSH Recovery" is added to "Management Regulatory Interaction" in the activity segment for the PM item to clarify the item. PM time allotted per month is increased from 0.5 hours to 2.0 hours because stakeholders indicated that the current 0.5 hours per month for project management for PSH removal was insufficient to properly evaluate field data and manage field activities. The item "Staff E/G/H (SF)" with its corresponding activity description, Hours/Units, and Rate is deleted as no longer necessary due to the increase in allowable PM time in this section. The term "Cost Proposal/Workplan" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

A new Activity 02, Part A, Section 3: Office Costs - MDPE Events - See Note 2, is adopted to address this new technology. The first item is PI-7 Standard Exemption Form (MDPE Events only); the corresponding activity is Preparation and Submission; the corresponding Hours/Units is 1; and the corresponding Rate and Total are $195 and $195, respectively. The second item is MDPE Report Preparation - (8-hour event); the corresponding activity is Report Preparation and Submission; the corresponding Hours/Units is 1; and the corresponding Rate and Total are $260 and $260, respectively. The third item is MDPE Report Preparation - (24-hour event); the corresponding activity is Report Preparation and Submission (includes periodic reporting to the agency, as required); the corresponding Hours/Units is 1; and the corresponding Rate and Total are $330 and $330, respectively. The fourth item is MDPE Report Preparation - (72-hour event); the corresponding activity is Report Preparation and Submission (includes periodic reporting to the agency, as required); the corresponding Hours/Units is 1; and the corresponding Rate and Total are $395 and $395, respectively. The fifth item is MDPE Report Preparation - (7-day event); the corresponding activity is Report Preparation and Submission (includes periodic reporting to the agency, as required); the corresponding Hours/Units is 1; and the corresponding Rate and Total are $535 and $535, respectively. The sixth item and corresponding activity is Workplan and Cost Proposal; the corresponding Hours/Units is 1; and the corresponding Rate and Total are $195 and $195, respectively, to be consistent with the amount allowed for this item throughout the RCSs, as discussed in this preamble in Section 1, Activities.

The existing Activity 02, Part A, Section 3: Field Personnel Costs, is renumbered from "3" to "4" to reflect the insertion of the previous new section and the section title is changed to "Field Personnel Costs - Non-MDPE - See Note 2" to reflect that these costs are allowed specifically for non-MDPE PSH recovery events.

A new Activity 02, Part A, Section 5: Field Personnel Costs - MDPE - See Notes 2 and 3, is adopted as a new section to address the time required in the field for overseeing an MDPE event. Units are specified as (# of events/hours). Each item contains a referral to a specific section note that contains applicable details pertinent to that event. The first item is "MDPE 8-hour event (See Note 6)" with a corresponding Rate of $1,150. The second item is MDPE 24-hour event (See Note 7) with a corresponding Rate of $3,100. The third item is MDPE 72-hour event (See Note 8) with a corresponding Rate of $2,650. The fourth item is MDPE 72-hour event (See Note 10) and is specific to security needs for that event; the corresponding activity is Security Personnel; the corresponding number of hours is 35; the corresponding Rate is $30; and the corresponding Total is $1,050. The fifth item is MDPE 7-day event (See Note 9) with a corresponding Rate of $3,800. The sixth item is MDPE 7-day event (See Note 10) and is specific to security needs for that event; the corresponding activity is Security Personnel; the corresponding number of hours is 96; the corresponding Rate is

$30, and the corresponding Total is $2,880. If this field activity is subcontracted out, a 15% markup is allowed.

In Activity 02, Part B: Equipment Costs, the original Part B is made a section and titled "Section 1: Equipment Costs - (Non-MDPE)" and a second section is added entitled "Section 2: Equipment Costs - MDPE" because the agency recognizes that it is necessary to differentiate itemized equipment costs for various PSH removal activities. A distinction is made between equipment costs associated with non-MDPE events (reflected in Section 1) and MDPE events (reflected in Section 2). At a stakeholder's meeting, it was suggested that Section 1 include an increase for absorbent socks to $40 a dozen; an increase in small passive skimmer costs from $350 to $400; an increase in large passive skimmer costs from $750 to $900; an increase in dedicated PVC bailer costs from $15 to $35, and the addition of a new line item titled "Small Items (for use with fluid pump)" at a lump sum rate of $35 per site per day to replace the existing item "(Other)." These suggested changes/additions are within the new Section 1. A new Part B, Section 2: Equipment Costs - MDPE, addresses MDPE-related events and includes seven proposed new line items. The agency recognizes that MDPE is an effective technology for the removal of PSH in the subsurface. However, the term "MDPE" encompasses a variety of technologies and equipment, each with variable treatment times. In addition, pricing is further complicated because some RCAS companies own their own MDPE equipment, while others are contractors, thereby further complicating a plan for a fair and equitable reimbursement pricing scheme. A number of subcommittee stakeholder teleconferences/meetings were held to develop a consensus for an effective pricing schedule. It became apparent that any comprehensive pricing list covering all aspects of MDPE-related work would become very lengthy and cumbersome for the agency to implement. Given the variety of MDPE-related technologies on the market and the fact that the agency did not want to prescribe a list limiting current or future development of MDPE-related technologies, a pricing scheme based upon operating time was developed and proposed by the agency. The agency feels that a lump sum approach per event for reimbursing MDPE equipment that is based upon operational time coupled with specific performance measures will be the most straightforward to implement. Pricing for these line items is based upon actual costs reimbursed by the agency for past pre-approved MDPE events and from verbal and written input from the stakeholders. Each MDPE event item contains a referral to a specific section note that contains applicable details pertinent to that event. The first item is MDPE - All Technologies - (8-hour event) - See Note 6 with a corresponding Rate of $2,050. The second item is MDPE All Technologies - (24-hour event) - See Note 7 with a corresponding Rate of $3,100. The third item is MDPE All Technologies - (72-hour event) - See Note 8 with a corresponding Rate of $6,100. The fourth item is MDPE All Technologies - (7-day event) - See Note 9 with a corresponding Rate of $11,750. The remaining three items in this section address issues that are beyond the defined MDPE event (e.g., these may include some construction costs to hook up the MDPE system to wells, where water recovery is anticipated to be beyond 2,500 gallons; a cost for bringing in additional holding capacity and an "Other" item for those costs out of the ordinary). Therefore, the fifth item is Construction costs - See Note 11 with no stated Units, Rate, or Total; the sixth item is Additional holding tank with no stated Units, Rate, or Total; and the seventh item is Other with no stated Units, Rate, or Total. Since this field work may be contracted, a markup of 15% is adopted that will follow the conditions set in Appendix A, Part 9, Markup.

A new Activity 02, Part C: Analytical Costs - See Note 12, is added to facilitate the preparation of proposals for MDPE-related events. During the course of an MDPE event, air, water, and possibly soil samples must be collected to verify the effectiveness of the MDPE treatment at the site and whether continued treatments are necessary. Air samples are required to be collected and analyzed from recovery lines prior to being treated; exhaust gases may need to be analyzed to verify compliance with discharge permits. Water samples from wells, intake, or discharge lines may need to be collected and analyzed, and under special conditions, soil samples may need to be collected. Sixteen new line items are adopted for Part C: Analytical Costs shown in this section and are identical to those listed in Appendix A, Part 2: Laboratory Analysis Costs and specific line item comments.

The existing Activity 02, Part C: Waste Management Costs, is renamed as Part D to reflect the addition of the new Part C. The hourly rate for Vacuum Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased. Also, the Total Activity Costs block is changed to reflect Part D instead of Part C.

The existing Activity 02, Part D: Travel Costs, is renamed as Part E to reflect the addition of the new Part C. The rate per mile for mileage is increased from $.31 to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable Official Mileage Guide for the State of Texas (OMGST) rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates. Also, the Total Activity Costs block is changed to reflect Part E instead of Part D.

The existing Activity 02, Part E: Other Costs, is renamed as Part F to reflect the addition of the new Part C, and the Total Activity Costs blocks are amended to reflect Part F instead of Part E.

The Notes for Activity 02 are amended to address the changes to various line items within the activity. Note 1 references Part 8 of Appendix A, to provide a more specific point of reference and an explanation of when the agency will approve an MDPE CAP; namely, for those events that will operate continuously for 14 days or more and for those instances where special conditions exist, such as complex site conditions or special waste discharge considerations that require further plan preparation. Note 2 references Parts 1 and 8 of Appendix A to provide a more specific point of reference and to address allowances regarding PI-7 Standard Forms. Note 3 deletes the phrase "for subcontracted expenses only" because it is redundant in the RCSs and provides specific reference to Appendix A, Part 9 for further information with respect to markup. Note 4 provides a more specific reference to Appendix A, Part 4 for a breakdown of travel costs. Notes 5 - 12 are new additions that explain the components that define MDPE treatment for reimbursement consideration and provide specific detail with respect to each separate duration event addressed by the RCSs. Details in each of the notes are based upon the agency's past experience with case-by-case approval of MDPE technology at various sites across the state and also upon verbal and written input from stakeholders. Note 5 details what is included in MDPE equipment costs and states that real time data acquisition will be required for continuous monitoring through the duration of an event, that no distinction is made as

to type of equipment or technology used for a given event, and that the RCAS is to propose the best available technology that is most appropriate for a given site. Notes 6, 7, 8, and 9 separately define related specifics for purposes of reimbursement, with regard to the 8-hour event, 24-hour event, 72-hour event, and 7-day event, respectively. Note 10 addresses site security. Note 11 addresses construction costs and refers the reader to Activity 09 of the RCSs for the detail calculation of associated construction costs, the total of which is to then be reflected in Activity 02, Section 2. Note 12 provides a specific reference to Appendix A, Part 2 for additional information concerning laboratory analyses and costs.

ACTIVITY 03: EXCAVATION/WASTE MANAGEMENT. Modifications to line items costs are made in Part A: Personnel Costs, and reasons for the changes are discussed in this preamble in Activity 02. The changes for Part A include: the term "Cost Proposal/Workplan" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs; the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities; and a corresponding increase in the total for Section 1 from $995 to $1,030. In Part C: Waste Management Costs, the hourly rate for Vacuum Truck (Fluids Transport for Disposal) is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased. In Part D: Analytical Costs, most costs are decreased to commensurate with the changes and reasoning provided in Appendix A, Part 2 of the RCSs and in preamble language applicable to Appendix A, Part 2. Also, analytical methodologies are specified to provide clarity. In Part E: Travel Costs, the rate per mile for mileage is increased from $.31 to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates.

The following changes are adopted for the Notes. In Note 1, the term "standard work day" replaces the term "10-hour day" to prevent the specification of the length of a work day. Note 2 deletes the phrase "allowed on subcontracted costs" because it is redundant in the RCSs and adds specific reference to Appendix A, Part 9 for further information with respect to markup. Note 4 deletes specifics that are addressed in Appendix A of the RCSs and adds a specific reference to Appendix A, Part 7 of the RCSs.

ACTIVITY 04: SITE ASSESSMENT. In the opening paragraph, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. In Activity 04, Part A: Personnel Costs, Section 1, the term "Workplan/Costs Proposal" is changed to "Workplan and Cost Proposal/Workplan and Cost Proposal with Bidding" to be consistent with the remainder of the RCSs and to address situations where bidding is involved. The Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities. The Workplan and Cost with Bidding amount is proposed to be $355. A new line item (Licenses/Permits) addresses in rule the reimbursement of the cost of licensing and permitting fees charged for monitor wells on municipal and government property with a reimbursable amount specified as a maximum of $500 per well or boring.

In Activity 04, Part A: Personnel Costs, Section 2, Subsection 2A, all listed Unit Cost amounts are increased, with the exception of the item "Plan A Risk Assessment Report Form." Currently, the submittal of data results when no report is required is not reimbursed. Comments were received from stakeholders that labor is expended to send in these results and should be reimbursed. The agency concurs and the Unit Cost amount for the "Submit Results (Labs and Drillers' Logs) Only" activity is changed to $120 to address RCAS time spent; to review and submit this data; to verify that the information is correct; and to submit it in a format that is easy for the agency to interpret. A reference to Note 9 is added to the item "Plan B Risk Assessment" and the item "RA Update" is changed to "RA Update/Preparation." Unit Cost amounts are increased for the following reports: FAR - Site Assessment from $485 to $765; Plan B Risk Assessment from $5,715 to $5,765; and RA Update/Preparation from $485 to $765. (See discussion in this preamble of Activity 05 and Appendix A, Part 8 for specifics.)

In Activity 04, Part A: Personnel Costs, Section 2, Subsection 2B, the project management Unit Cost amount is increased from $40 to $80 to allow for a full hour of PM time.

In Activity 04, Part A: Personnel Costs, Section 2, Subsections 2C - 2G, no changes are made.

In Activity 04, Part B: Drilling Costs, Section 1, Subsection 1B, the Unit Cost amount for Mobilization/Demobilization for the first 50 miles, one way, is increased from $245 to $300 to reflect current and anticipated costs for this activity. The Drill Crew Per Diem is increased from $190 to $240 per day (as provided in Appendix A, Part 3 for a three-man crew) to reflect current and anticipated per diem costs.

In Activity 04, Part B: Drilling Costs, Section 2, the Drill Crew Per Diem is increased from $150 per day to $180 per day (as provided in Appendix A, Part 3 for a two-man crew) to reflect current and anticipated per diem costs.

In Activity 04, Part C: Waste Management Costs, the hourly rate for Vacuum Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

In Activity 04, Part D: Analytical Costs, ten line item costs are changed and two are deleted. In addition, analytical descriptions are expanded to clarify the items. Costs shown in this section are identical to those listed in Appendix 1, Part 2: Laboratory Analysis Costs and reasoning for the changes is provided in the portion of this preamble applicable to Appendix A, Part 2.

In Activity 04, Part E: Travel Costs, the rate per mile for mileage is increased from $.31 to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates.

The following changes are adopted for the Activity 04 Notes. In Note 1, the sentence, "Separate travel for a site visit can be pre-approved for the preliminary planning, receptor survey, or walking receptor survey" is added. This addition places into rule the agency's internal reimbursement policy for this task. In Note 3, the phrase "or as approved by an Agency Site Coordinator" is added to provide clarity; "TNRCC" is changed to "agency" to

be consistent with the remainder of this chapter; and language requiring consultation with an Agency Site Coordinator prior to attempting to obtain site access from a state agency is added because frequently the agency coordinator can facilitate access to state property, saving time and effort. Note 5 deletes the phrase "may only be applied to subcontracted costs" because it is redundant in the RCSs and adds specific reference to Appendix A, Part 9 of the RCSs for further information with respect to markup. Note 6 adds the phrase "per Appendix A, Part 9" to provide a more specific reference. Note 9 is added to provide clarification that reimbursement for a Plan B Risk Assessment will be based upon the number and type of pathways approved to be investigated. Note 10 specifies how the agency will reimburse permit fees charged by a municipality or government agency. Only one fee reimbursement per well installation is eligible, with no markup or periodic payments allowed.

ACTIVITY 05: RISK ASSESSMENT. The Plan B Risk Assessment Report Generation Costs title changes the reference from "Note 1" to "Note 2" to reflect a change in the applicability of Note 1. The number of hours for a Draftsperson II is increased from 10 to 11 and the total cost for that item is increased from $500 to $550 to address additional time necessary for this activity. The Plan B Risk Assessment Report Generation Costs total is increased by a commensurate $50 from a maximum of $5,715 to a maximum of $5,765. Note 1 changes the Workplan and Cost Proposal amount from $115 to $195 for the reasons discussed in this preamble in Section 1, Activities; adds the term "Plan A" for clarification; and deletes the second sentence, which refers to guidance manuals, as unnecessary. Note 2 is added to provide clarification by providing reference to Appendix A, Part 11 for an explanation of pricing with regard to the preparation of Plan B Assessment Reports dependent on number and type of pathways.

ACTIVITY 06: CORRECTIVE ACTION PLAN (CAP) FEASIBILITY TESTING. In Part A: Personnel Costs, Section 1: Slug and Bail Testing, the number of hours allotted to a Field Engineer/Geologist is increased from 10 hours to 15 hours and the total amount for that activity is thereby increased from $650 to $975. During a stakeholder's meeting, it was suggested that the professional who actually performs the field work associated with CAP testing does not have enough time to collate, check, and analyze the field data collected. The agency recognizes that the field data collected in this activity is vital, in that the results are directly utilized in optimizing the design of a remediation system. Therefore, it is reasonable to allow additional hours for data reduction and analysis. The amount applicable to the preparation of a PI-7 Standard Exemption Form is increased from $195 to $490 as recent revisions to the exemption form by the agency have increased the amount of time required to complete the form. The term "Workplan & Costs Proposal" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

In Activity 06, Part A: Personnel Costs, Section 2: Aquifer Pump Testing, the number of hours allotted to a Field Engineer/Geologist is increased from 10 hours to 20 hours and the total amount for that activity is thereby increased from $650 to $1,300. Reasoning is the same as that provided in Part A, Section 1 of this activity. The amount applicable to the preparation of a PI-7 Standard Exemption Form is increased from $195 to $490 as recent revisions to the exemption form by the agency have increased the amount of time required to complete the form. The term "Workplan & Cost Proposal" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

In Activity 06, Part A: Personnel Costs, Section 3: Soil Vapor Extraction Testing, the amount applicable to the preparation of a PI-7 Standard Exemption Form is increased from $195 to $490 as recent revisions to the exemption form by the agency have increased the amount of time required to complete the form. The term "Workplan & Cost Proposal" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

In Activity 06, Part A: Personnel Costs, Section 4: Dual-Phase Extraction Testing, the number of hours allotted to a Field Engineer/Geologist is increased from 15 hours to 25 hours and the total amount for that activity is thereby increased from $975 to $1,625. Reasoning is the same as that provided in Part A, Section 1 of this activity. The amount applicable to the preparation of a PI-7 Standard Exemption Form is increased from $195 to $490 as recent revisions to the exemption form by the agency have increased the amount of time required to complete the form. The term "Workplan & Cost Proposal" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

In Activity 06, Part C: Waste Management Costs, the hourly rate for Vacuum Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

In Activity 06, Part D: Analytical Costs, four line item costs are changed and one (TPH (Air)) is added. In addition, analytical descriptions are expanded to clarify the line items. Costs shown in this section are identical to those listed in Appendix 1, Part 2, Laboratory Costs, and applicable comments are provided in this preamble in Appendix 1, Part 2.

In Activity 06, Part E: Travel Costs, the rate per mile for mileage is increased from $.31 to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates.

Activity 06, Notes, is amended as follows. Note 1 provides clarification by adding a sentence referencing Appendix A, Part 9 of the RCSs for direction on how markup for subcontracted work is to be applied. Note 5 also adds a reference to Appendix A, Part 9 of the RCSs to provide clarification.

ACTIVITY 07: GROUNDWATER MONITORING. In Activity 07, Part A: Personnel Costs, Section 1: Fixed Annual Costs, the number of hours for the activity "Management, Regulatory Interaction" by a PM is increased from 5 to 12, resulting in a change in the total amount for that activity from $400 to $960. Increases in the item "FAR - Annual Groundwater Monitoring Report" (from $440 to $580) and the item "FAR - Single Monitoring Event" (from $260 to $435) are also adopted and are fully discussed in this

preamble in Appendix A, Part 8. The term "Workplan & Cost Proposal" is changed to "Workplan and Cost Proposal" to be consistent with the remainder of the RCSs, and the Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities.

In Activity 07, Part A, Sections 2, 3, 4, and 5, a new line item is added to each of these sections. The addition is time for a Technician I to perform natural attenuation testing on a well at a rate of $40 per well. Performing natural attenuation testing has been approved in the past by the agency with reimbursement following an internal pricing schedule. This statement places in rule the agency's internal reimbursement policy for this task. Also, in Sections 2, 3, 4, and 5, in the line-item activity, "Purge and Sample Wells, Each Additional 25' (75' Max)" the parenthetical is deleted to remove that depth limit.

In Activity 07, Part B: Equipment Costs, a new line item for "Field Instruments - Natural Attenuation Testing" replaces the item "(Other)" and a Unit Cost for that item of $75 is added to reimburse the RCAS for specialized field equipment used to collect natural attenuation parameters in the field.

In Activity 07, Part C: Waste Management Costs, the hourly rate for Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

In Activity 07, Part D: Analytical Costs, three line item costs are changed and one is deleted. In addition, Analytical Test descriptions are expanded to clarify the line items. Costs shown in this section are identical to those listed in Appendix 1, Part 2, Laboratory Costs, and applicable comments are provided in this preamble in Appendix 1, Part 2.

In Activity 07, Part E: Travel Costs, the rate per mile for mileage is increased from $.31 to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates.

Activity 07, Notes, is amended as follows. Notes 2 and 4 are amended by adding a reference to Appendix A, Part 9 of the RCSs for clarification. In Note 5 "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. Note 6 is added to place in rule the agency's internal reimbursement policy of reimbursing at half the field rate of $40 per well if a groundwater sample is not collected, but an attempt to enter the well was made. Note 7 is added to place in rule the agency's internal reimbursement policy of allowing the submittal of a reimbursement application for work performed during the first six months. A partial review will be performed to ensure that work was performed. A comprehensive review will be performed at the time the reimbursement application is submitted for the full year's work. Note 7 also states what technical information is necessary for evaluation of the six-month submittal.

ACTIVITY 08: CORRECTIVE ACTION PLAN (CAP) PREPARATION. In Activity 08, Part A: Corrective Action Plan - No Remediation System, the report generation cost total is increased by $375 from $1,150 to $1,525. This increase is due to adopted increases in allowed time (from 1 hour to 2 hours) for a Senior Engineer/Geologist and in allowed time (from 4 hours to 8 hours) for a Staff Engineer/Geologist (SF). Commensurate changes in total line item amounts are also adopted.

In Activity 08, Part B: Corrective Action Plan - With Remediation System, total report generation cost is increased by $1,485 from $6,660 to $8,145. This increase is due to increases in allotted hours, as follows: Associate Engineer (from 30 hours to 40 hours); Staff Engineer/Geologist (from 24 hours to 32 hours); and Draftsperson II (from 20 hours to 25 hours). Hours allotted to the Word Processor (WP) are decreased from 10 hours to 5 hours. Commensurate changes in total line item amounts are also adopted. These changes are adopted because oral and written comments from stakeholders indicated that current allowances for preparing a CAP were insufficient, and that the design of remediation systems is site dependent and typically requires many changes because of negotiations between the owner and the RCAS and between the agency and the RCAS. The agency recognizes that the preparation of a fully developed CAP is necessary for the proper and efficient operation of a remediation system. Additional hours to prepare the CAP are, therefore, adopted.

Activity 08: Part C: Travel Costs, is added as a new section. As was noted in stakeholder meetings, the agency concurs that if a registered engineer must design the system and seal the plans, that the engineer should visit the site to inspect it for special conditions that may influence the installation and operation of the system. The agency feels that reimbursing for the engineer's travel time will ultimately provide savings in construction costs and in operation of the system. Four line items are included in Part C, mileage rate of $.35 per mile, allowance of travel time of $70 per hour, a per diem rate of $90 per day, and air fare as needed. Discussion of the amounts for these line items is provided in this preamble in Activity 2, Part D, Travel Costs. A new line item is added to this activity that serves to total Parts A - C.

Activity 08, Notes. Note 1 reflects the change in the Workplan and Cost Proposal amount from $115 to $195, which is consistent throughout the RCSs as discussed in this preamble in Section 1, Activities. A new Note 4 is added to place in rule the agency's internal reimbursement policy of reimbursing for CAP preparation at 25% above the listed amount in Part B for sites that have special considerations. This amount could be approved for situations that are demonstrated by the RCAS as requiring an increased level of technical effort. Such situations will include off-site installation of recovery lines or wells or an engineering analysis of various disposal options. A maximum allowance for an approved CAP addendum ($305) is also addressed.

ACTIVITY 09: REMEDIATION SYSTEM INSTALLATION. In the second paragraph of the introduction, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter and the language "The agency requires specific descriptions of the items being quoted, including the item's exact type, model, warranty information, and verification that all quotes are at arm's length" is added to state specific requirements related to items being quoted. In the third paragraph, the word "should" is changed to "must" to appropriately reflect the requirement, and the language "The agency requires specific descriptions of the items being quoted, including the item's exact type, model, warranty information, and verification that all quotes are at arm's length" is added to state specific requirements related to items being quoted.

In Activity 09, Parts A1 - Section 1, A2 - Section 1, A3 - Section 1, and A4 - Section 1, the amount applicable to the preparation of a PI-7 Standard Exemption Form increases from $195 to $490

as recent revisions to the exemption form by the agency have increased the amount of time required to complete the form. The term "Workplan/Costs Proposal" is changed, from proposal, in these sections to "Workplan and Cost Proposal/Workplan and Cost Proposal with Bidding" to be consistent with the remainder of the RCSs and to address situations where bidding is involved. The Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities. The Workplan and Cost Proposal with Bidding amount is $355.

In Activity 09, Part B: Capital Equipment Costs, the word "Catalytic" in the line item "Catalytic Oxidizer" is removed to avoid preclusion of other types of oxidizers. Also, the line item for "(Other)" is deleted and replaced with "Carbon Canister (state size)." It was stated in a stakeholder's meeting that larger size carbon canisters are being incorporated more and more in system designs. The agency feels that it is beneficial to include this item for clearer line itemization of equipment costs.

In Activity 09, Part C: Installation Costs, a dollar sign is added to the Unit Cost amount for Trenching and for Plumbing as a correction. The amount for the line item Remediation compound fence is removed and bidding is now required for fencing, as explained in Appendix A, Part 5 of this preamble. Also, two new line items, Outside Electrical Power Connection(s) and System Integration Costs, are added. Oral comments in stakeholders' meetings suggested a breakout of costs associated with providing power from a utility pole for a system to hook into. This line item will facilitate bidding and the review of reimbursement costs by listing it separately. Likewise, the addition of a System Integration Costs line item will capture the small costs associated with minor equipment adjustments or hooking the system to either an outside power source or to a discharge point. The agency agrees that the addition of these two line items will facilitate documenting the installation of a system and the review of reimbursement claims.

In Activity 09, Part D: Waste Management Costs, the hourly rate for Vacuum Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

In Activity 09, Part E: System Performance Analytical Costs, four line item costs are changed and one line item, TPH (Air) (EPA 8015) Standard Rate/Rush, is added at a Unit Cost of $60/$90. In addition, Analytical descriptions are expanded to clarify the line items. Costs shown in this section are identical to those listed in Appendix A, Part 2, Laboratory Analysis Costs, and particular comments are provided in this preamble in Appendix A, Part 2, Laboratory Analysis Costs.

In Activity 09, Part F: Travel Costs, the first item, Equipment Truck, adds the parenthetical (Truck used by Technician II) to add specificity. A line item for vehicle mileage for a Staff Engineer is added because necessary travel for a site staff engineer may not coincide with necessary travel for a technician. The rate per mile for mileage is $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 cents per mile. The per diem rate is increased from $80 to $90 per day to reflect increases in motel and meal rates. The original line item for Travel Time is amended and a new line item for Travel Time is added to differentiate between travel by a staff engineer at $70 per hour and travel by a technician at $45 per hour.

Activity 09, Notes. In Note 2 the existing language is deleted and new language is added to more clearly show how costs for equipment should be tracked and which costs should have approval prior to purchase. The agency realizes that small items cannot be effectively tracked, while obtaining bids for higher priced equipment is financially sound. Three new groupings are presented. Equipment costs greater than $1,000 require a bid. Equipment costs between $100 and $1,000 must be itemized and supported by invoices. Equipment costs less than $100 will be included in the System Integration line item and not require invoices. A discussion of bidding containing specific requirements applicable to bids is also included. The agency reserves the right to refuse any and all bids believed not to be cost effective. A provision for allowing innovative technology without bidding is included. The agency believes that it should not inhibit the use of innovative technology and encourages its development if employing such equipment may significantly reduce the length of time for remediation.

Note 3 adds language that clarifies bid requirements. Three bids are required; however, in instances where it is demonstrated to the satisfaction of the agency that three bids cannot be reasonably obtained, fewer bids may be accepted. The agency reserves the right to refuse any and all bids believed not to be cost effective. The agency feels that this incorporates flexibility in the rules that benefits the PSTR Account. A reference to Appendix A, Part 9 of the RCSs is added to existing markup language, and language addressing unit costs per linear foot is added.

Note 5 adds language addressing bids for other chemical analyses not listed in the RCSs in order to provide flexibility. Three bids will be required and the agency reserves the right to refuse any and all bids believed not be cost effective. Reference to Note 3 is added, from proposal, with respect to bids. Reference is made that markup is applied only as stated in Appendix A, Part 9 of the RCSs.

Note 6 deletes text to clarify what the line items for travel time pertain to. Namely travel for an engineer and a technician are listed as separate line items instead of being combined as previously done.

ACTIVITY 10: OPERATION, MONITORING, & PERFORMANCE. In the opening paragraphs, the term "OM&P" is changed to "operation monitoring and performance (OMP)" to provide continuity in the RCSs.

In Activity 10, Part A: Personnel Costs, Section 1: Fixed Annual Office Costs, the line item "OMP Plan for Existing Systems - See Note 2" is replaced with "Revisions to OMP - See Notes 2 and 8 " for clarification. Because there should be no operating remediation systems without an OMP plan, this line item is changed so that amendments to an existing OMP plan can be made. Based upon the agency's experience with reimbursing OMP plans, an increase in the line item amount for this activity is necessary, therefore, the line item amount is changed from $500 to $750. An increase in allowable PM hours from 12 hours to 21 hours is adopted with a commensurate increase in the total for that line item from $960 to $1,680. Oral and written communications from stakeholders indicated that the current allowance of one hour a month for a PM to review the status of an operating system is insufficient. The item " OM&P Report" is changed to "OMP Report" and an increase in the Unit Cost and the total for the OMP Report (from $1,295 to $1,925) is adopted for the reasoning given

in this preamble in Appendix A, Part 8. A new line item and total is adopted for the preparation and submission of a cost proposal for continued OMP at $560. The routine maintenance of a system for one year requires considerable thought, especially when multi-phase units are remediating deep aquifers. The agency realizes that there is value in having a well-designed OMP plan. In addition, there are a variety of systems with OMP plans of varying complexity and the RCSs cannot address every situation. Therefore, the reimbursement amount is considered an average amount. The Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities. Also the word "Other" is added to the Workplan and Cost Proposal item to clarify the term.

In Activity 10, Part A: Personnel Costs, Section 2: Quarterly Monitoring Personnel Costs, Subsections 2A, 2B, 2C, and 2D, an increase from 1 hour a month to 2 hours a month for a staff engineer/geologist to coordinate quarterly sampling and evaluate the data is adopted with a commensurate increase in the total for that line item from $70 to $140. As was discussed in stakeholder's meetings, much emphasis is being placed on performance of system operation. Evaluation of groundwater monitoring is an important part of determining system performance and, hence, more time should be allotted to reviewing this data. The agency agrees with the necessity of an increase in review time.

In Activity 10, Part A: Personnel Costs Section 3: Operation and Monitoring Personnel Costs for the Remediation System Per Site Visit, the title of the section is amended by adding the phrase "and Routine Weekly Maintenance" to better define the related activities. Time for a Technician III for the activity "O&M, 1st System, Up to 3 Wells" is increased from $75 to $100, since stakeholders expressed concern that not enough time is allotted for the technician to collected weekly samples, inspect the system, and preform minor maintenance when required. The agency agrees that a 33% increase in unit cost is reasonable. Also, the time allotted for a staff engineer for Field Prep, Data Formatting and for Field Prep, Data Formatting, Each Additional 3 System Wells is increased from 0.5 hours to 1 hour with a commensurate increase in the total amount from $35 to $70 for each activity.

Two new sections are added to Activity 10. They are "Section 4: Operation and Monitoring Mechanical/Electrical Personnel Costs for the Remediation System, Per Site Visit - Routine System Maintenance - See Note 10" and "Section 5: Operation and Monitoring Mechanical/Electrical Personnel Costs for the Remediation System, Per Site Visit - Emergency Service." Discussion during a stakeholders meeting centered on the need to have time allotted to a technician who is trained and specializes in electrical/mechanical maintenance. The stakeholders stated that their experience with maintaining systems was that the current allowance of once-a-week visits by an environmental technician is not sufficient to keep a system running properly. A system is composed of many checkpoints that are electrically connected to shutoff equipment. If any one of those checkpoints notes a failed condition, the entire system will shut down. This could occur any time between visits. The time reimbursed for a weekly visit by a technician does not cover those instances where infrequent trips are required for troubleshooting and repairing of the complex equipment. The agency places a great emphasis on operation time and performance of a system to ensure that CAP goals are met and removal of hydrocarbons is occurring on a continuous basis. Currently, full reimbursement for an OMP activity is based upon whether or not a system has been operating for at least 85% of the time. The agency recognizes that time and money allowed for a trained technician to infrequently visit the site to repair a down system is good insurance for ensuring that a system remains operational for longer periods of time. The ultimate benefit will be that the cleanup goals will be more quickly achieved with remediation of the site ending quicker than anticipated, hence, a long-term savings in OMP costs could be realized.

Section 4 allows a trained Technician III (at an hourly rate of $50 per hour) to periodically visit the site to perform routine maintenance of the system. The RCAS will determine how many visits would be necessary for maintenance purposes only. Routine maintenance will include lubrication of components, validating flow rates, voltage checks of electrical equipment, and other measurements. A checklist is to be provided at the time of proposal and copies of all completed checklists to be submitted at the time for reimbursement requests. The agency does recognize that some systems may need to be "fine tuned" after initial startup to ensure sound long-term performance. This line item can be used for the purpose of having a trained technician present for a designated time interval to ensure that the system stays up and running. Spaces are provided for a subtotal for number of hours per trip, the number of trips, and a total cost for Section 4.

The agency realizes that there will be catastrophic events, whether natural (e.g., lightning strikes) or electromechanical failures that occur, causing the system to shut down. Section 5 provides for approval for a technician to visit the site during non-routine times to repair the system. Only the total number of approved site visits actually performed will be reimbursed. Spaces are provided for a subtotal for number of hours per trip, the number of trips, and a total for Section 5.

In Activity 10, Part B: Equipment Costs, the unit cost for the item "Carbon Canisters, includes installation, recycling, and/or disposal" is removed to allow greater flexibility. Three additional items, "Fencing"; "Soundproofing"; and "Winterization" are added. Since fencing around a system is usually required and in some instances, soundproofing of equipment and the protection from freezing conditions, these line items are added. Since the quantities and types of these items are variable, the agency believes that acquiring bids for the purchase of materials and installation will be best to be protective of the Account. The monthly amount allowed for the item "Small Items for System Maintenance" is increased from $50 per month to $200 per month and a commensurate total annual amount of $2,400 placed in the total column for that activity. In oral and written comments, stakeholders noted that replacement of sensors, repair or replacement of flow meters or other equipment, and material for repairs of leaks come out of this monthly stipend. The agency feels that the reimbursement of small items should be more equitable and expects to see operations times of systems dramatically improve because of this allowance.

In Activity 10, Part C: Analytical Costs, the reference to Note 3 in the title is changed to Note 5 as a correction. In Activity 10, Part C: Analytical Costs, Section 1: Groundwater Testing, three line item costs are changed and Analytical Test descriptions are expanded to clarify the line items. Costs shown in this section are identical to those listed in Appendix A, Part 2, Laboratory Analysis Costs, and particular comments are provided in this preamble in Appendix A, Part 2.

In Activity 10, Part C: Analytical Costs, Section 2: System Performance Analytical Testing, two line item costs are changed,

one is deleted, and two air analyses line items are added. In addition, analytical descriptions are expanded to clarify the line items. Costs shown in this section are identical to those listed in Appendix A, Part 2, Laboratory Analysis Costs, and particular comments are provided in this preamble in Appendix A, Part 2.

In Activity 10, Part D: Waste Management Costs, the reference in the section title is changed from "Note 5" to "Note 6" as a correction. Also, the hourly rate for Vacuum Truck fluids transport for disposal is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

In Activity 10, Part E: Travel Costs, the reference in the section title is changed from "Note 6" to "Note 7" as a correction. The parenthetical (Truck used by Technician III) is added to the Equipment Truck line item for clarification as to how to apply this line item in a proposal. The rate per mile for mileage is increased to $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. Two new line items are added. Stakeholders had brought up the issue that there are instances where either a malfunction of the system occurs or operational characteristics of the system are below expectations, requiring the services of an engineer. The agency agrees that these situations do arise from time to time and to ensure proper operation of the system, an allowance for an engineer to travel to the site should be allowed. The line item "Car mileage (Transportation to site by Staff Engineer can charge mileage only, no vehicle charge)" at $.35/mile is added. Also, since time for a trained technician to visit the site is added, a line item for "Travel Time - Technician III - electrical/mechanical" is added at $50 per hour. It is expected that if the technician is subcontracted and the subcontracted amount includes travel and vehicle, a separate vehicle charge for the technician will not be reimbursed. The phrase "Technician III - environmental" is added for clarity in preparing the proposal as the agency recognizes that the environmental technician conducts the routine weekly visits, while the electrical/mechanical technician visits the site irregularly. The per diem rate is increased from $80 to $90 per day to reflect increases in motel and meal rates.

ACTIVITY 10: Notes. In Note 1, language is added stating that additional hours may be approved on a case-by-case basis for project management.

In Note 2, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

In Note 5, the phrase " per Appendix A, Part 9" is added as a reference.

In Note 7, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter and additional language is added to address separate vehicle charges for subcontracted technicians.

A new Note 8 is added to provide clarification with regard to the approval of revisions to OMP plans as those revisions must be approved by the agency.

A new Note 9 is added to provide clarification as to when reimbursement claims can be submitted and what information needs to be provided with regard to sites that have been approved for an OMP activity.

A new Note 10 is added to provide the requirement for the submission of a checklist in the Workplan and Cost proposal for routine system maintenance performed in accordance with Part A, Section 4 of this activity.

ACTIVITY 11: SITE CLOSURE. In the sentence below the activity title, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

In Activity 11, Part A: Personnel Costs, Section 1: Office Costs, the unit cost and total for the preparation and submission of a Site Closure Request are increased from $275 to $550 for reasons addressed in this preamble in Appendix A, Part 8. An increase in the PM's hours from 2 hours to 4 hours is adopted, as during stakeholders meetings, it was noted that 2 hours did not cover the time for organizing the project and coordinating with staff, the owner or operator, and the driller or contractor to remove remediation systems. If site access or coordination problems arise, the PM can spend several times that amount of time. The agency agrees that an increase of 2 additional hours is reasonable and these changes are also reflected in the total for this line item, which is changed from $160 to $320. An increase in the unit cost and total for the preparation and submission of a Final Closure Report (from $195 to $230) is addressed in this preamble in Appendix A, Part 8. The term "Workplan/Costs Proposal" is changed, from proposal, in these sections to "Workplan and Cost Proposal/Workplan and Cost Proposal with Bidding" to be consistent with the remainder of the RCSs and to address situations where bidding is involved. The Workplan and Cost Proposal amount is changed in this section and throughout the RCSs from $115 to $195 as discussed in this preamble in Section 1, Activities. The Workplan and Cost with Bidding amount is $355. All individual totals are increased commensurate with the previous individual increases and the overall total is changed from $745 to $1,295.

In Activity 11, Part A: Personnel Costs, Section 2: Field Personnel Costs, stakeholders had noted that the line item costs allowed to remove a remediation system are underestimated, especially if large equipment (such as a thermal oxidizer) is to be removed. Stakeholders suggested that system removal be subdivided into two line items, small and large. The agency agrees that the distinction for removing a large or small unit should be added. To incorporate this, the line item "Remediation System Removal" is amended: to add a reference to Note 5, which helps clarify the use of bids for system removal; to amend the activity description to specify "small" systems "with few" capital components; and to increase the unit cost for that activity by 50% from $500 to $750 to compensate an RCAS for the removal of more complex small systems. A new line item for reimbursing the costs of removing large systems, "Remediation System Removal (See Notes 2 & 5)," is added with the activity descriptor "Remove and dispose of large system with large capital components." Since the agency recognizes that reimbursing a fixed amount would be too restrictive given the variety of systems present in locales across the state, it believes that it will be best to have bids for the removal services.

In Activity 11, Part B: Rig Costs, the title replaces the term "Rig Costs" with the term "Well Plugging and Abandonment Costs." The unit cost and total for the item "Mobilization (less than 50 miles)" is increased from $245 to $300. The agency notes that the average mob-demob rate for a drilling crew has increased since the last revisions to the reimbursement guidelines. Per diem for a drilling crew is increased from $190 per day to $240

per day to more accurately reflect actual per diem costs for a three-man drill crew.

In Activity 11, Part D: Travel Costs, the rate per mile for mileage is $.35, as mileage rate is the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35 per mile. The average per diem rate is raised from $80 per day to $90 per day to reflect increases in motel and meal rates.

Activity 11, Notes. Note 2 adds a new sentence, which explains that all capital remediation equipment purchased with agency reimbursement funds is owned by the owner/operator of the LPST site. This statement places in rule the agency's internal policy regarding capital equipment ownership.

Note 3 deletes the phrase "for subcontracted costs only" as it is redundant in the RCSs; adds specific reference to Appendix A, Part 9 of the RCSs for further information with respect to markup; and adds a sentence that further limits reimbursement for plugging and abandoning of wells. The agency believes that fewer costs are encountered by a drilling company if a well casing is not removed. Therefore, if the well casing is not drilled out or otherwise removed, only $150 will be reimbursed for that well.

A new Note 5 is added. This note defines what a large remediation system is composed of; that two or more bids are required to dismantle and remove the system; and that the agency may reject any proposal on technical grounds or believed not to be cost effective. The two-bid requirement is imposed because in remote locations where contractors may not be readily available for equipment removal, imposing a three-bid requirement could unnecessarily increase dismantling and removal costs.

Appendix A, Reimbursable Unit Costs, Part 1, is amended, from proposal, to remove the word "Maximum" in the heading "Maximum Rate/Hour." Part 1, Notes, is amended as follows. Note 3 is amended by adding a new sentence that clarifies how the agency will reimburse for labor rates when a person who bills at a higher rate (e.g., a Geologist) performs a task for another person who bills at a lower rate (e.g., a Technician II).

Note 4 is amended to include a reference to Appendix A, Part 9 for further direction concerning markup, and to remove redundant language from the note.

Note 5 is added to ensure that owners/operators who are responsible for a petroleum release and who also perform the cleanup of any contamination do not profit as a result of that release and are not fully reimbursed for cleanup activities funded internally. If an owner/operator uses in-house labor to perform the corrective action activities, then those costs will only be partially reimbursed. Since the agency feels that it will be too cumbersome to adjust all the applicable line item amounts that could possibly be requested for reimbursement by an owner/operator claimant, the agency has decided it will be more prudent to limit the reimbursable amount to labor line items. A flat rate of 85% of the requested amount for labor performed by an owner's/operator's staff is felt to be appropriate.

Appendix A, Part 2: Laboratory Analysis Costs. In general, changes in this part reflect the results of the agency's analysis of current costs with respect to analytical testing of samples related to LPST sites. Where noted, analytical rates have been adjusted downward. The new rates were obtained from averages of prices submitted by private laboratories, from invoices submitted to the agency through reimbursement applications, and from prices submitted by contractors in the State Lead LPST Program. Also, the most recent version of applicable United States Environmental Protection Agency (EPA) analytical methodology is referenced.

Adopted changes to testing for TPH. Since 1998, the agency has required that all testing of water and soil for TPH be performed using Method TX1005. Previously, the agency reimbursed analytical costs for TPH analysis only if EPA Method 418.1 was used. Reimbursement for Method 418.1 analysis is left in because the agency believes it will continue to receive claims for reimbursement for the old analytical method because analysis performed prior to the date Method TX1005 was required. Four new lines are added that place in rule the agency's internal reimbursement policy of reimbursing for costs associated with TPH analysis. These additions are "TPH-TX 1005" for "Soil"; "Water"; and "TPH Air (8015)." Listed prices for these were obtained as described in the previous paragraph.

Adopted changes to testing for BTEX - EPA 8021B. Reimbursable prices are lowered for reasons previously described.

Adopted changes to testing for BTEX w MTBE-EPA 8021B. Reimbursable prices are lowered for reasons previously described.

Adopted changes to testing for PAH - EPA 8270. The analytical method 8270C replaces the outdated analytical method 8270 and reimbursable prices are lowered for reasons previously described.

Adopted changes to testing for Soil Parameters. The reimbursable price is raised for reasons previously described.

Adopted changes to testing for Volatile Organic Compounds - VOCs - EPA 8260B. The standard rate reimbursable prices are adjusted downward for reasons previously described.

Adopted changes to testing for Semi-VOCs - EPA 8270. The analytical method 8270C replaces the outdated analytical method 8270 and the standard rate reimbursable prices are adjusted downward for reasons previously described.

Adopted changes to testing for TCLP Benzene - EPA 1311 w 8020. The analytical method "8021B" replaces the outdated EPA method 8020.

Adopted changes to testing for Reactivity, Corrosivity, Ignitability (RCI) on soil. The standard rate reimbursable price is raised for reasons previously described.

The phrase "(See Note 5)" is added to the line item for "Mobile Laboratory" to provide clarification.

Appendix A, Part 2, Notes, is amended as follows. In Note 4, a minimum reimbursable amount for shipping is allowed. This amount is set at $40.

In Note 5, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

Note 6 is amended by deleting analytical method specific language and replacing it with language that indicates that the agency acknowledges that analytical methods will change in the future. Instead of going through the rule change process to update the analytical tables, it is more prudent and cost effective for the agency to notify an RCAS through written correspondence when new analytical procedures are adopted.

Appendix A, Part 3: Drilling, Well Installation, and Direct Push Technology Costs. The term "Water Well Report generation

costs" replaces the term "Water Well Report Generation" in the opening paragraph for clarification purposes.

In Appendix A, Part 3, Section A: Conventional Drilling, in each of the first three separate blocks of Section A: the Depth Interval "51' to 100'" is replaced with ">50'" and a reference to Note 6 is added, and the Depth Interval ">100'" is deleted along with the accompanying footage rates. The agency, in reviewing amounts reimbursed for drilling boreholes and installing monitor wells, noted that the current reimbursable guidelines for drilling costs do not reflect market rates for such services. It was further noted that the current guidelines are representative of market rates for shallow wells (wells installed less than 25 feet deep) and for low number of wells installed (three or less). However, as the depth of the well increases and the number of wells installed during one session increases, the current guideline rates are skewed higher than a competitive market rate for the same work. Various pricing scenarios to alleviate this situation were reviewed, including a more detailed breakout on pricing, bidding, or no change to the pricing schedule. Producing a more detailed pricing list with lower rates was felt to be too cumbersome to manage, too time consuming with regard to analyzing the market, and would, in the end, remain too rigid to address the variety of drilling conditions faced across the state. A modified bidding process was decided upon. The agency believes that strict bidding for all drilling will not be cost effective to administer and will impose an undue burden on the RCAS to obtain bids for every well or boring installed. The agency also acknowledges that the greatest cost discrepancy exists for the deeper wells and wells drilled in hard rock. These sites are principally located in central and west Texas. Therefore, a system was devised that will require bidding that will focus on these types of wells while paying up to an RCS amount for the shallower wells drilled in the eastern, central, or southern portions of the state. The agency has decided that a workable arrangement will be to pay up to RCSs amounts for any drilling project that had 150 feet or less of the drilling footage, regardless of the number of borings or wells installed. In addition, if a well or boring is drilled to a depth of 50 feet or less, reimbursement will be eligible up to RCSs amounts. For drilling projects that exceed this, bidding will be required.

In the Appendix A, Part 3, Section A block entitled "Completion Footage Rates Expected in a Standard (10-Hour) Work Day," the parenthetical (10-Hour) is deleted to prevent the specification of the length of a work day.

In the Appendix A, Part 3, Section A block entitled "Mobilization/Demobilization and Per Diem," mobilization for a driller, crew, and equipment to a site is increased from $245 to $300. The phrase "450 additional miles" is deleted and replaced with "500 miles round trip" to clarify and place in rule the agency's internal reimbursement policy of reimbursing for mob/demob costs only for travel to and from sites that are located 250 miles or less from the RCAS's home office. The agency notes that the average mob-demob rate for a drilling crew has increased since the last revisions to the reimbursement guidelines. Per diem for the drilling crew is increased from $190 per day to $240 per day to more accurately reflect actual per diem costs for a three-man drill crew.

In the Appendix A, Part 3, Section B block entitled "Mobilization/Demobilization and Per Diem," the phrase "450 additional miles" is deleted and replaced with "500 miles round trip" to clarify and place in rule the agency's internal reimbursement policy of reimbursing for mob/demob costs only for travel to and from sites that are located 250 miles or less from the RCAS's home office. The agency notes that the average mob-demob rate for a drilling crew has increased since the last revisions to the reimbursement guidelines. Per diem for the drilling crew is increased from $130 per day to $180 per day to more accurately reflect actual per diem costs for a two-man drill crew.

Appendix A, Part 3, Notes, is amended as follows. In Note 1, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. To ensure that bids received are reasonable, language is added to Note 1 that specifies the number of bids required and states that the agency has the right to reject any proposal on technical grounds, or if it is believed not to be cost effective. The sentence "Submitted costs will be reviewed on a case-by-case basis." is deleted as redundant.

In Note 4, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

A new Note 5 is added to explain that when certain ceilings are reached, bidding of drilling projects will be required as explained in this preamble in Appendix A, Part 3. The note further states that the bids must be independent, specifies the minimum number of bids, and states that the agency may reject any proposal on technical grounds, or if the proposal is believed not to be cost effective. This note is added to allow the agency to be protective of the PSTR Account if it believes that the bids are not representative of similar work performed in the area or are too expensive to be cost effective.

A new Note 6 is added to specify and clarify when stated rates apply to wells greater than 50 feet in depth.

A new Note 7, Defining Drilling Equipment Categories, is added to specify and clarify the applicable reimbursement rate to a specific type of drill rig. It is recognized that lighter, more versatile drill rigs have entered the market designed to drill soil borings and install shallow monitor wells in locales that a larger drill rig cannot access. Correspondingly, these smaller, more specialized drill rigs have decreased capacities to drill deep borings in a variety of soil conditions and obtain continuous samples as directed in agency guidance for soil sampling at LPST sites. The capitalization and operating costs for these pieces of equipment are lower. A lower drilling rate is adopted for these lighter drilling rigs to more closely align the drilling rates allowed in the RCSs with the market rates.

Also in Note 7 are definitions for three categories of drilling equipment. The first is TYPE I Rigs defined as a typical large truck-mounted drilling rig of sufficient capability to drill a ten-inch diameter borehole to 50 feet or deeper using a hollow-stem auger. Additional capabilities and the necessity of a three-man crew also differentiate this type of drilling equipment. The second type is termed TYPE II Rigs that are smaller, typically trailer-mounted, capable of turning solid flight augers, but not having the capability of obtaining blow counts. Typically, these trailer-mounted rigs are pulled by a truck and have a two-man crew. The third type, TYPE III Rigs, are usually mounted on a truck, such as a 3/4 ton flat bed truck and are only capable of direct push drilling.

A reimbursement rate for TYPE I Rigs is the standard RCS rate for well and boring installation for augering and rotary drilling. TYPE II Rigs drilling rates will be reimbursed up to 65% of the standard RCS rate. The standard RCS mobilization and demobilization rates will apply. Any additional amount requested must be justified. TYPE III Rigs will be reimbursed at the published RCS rate for a direct push drill rig.

Appendix A, Part 4: Travel Costs is amended. In the section entitled "Travel by Air vs. Travel by Surface Vehicle," in the first paragraph, the term "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. Wording in Paragraph 2 is modified to clarify that an RCAS should try to limit travel expenses by combining corrective activities conducted at several sites into one trip, when possible. A second change in this paragraph is to update the reference date and amount that the mileage reimbursement rate is tied to. A new Paragraph 3 is added that clarifies how the agency will reimburse for labor rates when a person who bills at a higher rate (e.g., a Geologist) performs a task for another person who bills at a lower rate (e.g., a Technician II). The agency realizes that an RCAS can achieve cost savings by shifting personnel to perform multiple tasks at multiple sites and encourages this, if it is protective of the fund.

In the section entitled "Per Diem and Non-reimbursable Costs," changes in the first paragraph include raising per diem rates from $80 per day to $90 per day as discussed in the preamble in Activity 2, Part D, Travel Costs. Also, per diem for two- and three-man drilling crews is increased to more accurately reflect current per diem costs for these crews.

In Appendix A, Part 5: Equipment and Supply Costs, the phrase "plus mark-up" is deleted in the first paragraph because it is redundant. Further, the agency requested from many suppliers current pricing concerning equipment and supply costs. Although a limited response was received, sufficient information was obtained to allow proposed modifications to this part. Where current prices could be obtained, the agency has modified up or down the respective line item price. In some areas, prices were supplied that were previously unavailable. One new line item, Fencing and Enclosures, is adopted to reflect the addition of this item in the Remediation Installation Activity. Specifically, "Fencing and Enclosures" replaces "Fences" with an added reference to a new Note 8 that will require bidding. Since bidding is required for fencing and enclosures, the line item amounts for "Compound Fence (Wood/Chain)" and "Chain Link, $/Foot" are removed. In special situations, winterizing and soundproofing of remediation is necessary and are added in this section for completeness. Bidding is adopted for costing these two line items. A new line item, Water Treatment Trailer, with a reference to a new Note 10 and a pricing of $75 per day addresses the common use of this equipment. A reference to a new Note 9 is added to the line item "Traffic Control Components."

Appendix A, Part 5, Notes, is amended as follows. In Note 1, the word "quote" is replaced with the word "bid"; specific requirements related to bids are included; language addressing the use of innovative remedial technologies is added; language stating that the agency may require methods of identification such as serial numbers for capital equipment items in order to track the purchase, use, and condition of these items is added; and language stating that the agency may restrict reimbursable amounts for capital equipment items to prorated amounts that consider usage is added. Also, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

A new Note 7 is added to allow an RCAS to be reimbursed for extra rental days because of shipping-related delays. The agency recognizes that there are many sites statewide that are distant from equipment rental businesses, or that equipment must occasionally be rented from out-of-state businesses and that additional shipping or rental charges are accrued because of the distance to these sites. So to not penalize these sites for requiring specialized equipment, the allowance for shipping charges and extra rental days are allowed.

A new Note 8 is added to provide detailed conditions for bidding and acceptance of bids with regard to fencing.

A new Note 9 is added to provide a minimum amount to be reimbursed for rental of traffic control components. The agency recognizes that companies charge minimum rental rates for traffic control equipment and minimum daily, weekly, and monthly rates are added.

A new Note 10 is added to provide details as to the use and components of a water treatment trailer. The agency believes that with the use of this equipment, a savings on the disposal of contaminated water at LPST sites can be seen. The treatment trailer is designed to treat and discharge, on-site, small amounts of water collected during short-term field testing and groundwater monitoring events.

Appendix A, Part 6: Excavation, Backfilling, and Resurfacing Costs. In Note 1, the phrase "A TCEQ coordinator" is replaced with the phrase "An agency Site Coordinator" to provide consistency in terminology in the RCSs.

Appendix A, Part 7: Soils and Wastewater Management Costs. The hourly rate for the Truck under the activity "Load Haul, & Dispose" is lowered from $75 per hour to $70 per hour. This reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased.

Appendix A, Part 7, Notes, is amended as follows. In Note 1, nearly all the existing language is deleted and replaced with a reference to Appendix A, Part 9 for an allowable markup to provide simplification.

In Note 2, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

A new Note 3 is added to address an issue, which stakeholders had noted, that at times there are no reasonably close waste disposal sites to a generating site and additional costs must be incurred to dispose of waste at more distant sites. The agency believes that in these cases an ability to receive bids for waste disposal is warranted and protective of the PSTR Account and a minimum number of bids is specified. There is adopted language that provides for reimbursement up to $75 per day for the rental of a water treatment trailer consisting of a pump, holding tank, and drums of granulated activated carbon and $.40 per gallon for the treatment of wastewater by the water treatment trailer. Adopted is a flat rate of $250 to dispose of clean soils on- or off-site, derived from on-site corrective action activities.

Existing Note 3 is renumbered as Note 4 to reflect the insertion of the adopted new Note 3 and "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter. The following additional language is added, from proposal, to provide allowances for the cost of preparation of Class V injection well permits and Texas Pollutant Discharge Elimination System (TPDES) storm water discharge permits: "The cost of Class V injection well permits and the cost of TPDES storm water discharge permits associated with on-site treatment and discharge will also be considered for payment."

A new Note 5 is added to clarify issues with regard to wastewater hauling and disposal. The agency acknowledges that many RCAS have scheduled a wastewater hauler to pick up wastewater, in sequence from multiple sites in one run. In doing so, cost

savings are incurred. The agency believes that these cost savings should be realized by the PSTR Account and that an RCAS can prorate costs to multiple sites, thus recouping its costs.

Existing Note 4 is renumbered as Note 6 to reflect the insertion of the adopted new Notes 3 and 5. The second sentence stating what the agency will pay for landfill disposal is removed, as this language is made unnecessary by new Note 3, and a reference to Notes 1 and 3 is added.

Appendix A, Part 8: Report Generation Costs. An increase in the amount allowed for preparation of most reports listed in this part is adopted. During and after the stakeholder meetings, oral and written comments were received stating that time allotted for an RCAS to research, collate, and analyze field data and prepare it in a format acceptable to the agency for the 11 listed activities was insufficient to properly prepare a well thought out and comprehensive document with supporting information. The task remains more challenging given that the sites remaining in the program are older sites having reams of information that must be reviewed in context of newly collected data. The agency has eased the task of preparing and submitting field data by having pertinent information submitted on provided forms. For some tasks, such as site closure, the form has simplified the report writing process. However, the agency acknowledges that these forms are not stand-alone documents and require additional information to be attached such as tables, graphs, maps, and written commentary. In light of this, the agency acknowledges that an increase in hours allowed for report preparation will translate into reports with clearer data presentation and more concise conclusions and recommendations that will allow agency coordinators less time for review.

RELEASE DETERMINATION REPORT. The hours for a PM are increased from 2 hours to 4 hours. Additional information is required to be added to the report warranting an increase in the time for the PM to analyze the data. Correspondingly, more time is allotted for the WP to finalize reports and prepare files and the hours for a WP are increased from 1 hour to 2 hours. These increases result in changes in total amounts, as follows: the PM total increases from $160 to $320; the WP total increases from $35 to $70; and the Total for the report increases from $195 to $390.

FIELD ACTIVITY REPORT (FAR) - SEMI-ANNUAL PSH RECOVERY, PSH RECOVERY SYSTEM O&M The title is amended to "Field Activity Report (FAR) - Groundwater Monitoring - One-time Event" to provide clarification. The hours for an SF are increased from 2 hours to 4 hours with a commensurate increase in the total amount for the SF from $140 to $280. The hours for a WP are increased from 1 hour to 2 hours with a commensurate increase in the total amount for the WP from $35 to $70. The Total for the report is increased from $260 to $435. The agency recognizes that the sites remaining in the reimbursement program are older with a large history of data accumulation that must be interpreted with respect to new information developed. Presentation of this data in tables, graphs, and maps must be updated. The agency believes that more hours are required to adequately process this information.

PSH REPORT/MDPE REPORTS (PER EVENT) FOR 8-HOUR OR 24-HOUR EVENTS. These are new reports that cover three types of events: the PSH report prepared at the end of each PSH recovery phase and reports prepared at the end of an 8-hour or 24-hour MDPE event. The PSH report documents all field activities and amounts of free product recovered associated with passive and active free product recovery systems. The MDPE reports document the MDPE activities and amounts of free product recovered. The hours for an Associate Engineer (P1) are 1 hour for each event with a commensurate total amount for the P1 of $85 for each event. The hours for an SF are 2 hours for the 8-hour event and 3 hours for the 24-hour event with a commensurate total amount for the SF of $140 and $210. The hours for a WP are 1 hour for each event with a commensurate total amount for the WP of $35 for each event. The total for the report is $260 for the 8-hour event and $330 for the 24-hour event.

MDPE REPORTS (PER EVENT) FOR 72-HOUR OR 7-DAY EVENTS. These are new reports that are prepared at the end of the 72-hour and 7-day MDPE events. The MDPE reports document the MDPE activities and amounts of free product recovered. The hours for a PM are 1 hour for the 72-hour and 7-day events with a commensurate total amount for the PM of $80 for both events. The hours for an SF are 4 hours for a 72-hour event and 6 hours for a 7-day event with a commensurate total amount for the SF of $280 and $420, respectively. The hours for a WP are 1 hour for the 72-hour and 7-day events with a commensurate total amount for the WP of $35 for both events. The total for the report is $395 for a 72-hour event and $535 for a 7-day event.

INTERIM CORRECTIVE ACTION PLAN (ICAP). The title is changed to include the phrase "/Mobile Dual Phase Extraction Corrective Action Plan (MDPE CAP)" to reflect additions made in Activity 02, Part A of the RCSs. No changes to the ICAP portion are made. For the added Mobile Dual Phase Extraction Corrective Action Plan (MDPE CAP) portion, the following amounts are added. The hours for a Principal Engineer (P3) are 1 hour with a commensurate total amount for the P3 of $110. The hours for a P1 are 2 hours with a commensurate total amount for the P1 of $170. The hours for a PM are 6 hours with a commensurate total amount for the PM of $480. The hours for an SF are 20 hours with a commensurate total amount for the SF of $1,400. The hours for a Draftsperson II (D2) are 12 hours with a commensurate total amount for the D2 of $600. The hours for a WP are 3 hours with a commensurate total amount for the WP of $105. The total additional proposed MDPE CAP amount for the report is $2,865.

FAR - PSH RECOVERY SYSTEM INSTALLATION. The "Rate/HR" and "Hours" values in this table are switched as a correction to the table.

RISK ASSESSMENT UPDATE OR FAR-SITE ASSESSMENT. A reference to Note 1 is added. Hours for an SF are increased from 4 hours to 8 hours, with a commensurate increase in the total for an SF from $280 to $560. The increase in the overall total for the report is from $485 to $765. The agency believes that if an update is required, more time is required to produce the assessment because the sites remaining in the reimbursement program are older with a larger amount of historic data that must be interpreted with respect to new information developed.

REPORT GENERATION - MISCELLANEOUS. This is added with a reference to Note 3 and an amount of $485, to address situations where reports are specifically requested by an agency Site Coordinator when the Coordinator determines that the subject of the report does not easily fit into other line items within the RCSs.

ANNUAL REPORT - GROUNDWATER MONITORING ONLY. Hours for an SF are increased from 4 hours to 6 hours, with a commensurate increase in the total for an SF from $280 to $420. The increase in the overall total for the report is from

$440 to $580. The agency believes that more time is required to produce the assessment because the sites remaining in the reimbursement program are older with a larger amount of historic data that must be interpreted with respect to new information developed.

ANNUAL REPORT - OPERATION, MONITORING, AND PERFORMANCE. Hours for an SF are increased from 6 hours to 14 hours, with a commensurate increase in the total for an SF from $420 to $980. Hours for a WP are increased from 3 hours to 5 hours, with a commensurate increase in the total for a WP from $105 to $175. The increase in the overall total for the report is from $1,295 to $1,925. The agency believes that more time is required to produce the assessment because the sites remaining in the reimbursement program are older with a larger amount of historic data that must be interpreted with respect to new information developed.

SITE CLOSURE REQUEST. Hours for a PM are increased from 3 hours to 6 hours with a commensurate increase in the total for a PM from $240 to $480. Hours for a WP are increased from 1 hour to 2 hours, with a commensurate increase in the total for a WP from $35 to $70. The increase in the overall total for the report is from $275 to $550. The agency believes that more time is required to produce the assessment because the sites remaining in the reimbursement program are older with a larger amount of historic data that must be interpreted with respect to new information developed.

FINAL SITE CLOSURE REPORT. Hours for a WP are increased from 1 hour to 2 hours, with a commensurate increase in the total for a WP from $35 to $70. The increase in the overall total for the report is from $195 to $230. The agency believes that more time is required to produce the assessment because the sites remaining in the reimbursement program are older with a larger amount of historic data that must be interpreted with respect to new information developed.

Appendix A, Part 8, Notes, is amended as follows. Note 1 is amended to remove the hourly rate for a PM "($80.00)" as a correction and to add a reference to Activity 03 for costs applicable to FAR Preparation and Submission.

A new Note 2 is added to ensure that owners/operators who are responsible for a petroleum release and who also perform the cleanup of any contamination do not profit as a result of that release and are not fully reimbursed for cleanup activities funded internally. If an owner/operator uses in-house labor to perform the corrective action activities, then those costs will only be partially reimbursed. Since the agency feels that it will be too cumbersome to adjust all the applicable line item amounts that could possibly be requested for reimbursement by an owner/operator claimant, the agency has decided that it will be more prudent to limit the reimbursable amount to labor line items. A flat rate of 85% of the requested amount for labor performed by an owner's/operator's staff is felt to be appropriate.

A new Note 3 is added with respect to Report Generation - Miscellaneous, to include the cost of preparation of Recovery Well Installation FARs and to address situations where reports are specifically requested by an agency Site Coordinator when the Coordinator determines that the subject of the report does not easily fit into other line items within the RCSs.

Appendix A, Part 9: Markup changes the item "All Other Subcontractor Invoices" to "All Other Allowable Subcontractor Costs" for clarification.

Appendix A, Part 9, Notes, is amended as follows. Note 1 is amended to delete redundant language and to add new language to clarify who is and is not allowed to add markup and what can be marked up.

Note 2 is amended to clarify that though a Prime may not mark up in-house costs, there are in-house costs incurred by a Prime to which the Prime is entitled. The agency realizes that the RCSs inherently contain profit as they are representative of market rates for such services. The agency realizes that the RCSs were not constructed to anticipate all instances where a Prime may ask to be reimbursed for an in-house service. The agency believes that those instances do not occur frequently enough to warrant that the agency expend the time and effort to review them.

Appendix A, Part 10: Change Orders. In the second paragraph under Field Activity Change Orders, and in the first paragraph under General Change Orders, "TNRCC" is changed to "agency" to be consistent with the remainder of this chapter.

Appendix A, Part 11: Allowable Reimbursable Costs for the Risk Evaluation of Individual Exposure Pathways, is a new part that is added. The addition of this part places in rule, the agency's internal reimbursement policy of defining the reimbursable costs associated with preparing a Plan B Risk Assessment report.

APPENDIX B, DEFINITIONS AND ACRONYMS is amended as follows. Part 1: Definitions, is amended by deleting and adding language to clarify the definition of "Free Product."

Part 2: Acronyms, adds the term "Mobile Dual Phase Extraction (MDPE)" since this methodology is added to the RCSs; replaces the term "Reimbursable Cost Guidelines (RCG)" with the term "Reimbursable Cost Specifications (RCSs)"; adds the term "Site Specific Target Level (SSTL)" because the term is used in Appendix A, new Part 11; and changes "Texas Natural Resource Conservation Commission (TNRCC)" to "Texas Commission on Environmental Quality (TCEQ)."

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the rulemaking in light of the regulatory impact analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute. A major environmental rule means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. Further, it does not meet any of the four requirements listed in §2001.0225(a).

The vast majority of these rule amendments concern an attempt by the agency to handle PSTR reimbursement claims in a way that makes best use of limited agency resources given statutory processing deadlines and the sunset date of the PSTR Account (revised during the last legislative session). The agency is charged under TWC, §26.3573(h) with being a good steward of the PSTR Account, but is also charged by statute to process and pay reimbursement claims within certain time frames when the agency believes the legal requirements have been met. To balance these two charges, the rule amendments eliminate "actual costs" reviews from the regulatory reimbursement scheme and replace them with reimbursement of the lesser of RCSs line-item amounts or invoiced amounts. (An element of actual

cost would remain in limited bidding situations for items that do not lend themselves to set line-item costs.) "Actual cost" reviews consume more resources than the agency can devote to them given existing personnel and statutory deadlines, and claimants have increasingly found ways to claim that their "actual costs" are the same as the line-item costs in Subchapter M (which reduces benefits to the PSTR Account achieved through actual cost reviews).

The PSTR Account was created by TWC, Chapter 26, Subchapter I, to provide a fee-driven pool of monies from which eligible owners and operators may apply for reimbursement for certain expenses associated with corrective actions that they are required to perform at LPST sites (the agency is also authorized to use the PSTR Account for certain expenses associated with the PST program). Under the current PST program rules, agency staff are required to perform two separate reviews of each reimbursement claim. The first involves matching the activities that were pre-approved, at costs listed in Subchapter M, to documentation that the tasks were actually done as pre-approved, then adjusting for changes in scope of work (e.g., a pre-approval for three monitoring wells but, with agency concurrence, once in the field the contractor only drills two). The second review of the claim is an "actual cost review." This involves a detailed submission of invoices, etc., whereby the applicant demonstrates what the pre-approved work actually cost to perform. Following these reviews, under current rules, the agency reimburses the lower of the amounts calculated in the two reviews for each claim.

The adopted amendments make reimbursements based largely on the amounts listed at Subchapter M. By basing reimbursements on listed amounts, the process for claimants to make claims and the agency to review them would be significantly simplified, with commensurate cost savings to claimants. A number of the current in-house reimbursement protests, filed under 30 TAC §334.315, are based on controversies involving actual cost reviews. The elimination of these reviews under §334.309(c) should prospectively reduce the number of new protests filed, with associated savings as litigation is avoided and reimbursement payments are made based on the new wording of §334.309(c).

The agency believes that this move away from "actual cost" reviews should remove many of the apparent incentives for fraud that exist in the current system. Current staff resources are insufficient to adequately police the "actual cost" submissions to prevent this fraud and still make the statutorily-mandated application processing deadline. Reduced fraud upon the PSTR Account leaves more money in the PSTR Account to reimburse legitimate claims and frees up staff time to process claims more quickly, which leads to payments going out more quickly.

This rulemaking package makes a variety of adjustments to the line-item amounts listed for various corrective action activities in Subchapter M. Following extensive discussions with stakeholders, the amounts were adjusted, where possible, to better reflect current market rates. However, the agency is limited in the adjustments it can make. During the 2001 session of the Texas Legislature, the agency was asked for a projection concerning the burden on the PSTR Account between that time and the Account sunset date. Based on that projection, as part of House Bill 2687, amendments were made to the TWC, Chapter 26, Subchapter I, which changed the fee schedule (for the fee which supplies the PSTR Account) and extended the Account sunset date to 2006. The line-item dollar amounts that the agency will reimburse for various eligible remedial activities are contained in Subchapter M. Current changes to these line-item amounts include increases in some areas and decreases in others to reflect applicable changes in market pricing and costs of services. Because the agency needs to adhere to the PSTR Account Burden projections given to the legislature during the drafting of House Bill 2687, the agency seeks to assure that these line-item increases and decreases remain within the limits of the projected income to the Account established by the House Bill 2687 fee schedule to address remaining eligible LPST sites, statewide.

In addition, because stronger accountability provisions are being adopted for Subchapters H and M to work in tandem with the elimination of "actual cost" from §334.309(c), the savings to the PSTR Account can make more money available for the reimbursement of legitimate claims. The simplifying of the process by which an owner or operator may assign his reimbursements rights under Subchapter H should save claimants application preparation time, with commensurate savings.

This rulemaking contains provisions seeking to eliminate profit for owners or operators who are also their own prime contractors, because the agency's stewardship duty toward the PSTR Account under TWC, §26.3573(h) calls for money to go to reimbursing corrective action expenses as opposed to creating a financial benefit for being liable for pollution at an LPST site. However, there are few such owners or operators in the reimbursement program and, because no new sites have come into the PSTR Account since December 1998, that number should not increase. Monies that do not go toward profiting polluters will instead be available to reimburse other corrective action activities.

In addition, even if a rule was to be considered a "major environmental rule," a draft regulatory impact statement is not required because the rules do not exceed a standard set by federal law, exceed an express requirement of state law, exceed a requirement of a delegation agreement, and are not adopted solely under the general powers of the agency.

Greater efficiencies and accountability in the PST reimbursement program facilitate better and faster corrective action at LPST sites, leading to faster closures of those sites. PST program delegation from EPA requires TCEQ to have an effective program in place to bring these sites to timely closure (see 40 Code of Federal Regulations §281.34). These rules also do not exceed an express requirement of state law. TWC, §26.3573(h) requires the agency to be a good steward of the PSTR Account, and as part of this obligation this rulemaking improves accountability in the reimbursement process. TWC, §26.35731(c) puts a deadline on the agency for issuing a Fund Payment Report for each complete claim within 90 days, and other sections of TWC, Chapter 26, Subchapter I, describe when the agency should make reimbursement payments. That statutory subchapter also sets the PSTR Account sunset date as 2006. A large majority of the changes are designed to improve efficiencies in the reimbursement process to help ensure that statutory processing and payment requirements are met, and that all good claims are paid before PSTR Account sunset. This rulemaking is authorized as described in the STATUTORY AUTHORITY section of this preamble. It is not adopted solely under the general powers of the agency, but rather under specific state law.

TAKINGS IMPACT ASSESSMENT

The commission evaluated this rulemaking action and performed an analysis of whether the rules are subject to Texas Government Code, Chapter 2007. To better ensure that all payable reimbursement claims can be paid before the PSTR Account sunsets in 2006, given limited agency resources, the standard for the reimbursement of eligible cleanup expenses related to LPST sites is revised to move away from an "actual cost"-based system. Reimbursement will instead be based on the lesser of either invoiced amounts or line-item amounts listed in Subchapter M, with limited updates to those line-item amounts adopted in this rulemaking. In addition, better accountability provisions are added in the reimbursement rules as a result of the agency's experiences with PST audit cases over the last few years. The rulemaking also updates and clarifies existing program rules, including the correction of typographical and other errors. This action will not create a burden on private real property. The PSTR Account was created many years ago by TWC, Chapter 26, Subchapter I, to provide a fee-driven pool of monies from which eligible owners and operators may apply for reimbursement for certain expenses associated with corrective action they are required to perform at LPST sites (the agency is also authorized to use the PSTR Account for certain expenses associated with the PST program). Greater efficiencies and accountability in the PST reimbursement program facilitate better and faster corrective action at LPST sites, leading to faster closures of those sites. Once an LPST site has been closed, the potential marketability of that real property is greatly increased. The small number of rules adopted as part of the commission's regulatory reform effort, not concerning the PSTR Account, also do not create a burden of private real property. These rules clarify existing rules, correct errors, allow greater flexibility with regard to the certification of testers of corrosion protection on USTs, increase flexibility, delete outdated language, and add ASTs to the seller's obligation to disclose in property conveyances. This last point should help ensure that purchasers of real property are aware if ASTs are present on property they are considering buying (the requirement already exists as to USTs), thus avoiding the inadvertent purchasing of encumbered property. A seller might now elect to deal with environmental issues related to ASTs before selling property, as opposed to attempting to pass the problem on without disclosure. This should result in more property in Texas where PST-related environmental problems have been addressed. As a whole, this rulemaking will not be the cause of a reduction in market value of private real property, does not create a burden on private real property, and will not constitute a takings under Texas Government Code, Chapter 2007.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed this rulemaking for consistency with the Texas Coastal Management Program (CMP) goals and policies in accordance with the regulations of the Coastal Coordination Council and determined that the rulemaking is consistent with the applicable CMP goals and policies.

PUBLIC COMMENT

A public hearing on this proposal was held in Austin on May 25, 2004 and oral comments were received. The public comment period ended at 5:00 p.m. on June 1, 2004. Comments were submitted by Bourdeau Research Group (BRG); Chapman Engineering (Chapman); Earth Solutions, Inc. (ESI); EnVac Environmental Services, L.L.C. (EES); Grissom & Thompson, L.L.P. on behalf of Universal Engineering Sciences, Inc. and B&A Laboratories, Inc. (G&T); High Plains Underground Water Conservation District No. 1 (HPUWD); Industry Council on the Environment (ICE); McCleskey, Harriger, Brazill & Graf, L.L.P. on behalf of Harrison & Cooper (MHB&G); Meridian Alliance Group, LLC (MAG); Texas Board of Professional Geoscientists (TBPG); Ranger Environmental Services, Inc. (RESI); Shaw Environmental, Inc. on behalf of 7-Eleven, Inc. (SEI); Texas Association of Storage Tank Professionals (TASTP); Texas Department of Transportation (TxDOT); Texas Petroleum Marketers and Convenience Store Association (TPCA); Trace Analysis, Inc. (TAI); and Xenco Laboratories (Xenco).

The commenters generally supported the proposed rules and provided both general and specific comments on the rules.

RESPONSE TO COMMENTS

ICE, in a general comment regarding this rulemaking stated that ICE has participated in stakeholder meetings regarding this rulemaking beginning in the summer of 2002 and thanked the TCEQ staff for the opportunity to share ideas and constructive criticism throughout the process.

The commission thanks ICE for its participation and for its expression of gratitude.

ICE, in comments regarding the PSTR fund, stated that in 1998, 1999, and 2001, it worked with TCEQ staff and the TPCA to project estimates of the funds needed to properly close the known LPST universe and that most of those projections and the PSTR fund's balance information to date show that the TCEQ is not threatening the Fund balance with its current patterns of spending. ICE further stated that the TCEQ should ensure that the assets of the fund are only spent on the proper assessment and cleanup of properties, that those funds should not be earmarked for any other program areas or swept into general revenue when the PSTR fund sunsets, and that those funds should be spent on proper reimbursements to the maximum practical extent. ICE commented that it is concerned that legislators and/or regulators may try to appropriate remaining funds for non-assessment uses.

The commission responds that the assets of the PSTR Account have been, and will continue to be, utilized by the agency in strict accordance with applicable statute and rule. No change has been made in response to this comment.

ESI commented that the TCEQ should abolish the requirement for the RCAS that requires a company to have $25,000 in assets to be registered as an RCAS. ESI also commented that other TCEQ programs do not have such a requirement to do work and questioned why it is different for the PST program.

The commission responds that the requirement for demonstrating minimum net worth to become an RCAS is contained in 30 TAC Chapter 30 and only referenced in Subchapter J of this chapter. Neither Chapter 334, Subchapter J nor Chapter 30 are contained in this rulemaking and, therefore, this concern cannot be addressed as part of this rulemaking. The commission has made this concern known to the agency's Operator Licensing Section.

TxDOT referred to the definition for corrective action and asked that the first occurrence of the word "and" be changed to "or" to clarify the definition. TxDOT further requested that a definition of professional geoscientist be included in this rulemaking.

The commission agrees, has made the requested change to the definition of corrective action, and has added a definition for professional geoscientist in this rulemaking.

TxDOT referred to the definition for tank removal in §334.322(18) and requested that the term "petroleum storage tank" with which the agency proposes to replace the term "an UST" be changed to the term "petroleum underground storage tank."

The commission responds that the existing proposed language is clear. No change has therefore been made in response to this comment.

SEI commented on the definition of action level and stated that the definition pertains to samples obtained in "native soils or water." What about samples obtained from pea gravel or tank pad back fill (under repairs)? What if the levels in these samples exceed action levels? SEI asked if the definition should read "groundwater" and not just "water."

The commission responds that the proposed definition of action level refers to "soils" not "native soils" and the term "water" was chosen to include not only groundwater, but also rainfall or runoff, which might enter an open tank pit and become contaminated. The proposed definition was also carefully written to preclude conflict with Texas Risk Reduction Program rules. No change has been made in response to this comment.

SEI referred to the definition of ancillary equipment and stated that the definition only references appurtenances to USTs and asked whether the term "aboveground storage tank" should be included.

The commission responds that the definition is intended to apply only to USTs. No change has therefore been made in response to this comment.

SEI commented on the definition of corrective action and asked if remedial activities other than emergency response can be performed without an approved Corrective Action Plan/Remedial Action Plan.

The commission responds that remedial activities other than emergency response can be performed with an approved Corrective Action Plan/Remedial Action Plan. The commission recommends that SEI contact the Responsible Party Remediation Section of the agency's Remediation Division to discuss the issue in detail. No change is therefore considered necessary and none has been made in response to this comment.

ICE commented that the cathodic protection training market place is not regulated directly. ICE stated that for TCEQ to accept more than one or two organization's training is appropriate, but for TCEQ to make claims that training costs will fall seems improper at best, and misleading in the main. ICE further commented that NACE International is the leading organization in the cathodic and corrosion protection field and that both it and the Steel Tank Institute have good reputations and deliver much-needed standards and training to the market. ICE stated that it doubts that one group's new training program will "drive down" costs and time commitments for training at least in obtaining equivalent strength of certification and that this claim should be considered out of bounds for the agency to make, on principle. ICE stated that the TCEQ's mission calls for it to regulate responsible persons and in only a few instances does it regulate contractors and never has it regulated standards-producing bodies. ICE also commented: "In practice, NACE International requires five and a half days of training for its Level I Cathodic Protection Tester designation. Does the Agency have any way to force NACE to shorten its course to match what Steel Tank Institute is offering? No it does not. Does the Agency have the means to say how two training courses and training results compare? That is difficult."

The commission responds that it is merely adding the Steel Tank Institute (a standard-making organization in the steel tank field) as an additional entity from which the agency will recognize the certification of a Cathodic Protection Tester, which is the *minimum* certification level recognized by the agency for a person who engages in the practice of inspection and testing of corrosion protection and control. The commission is not making any comparison between the two organizations it proposes to recognize with regard to the certification of cathodic protection testers. The rule preamble merely points out that the certification course provided by the Steel Tank Institute is shorter and less expensive than that provided by NACE International. There was, and is, no attempt by the commission to infer any equivalency comparison between the courses/certifications provided by each entity. No change has been made in response to this comment.

TBPG requested that the following language be added to §334.10 (Reporting and Recordkeeping): "All engineering, geoscientific, and surveying information submitted to the agency shall be prepared by, or under the supervision of, a licensed professional engineer, licensed professional geoscientist, or licensed professional surveyor and shall be signed, sealed, and dated by these qualified professionals as required by the Texas Engineering Practice Act, the Texas Geoscience Practice Act, the Texas Professional Land Surveying Practices Act and under the rules of the licensing and registration boards under these acts." With the exception of the word "these" that precedes the term "qualified professionals," TxDOT requested that identical language be added as §334.10(a)(11).

The commission agrees that the rule should address this issue and has added the following language at §334.10(a)(10): "When agency requirements specify documents that must be prepared by, or prepared under, the supervision of a duly licensed professional engineer, a duly licensed professional geoscientist, or a duly licensed professional surveyor, those documents must be prepared in accordance with all requirements of statute and rule applicable to that respective professional."

SEI commented on §334.302(c)(7) and stated that no payments will be made after September 1, 2006. The PSTR fund was set up and funded by fees paid by the responsible parties (RPs) to assist them in assessing and remediating their sites impacted by releases from the UST system(s). SEI asked why the fund should not pay claims until the fund is exhausted and no monies are remaining in the fund and stated that this should be amended to allow full depletion of the fund before sunset.

The commission points out that the statute controls the deadline for when the last payments from the PSTR Account can be made and the statute does not allow amendments to the rules so that payments of funds could occur after September 1, 2006 until the PSTR Account is exhausted. No changes have been made in response to this comment.

BRG commented that the recommended changes added in new §334.306(f) are disconcerting. BRG stated that it is totally understandable and reasonable to be concerned that subcontractors who have performed pre-approved work do, in fact, get paid for performance of that work. It is also reasonable to understand that in today's business world, that doesn't always happen. That is not just in this program, but business in general. BRG stated that the disconcerting point here is that the agency may be placing itself in the middle of a legitimate disagreement between a

prime contractor and a subcontractor. BRG further commented that it is understood that the agency is not "choosing sides" in the disagreement, but is rather providing funds to the court for distribution based on its determination; however, it still seems to provide the court a "third party" concern that the subcontractor is correct in his assertion or defense and may place an unfair influence on the outcome.

BRG commented that the commissioners' concern, as stated in the preamble considering the proposed language in §334.306(f) regarding the ability of the agency to ensure that subcontractors receive payment for work performed as part of the PST reimbursement program is a valid one, but asked whether the agency truly wants to assume the role of enforcing this assurance, or does it want to establish a vehicle that provides the subcontractors with evidence it can use in support of its claim against a prime contractor or owner or operator. BRG stated that §334.306(b)(7) provides a certification that legally obligates the payments. This form is not available for review at this juncture, but it could easily be one that is used for the owners or operators, and for prime contractors as well. The subcontractors could then file a Uniform Commercial Code financing statement that secures them for the specific amount until paid and would raise them, even in bankruptcy, above unsecured creditors. BRG also stated that considerable protection to the environment and public health and safety has been completed during the past years by leveraging capital from all levels of the parties to this program, and it would seem prudent to continue to leverage this capital, considering the short time frames remaining to complete this program. It is necessary to tighten the "loopholes" to afford equal protection for those multiple levels of participants, yet still provide for the most efficient use of capital, not only from the "account" but from the industry as well. BRG commented that further support to subcontractors can be provided by the commission adopting the rule as provided under the rulemaking petition submitted by Universal Engineering Sciences, Inc., Harrison & Cooper, Inc., and B & A Laboratories, Inc., which was supported by a decision of the commission regarding said petition, dated April 14, 2004. In cases of insolvency or bankruptcy, this further protection satisfies the concern of the commissioners, as well as provides for the efficient use of the account.

BRG also commented that §334.306(b)(7)(A) still does not provide protection to the subcontractors. It provides the prime contractor with a certification of legal obligation to pay, but not the subcontractors. BRG also stated that the recommended change includes both. This still provides prime contractors, and in some cases, subcontractors, with the ability to enter into contracts with one another that maximize the use of all available capital to perform corrective action activities, yet provide a vehicle to assist all parties in securing their interests in the normal course of business through the Uniform Commercial Code, the appropriate enforcer.

Xenco requested that language be included in the rules to ensure payment of subcontractors by the owner/operator or prime consultant.

Chapman commented that there are a lot of subcontractors who have done work in good faith, reports have been submitted, reimbursement claims have been paid, and the subcontractors have been told to wait. Those subcontractors quite often carry the costs for long periods of time. Chapman stated that it would appreciate it if the commission could help subcontractors and primary contractors with problems with RPs that do not want to pay and that do not sign reimbursement claims after the work is complete.

EES commented that applicable statutes and regulations must be revised to provide subcontractors with some protection. EES stated that the easiest way to resolve this issue would be to codify the ruling in the Key case and condition any contractor's or property owner's entitlement to reimbursement upon proving that all subcontractors have been paid. EES further commented that absent such a showing, the state should be entitled to withhold such unpaid amounts and be authorized to make payments directly to subcontractors that are owed money.

ICE commented that in general, it is in favor of TCEQ's attempt to aid subcontractors in getting payment of their invoices, but the proposed process appears very cumbersome. ICE further commented that a different approach may be to create a subcontractor-specific signature form for the reimbursement application, which allows the subcontractor to sign in place of the RCAS only if the subcontractor has proof of inadequate performance by that RCAS. If the RP is willing to sign the form, then the subcontractor can attempt to lodge a reimbursement claim directly with TCEQ. If payment for the subcontractor on that claim has already been made to the RCAS then the next claim up for consideration on that LPST case by that RCAS could be "garnished" for payment to the subcontractor.

SEI commented that at §334.306(f) clarification of the "Interpleader process" is needed. SEI asked the following questions. How is the RP to know when this has occurred? How will it impact the RP and his future claims? Will processing of future claims be delayed up until the issue is resolved? If the subcontractor is owed payment, will the next reimbursement application be encumbered for payment of this unpaid subcontractor invoice?

G&T commented that there currently is no rule by which the commission pays subcontractors directly for work performed by the subcontractors for a prime corrective action specialist at an eligible LPST site. G&T filed a rulemaking petition with the commission on February 10, 2004, which requested the adoption of an amendment to Chapter 334, Subchapter H. The proposed rule in the petition would allow the agency to pay subcontractors for work they performed for prime corrective action specialists at LPST sites. The rule proposed in the petition would apply only if the prime corrective action specialist is found to be financially unable to pay the subcontractors due to bankruptcy or insolvency. The rule proposed in the petition also contains a provision stating that the rule is to be retroactive, but would require that all claims made by subcontractors to the agency for direct payment be made within 120 days of the effective date of the rule. On April 7, 2004, the commission directed the executive director to examine the issues raised in the G&T petition and to initiate rulemaking related to direct reimbursement to subcontractors.

G&T also commented that at the commission agenda on April 7, 2004, Commissioner Soward and Chairman White agreed with G&T that the executive director's proposed language in §334.306(f) regarding the filing of interpleaders was not an effective way to get subcontractors paid. G&T recommended that the commission replace proposed §334.306(f) with the text of the proposed rule that was included in the G&T rule petition dated February 10, 2004. G&T stated that the rule language in its proposal clearly sets out the requirements for when a subcontractor is eligible to be reimbursed directly by the commission and provides an effective method of assuring payment to subcontractors without the necessity of involving courts.

MHB&G commented on §334.306(f) and recommended the adoption of language contained in G&T's petition for rulemaking, which would allow for direct payment to subcontractors. MHB&G also commented that the current proposed language in §334.306(f) allowing payment to subcontractors through the use of an interpleader would not be an adequate way to allow payment to subcontractors.

TPCA commented on §334.306(f) and recommended the adoption of language contained in G&T's petition for rulemaking, which would allow for direct payment to subcontractors.

The commission appreciates the comments and agrees that changes in the proposed rules should be made so that the commission is able to pay subcontractors directly. The commission has incorporated language similar to that in G&T's rule petition into §334.306(f) and §334.302(i) so that the commission is able to pay subcontractors directly, but has added a fourth requirement to the subchapter that would require that the commission has not paid for the work performed or that the commission has successfully recovered money paid before money can be paid to subcontractors. This additional language is needed to make it clear that the commission will not pay twice for the same work performed. The commission has also removed the language "bankruptcy or" at §334.306(f)(3) and added the language "subject to the limitation of 11 United States Code, §365(e)(1)" because the petitioned language would be contrary to federal bankruptcy law. Proposed language allowing for the filing of an interpleader has been removed from this rulemaking. The commission also agrees with the comments that the commission should find a way to help subcontractors get paid by prime contractors. The rule language regarding certification on the designated agency form and the rule language that seeks to ensure payment of subcontractors who have performed work has been modified at §334.306(b)(6)(F) and (7) by removing the phrase "legally obligated to be paid" and adding the phrase "ensured to be paid in full through the posting of a payment bond in the amount not yet paid in full by the claimant." The commission agrees with the comment that subcontractors should make Uniform Commercial Code filings in order to secure their right to payments from prime contractors. The commission disagrees with the comments regarding codifying the ruling in the Key case. The Key decision was based on current rules and proposed language will allow for payment to subcontractors directly. The commission disagrees with the comments regarding creating a subcontractor-specific signature form for the reimbursement application. A new application form will be created that subcontractors can submit in order to get paid directly when subcontractors can show that they have not been paid by a prime contractor.

HPUWCD referred to §334.308(b) and (g)(12), cited TWC, §26.35731(b) that prevents consideration, processing, or payment of non-pre-approved claims for reimbursement before those which have been pre-approved, and contended that "TCEQ must provide an adequate window of opportunity to reimburse for non pre-approved work."

The commission responds that the cited statute is clear and can only be changed by the Texas Legislature. This rulemaking cannot provide any specific "window" without statutory change. The commission will make every attempt to complete all consideration, processing, and payment of eligible pre-approved claims for reimbursement prior to PSTR Account sunset in order that as many eligible non-pre-approved claims as possible can be addressed.

ICE commented on Chapter H, Reimbursement, by stating that the agency claims not to need the "two review" and "actual cost" reimbursement approach now in use, once the proposed rule changes become final. ICE stated that one must consider that the current process really involves three cost reviews over and above the original proposal's "proposed costs." When a reimbursement claim is submitted now, it goes through another technical review to compare the proposed work and costs to performed work and costs. That technical review may be the "actual cost" review, but it is done in tandem with a detailed comparison of "actual work performed" to "work proposed." ICE further commented that technical review may or may not compare invoice line-item descriptions and costs to proposed line-item descriptions and costs and is probably the most time-consuming part of the process at TCEQ.

ICE also stated that the new set of RCSs may do a better job of defining line items and their specific costs, but the reviewer is still going to compare the technical work done and its corresponding line items as invoiced and costs associated with those line items, and that of course, the reviewer will recommend payment of amounts that are both justifiable and no higher than the RCSs amounts. That is what happens currently, unless an RP and/or consultant have not yet learned to construct invoices in general accordance with reimbursable costs. ICE commented that if the actual costs for a scope of work exceed pre-approved costs, without any approved change orders involved, then the TCEQ reviewer is only continuing the review to see if the agency can cut the reimbursable amounts even further than RCSs limits, based on inaccurate billing, insufficient documentation (subcontractor invoice copies and similar), or inadequate reporting by the consultant. ICE agreed that this review step is necessary to make sure an RP and consultant are dealing in good faith. However, ICE also commented that in the end, review times and needs appear similar under both current and proposed new models.

BRG commented on §334.309 and stated that continual use of an actual cost analysis should not be maintained, as it requires a thorough definition of actual costs, written and prepared by someone with extensive knowledge of the professional services industries, the construction industries, manufacturing industries, drilling industries, and trucking industries. This knowledge needs to be in cost accounting for these industries, pricing structures within these industries, and business methodologies of these industries. In addition, BRG commented that when viewing Subchapter L related to audits, the definitions should also include required recordkeeping, as it is totally up to the discretion of the auditing unit to determine what it believes it needs to complete the audit, yet some of these industries may not, in fact, keep the type of records the TCEQ audit unit believes it needs, thereby placing the applicant in a position of notice of overpayment, not through a lack of wanting to assist, but for an inability to assist through the lack of documentation. BRG further commented that the line item replacement provides the audit group with two specific road maps by which to ascertain that the program is being appropriately followed, as stated in §334.530 and in compliance with the auditing standards as provided by TWC, §26.35735. By including all payments being subject to audit as §26.35735 requires ("Sec. 26.35735. CLAIMS AUDIT. (a) The commission annually shall audit claims for payment from the petroleum storage tank remediation account."), the audit unit would have both State Lead Contractor negotiated pricing to use in their reviews (which will assist in putting geographic differences into perspective) as well as the RCSs and pre-approvals

with which to match expected outcomes of work performed to the costs approved either by line item, pre-approval, or bidding. BRG stated that this is, after all, the primary principle found in all of the auditing standards listed in TWC, §26.35735, and should be the primary principle of all audits performed under this chapter.

BRG also commented that as to audit limitations being perceived by the changes in §334.309(d), it is difficult to understand where the limitations are. It is establishing that §334.309(c) is the governing section for audits, but it does not limit the auditors in their primary duties of assuring the most efficient use of the money available and to provide the most effective protection to the environment and public health and safety. BRG commented that when analyzing each and every cost, there may be some disagreement as to whether the "actual cost" amounts are more efficient than the line item amounts. However, in analyzing each and every cost, it is quite possible that the line item would be the more efficient. It would seem that the program personnel have had extensive experience in these costs, and have considered this in developing the RCSs, and recognize that in each and every case, those differences will arise, but in the program as a whole, the recommendations contained in §334.309 are the most reasonable, both for the agency and those it regulates.

The commission points out with regard to comment indicating that review times and needs appear similar under both current and proposed new models, that review times and needs represent only a portion of the time necessary to process reimbursement claims and that overall program efficiency is expected to increase as a result of the proposed discontinuation of actual cost review by the program. The commission appreciates those comments in support of the proposed discontinuation of actual cost review, however, responds that actual cost language has been added to the rule language so that audits may determine what costs have actually been paid for work performed.

SEI, with regard to proposed §334.313(a)(1)(C), requested that clarification language be added with respect to corrective action activity that has been done improperly, specifically with regard to unsuccessful pilot tests that have been performed properly, but show that a given remediation system design will not work at a given site.

ICE, with regard to proposed §334.313(a)(1)(C), requested a definition of "performed improperly" or that more descriptive and definitive terms be used with respect to corrective action activity that has been performed improperly. ICE referenced pilot tests as an example.

The commission points out that this issue would be one that should be discussed with the appropriate agency remediation coordinator so that a determination using current technical standards can be made on a case-by-case basis. This gives the ability to take advantage of the flexibility allowed under current and proposed rule language and not addressed by specific rule language. No changes are considered necessary and none have therefore been made with respect to this comment.

ICE appreciated that existing language in §334.313(d) is proposed to be relettered as §334.313(b) and amended to provide a consolidated statement of the agency's treatment of incomplete claims, and stated that it is appropriate that TCEQ codifies the means by which a TCEQ reviewer can pay much of a claim in reasonable fashion, rather than holding up the whole dollar amount based on minor deficiencies.

The commission appreciates ICE's comment in support of this rule amendment.

BRG commented on §334.322(16), and stated that the removal of the language, "In addition, any of the parties listed in this paragraph are related parties if they share common employees, common offices, or centralized accounting; if they operate under a common business name; or if one party pays the wages of another party's employees, makes undocumented transfers of funds to the other party, or allows its employees to render services on behalf of another party" does not seem to change the extent of relationship relative to ownership, but does eliminate some onerous additions that seem invasive of normal business practices. BRG commented that: the ability of a business in a certain locale to share an employee who holds specific skills with another business that requires these skills reduces the cost to each business, and yet does not interfere with distinct separation of these businesses; the ability of a business in a certain locale to rent its facilities to another business in that same locale does not interfere with distinct separation of these businesses; the ability of a business in a certain locale to purchase accounting services from an agency that also provides accounting services for another business in that locale does not interfere with distinct separation of these businesses; and the ability of a business in a certain locale to subcontract an employee to another business in the same locale for a specific purpose does not interfere with the distinct separation of these businesses. BRG further commented that all of these items happen on a day-to-day basis in normal business environments. To restrict them here seems extremely invasive and ludicrous. If there are not any ownership relationships as defined by this section, then there does not seem to be any legitimate reason to further invade the ability of businesses to perform business.

The commission disagrees and responds that the definition of "Related parties" proposed in this rulemaking is considered appropriate because the proposed language allows the executive director to consider the relationship of parties so that a proper determination of allowable markup can be made; therefore, no change has been made in response to this comment.

Meridian commented that there are several sections of the proposed regulations that reference "related parties" and "arms length" bidding. Meridian asked who will be making the decisions as to what is considered a related party or if the bids are arms length. Additionally, Meridian questioned when this decision will be made, prior to pre-approval, upon invoicing, or at any time? Meridian recommended that any questions involving related parties or arms length bidding are clarified and approved along with the pre-approval process to reduce the potential for disagreement after the work has been performed and reimbursement application submitted to the TCEQ.

The commission disagrees with this comment. The definition of related parties proposed in this rulemaking is considered appropriate because the proposed language allows the executive director to consider the relationship of parties so that a proper determination of allowable markup can be made. The executive director will consider "related parties" and "arms length bidding" throughout the reimbursement process and make a determination based on language and documentation submitted. No change has been made nor is one considered necessary in response to this comment.

ICE, with regard to the commission's specific solicitation of comments concerning the utilization of "actual cost analysis," defining "actual cost," and whether proposed rule language limits the

agency's audit authority, stated that in general, it agrees with proposed changes to the auditing and overpayment prevention rule language. ICE also pointed out that it is vital that TCEQ root out fraud or financial abuse of the PSTR fund when and if it exists, but cautioned that auditing must be done in an ethical manner, using good accounting practices and defensible principles.

The commission appreciates ICE's comment in support of the changes to the auditing and overpayment prevention rule language.

BRG commented regarding §334.531(a) and TWC, §26.35735 (concerning Claims Audit) and recommended that proposed language be amended to include the phrase, "The party who has entered into a contract with the agency pursuant to this Chapter to perform corrective action work," to allow audit of PST Remediation Account funds utilized in the agency's State Lead program.

The commission agrees with the comment and language addressing this issue has been incorporated into the rule.

Meridian commented that §334.531 states that all Corrective Action Specialists, contractors, and subcontractors shall cooperate in the event of an audit and shall provide copies of all "documents" relating to an audited claim. Additionally, if the requested documents are not provided, a notice of overpayment can be made to the party that received the reimbursement. Meridian requested that clarification be made as to what documents are required to be made available for an audit and what length of time is required for retaining those documents.

The commission disagrees with the comment and no change has been made in response to this comment. Audit needs the ability to obtain all documents relating to a particular claim and to have the documents for the time necessary to make a proper determination of the actual cost of the work performed.

BRG commented on §334.533 and stated that by referencing TWC, §26.3573 in §334.533(a)(1), it eliminates any discriminatory references to only one portion of the program and makes it all inclusive. That specific section of the TWC states: "The commission shall satisfy a claim for payment that is eligible to be paid under this subchapter and the rules adopted under this subchapter made by a contractor, from the petroleum storage tank remediation account as provided by this section and rules adopted by the commission under this section, regardless of whether the commission: (1) contracts directly for the goods or services; or (2) pays a claim under a contract executed by a petroleum storage tank owner or operator." Further, this provides the audit staff with comparison vehicles by which to perform their audits. BRG stated that it is entirely possible that certain eligible expenses paid for by the State Lead program are different than through the reimbursement program. The audit staff would have the ability to analyze those differences and recommend changes to either program to provide comparability and standardization. BRG also commented that in addition, this speaks to eliminating the "actual cost" review by the "line item" review. By providing the comparability, the pre-approved line items will almost, by definition, be the same as the negotiated prices paid by State Lead. Therefore, the "actual cost" review was done prior to the pre-approval and the stewardship obligation of the account is fulfilled. BRG commented that changing the wording in §334.533(b) from "actually paid" to "contractually obligated to be paid" eliminates any concern or questions that can be raised as to what "actually paid" means and is consistent with the changes in the certification language that makes it apparent that there is a legal obligation to pay.

The commission agrees with the suggested change to reference the TWC and has incorporated the reference to the TWC in §334.533(a)(1). No change has been made to §334.533(b) as the commission considers current proposed language to be appropriate. Further, the commission has changed language in §334.306(b) from amounts promised to be paid to amounts that "have been ensured to be paid in full through the posting of a payment bond in the amount not yet paid in full by the claimant."

BRG commented on §334.534 and stated that by changing the word "reimbursement" to "payment" in §334.534(a), one eliminates the discriminatory application of this section to include any payment from the account. BRG also commented that by adding the word "known" before the "incorrect or inaccurate documentation" portion, some of the due process concerns also disappear. It is entirely likely, especially when all subcontractors must comply with this subchapter, that the persons receiving the notice of overpayment were not aware of incorrect or inaccurate documentation supplied to them, and the results of an audit should disclose known or unknown or it wasn't a truly effective audit. BRG commented that by adding "either the party who contracted directly with the TCEQ for corrective action work" to §334.534(b) further eliminates the discriminatory application of this section and that by adding "and pursuant to the audit being a post payment audit" to §334.534(c), eliminates any disgorgement of funds prior to payment, as a prepayment audit would eliminate those funds from the fund payment report, and no loss would have occurred.

The commission agrees with the suggestion to change "reimbursement" to "payment" in subsection (a) and this change has been made in this rule; however, the insertion of the word "known" as suggested in the second sentence is considered unnecessary as contractors should be aware of the accuracy of documentation they submit for reimbursement, even if the contractor did not originally generate the documentation. The commission agrees with the suggestion to add the phrase "the party who contracted directly with the TCEQ for corrective action work" to the parenthetical which describes the claimant in subsection (b) and has amended §334.534(b) accordingly. Adding the phrase "and pursuant to the audit being a post payment audit" in subsection (c) would be redundant and the commission considers the current rule language in subsection (c) appropriate without change.

ICE, in a general comment regarding the RCSs, stated: "It is not reasonable for TCEQ to make cost changes in the proposed Reimbursable Cost Specifications (RCS) on the basis that changes in RCS should result in zero-sum changes in overall Petroleum Storage Tank Reimbursement (PSTR) fund budgeting or projecting." ICE pointed out that the cost of doing business has increased year by year since the inception of the PSTR Account and that although some areas of work have proven to cost less, most have increased.

The commission responds that it has not attempted to assure zero growth in the amendment of the proposed RCSs and references language included in the preamble to this rulemaking, which states that following extensive discussions with stakeholders, the amounts were adjusted, where possible, to better reflect current market rates. However, the agency is limited in the adjustments it can make. During the 2001 session of the Texas Legislature, the agency was asked for a projection concerning the burden on the PSTR Account between that time and the Account sunset date. Based on that projection, as part of House Bill

2687, amendments were made to TWC, Chapter 26, Subchapter I that changed the fee schedule (for the fee that supplies the PSTR Account) and extended the Account sunset date to 2006. Current changes to the line-item dollar amounts that the agency will reimburse for various eligible remedial activities include increases in some areas and decreases in others to reflect applicable changes in market pricing and costs of services. Because the agency needs to adhere to the PSTR Account Burden projections given to the legislature during the drafting of House Bill 2687, the agency seeks to assure that these line-item increases and decreases remain within the limits of the projected income to the Account established by the House Bill 2687 fee schedule to address remaining eligible LPST sites, statewide. The agency estimates that overall growth of expenditures for reimbursement will be less than 1%. No changes have been made with respect to this comment.

Ranger, in a general comment regarding the RCSs, recommended that the agency include costs for the preparation of Class V injection well permits and TPDES storm water discharge permits in the RCSs.

The commission responds that allowance for these costs has been made at Appendix A, Part 7, Note 4.

Meridian, in a general comment regarding the RCSs, recommended that the agency include a line item in the RCSs for the preparation of TPDES storm water discharge permits for long term (greater than three days) MDPE events.

The commission responds that allowance for these costs has been made at Appendix A, Part 7, Note 4.

SEI, with regard to proposed rule requirements for bidding addressed in RCSs Introductory Requirements and throughout the RCSs, stated that proposed changes add requirements for obtaining bids for additional items and pointed out that one gets what one pays for and that the low bidder is not the winner in all instances.

ICE, with regard to the proposed rule requirements for bidding, stated that the requirement for bidding for certain types of work will likely generate little savings because: 1) the drilling and remediation markets have not been highly profitable in the LPST arena in the past 12 years, related in part to the cost of money over time and in part to the unpredictable nature of TCEQ review times, approval processes, and elapsed times for reimbursement; and 2) many drillers, equipment contractors, and other subcontractors have on a recurring basis, been stuck with partial payments by RPs (owner/operators) or their consultants for LPST work. ICE also pointed out that it is often the case that the low bidder is not the best bidder.

Chapman commented that the agency should be flexible when it comes to bidding because there are times when you are in a remote portion of the state where you do not have a wealth of vendors to choose from. Chapman stated that the agency should consider and not question work, as long as the work is done within RCSs.

The commission responds that bidding requirements have been expanded in this rulemaking to help hold down overall costs, but that the rule does not require the agency to accept the lowest bid. A higher bid can be accepted in instances where the higher bid seems to be the best overall product and the most cost effective. As stated in this rule, the agency may reject any proposal on technical grounds or if the proposal is believed not to be cost effective. Also, as stated in the preamble to this rule, the agency reserves the right to refuse any and all bids believed not to be cost effective. Therefore, all submitted bids can be rejected if the agency considers them to be inappropriate and rebidding then required. No changes have been made with regard to these comments.

Ranger, with regard to a proposed rule requirement for the submission of a "Site Closure Schedule" in the RCSs Introductory Requirements, stated that such a schedule will typically be too hard to predict, based upon available information, will be prone to inaccuracy, and will be a significant added cost for which little value is gained. Ranger recommended that any schedule be limited strictly to those corrective action activities that are included in the corrective action proposal.

The commission responds that the Site Closure Schedule is intended to be a dynamic document, which is updated at the time of any new proposal, to provide a snapshot of the remedial progress of a site at any given time. It is also intended to function as a regularly updated form of disclosure to the Owner/Operator and its value to the agency and the owner/operator are felt to outweigh what the agency anticipates to be minimal associated costs. The suggested changes are not in keeping with the intent of the document and no changes have been made with regard to this comment.

Ranger, with regard to proposed rule language in the RCSs Introductory Requirements stating that records should be kept to show applicable quantities involved with corrective action activities, commented that it does not believe this will be practicable, that the level of detail required is not adequately defined, that it is too vague to implement, and that it will increase overhead costs and pose unnecessary burdens on private enterprise.

The commission responds that as stated in the preamble to this rulemaking, these records will better allow the agency to evaluate reimbursement claims to see if the regulatory requirements have been met at the initial review and the audit stages and are considered necessary to the program. Except for the change of the word "should" to "must" in this requirement, no other changes are made with regard to this comment.

SEI, with regard to Activity 02 (Phase-Separated Hydrocarbon (PSH) Recovery) stated that MDPE field personnel and equipment costs are too low for all events.

Ranger, with regard to Activity 02 (Phase-Separated Hydrocarbon (PSH) Recovery) recommended: adding costs for holding tank drop and rental charges; adding technician and engineer/geologist time for field preparation and for data formatting for MDPE events; increasing engineer time from 9.5 to 10 hours for the 8-hour MDPE event; allowing three-person crews (a staff engineer/geoscientist and two technicians) for the 24-hour through 7-day MDPE events; allowing for more time on-site for a staff engineer for the 72-hour and 7-day MDPE events; and recommending that all MDPE events be evaluated as 8-hour events.

ICE, with regard to Activity 02 (Phase-Separated Hydrocarbon (PSH) Reovery) stated that with respect to proposed changes related to MDPE, it is in general agreement with the comments offered by the TASTP and recommended: 1) that when an MDPE event lasts more than 8 hours, it should be staffed by a knowledgeable, well-trained technician (or one should be on-call from a nearby location) for virtually all the run time of the of the activity; 2) that for safety and security of equipment a person needs to be on the site; 3) that for human health and safety, either the buddy system should be used or other provisions for safety of a

solo operator should be in place; 4) that the proposed allowance of $20 per hour for security personnel is too low; and 5) that the proposed rates for equipment and labor are far lower than what was discussed in the past between TCEQ and industry representatives.

TASTP, with regard to Activity 02 (Phase-Separated Hydrocarbon (PSH) Recovery) stated that it is disappointed that TCEQ refused to accept input on costs from the stakeholders' MDPE subcommittee members. TASTP stated that unfortunately, the proposed RCSs for MDPE are deficient in the following areas: 1) costs have been lowered; 2) site location is not considered; 3) additional data collection (i.e., gauging and vacuum measurements) are not considered as extras; 4) no flexibility in costs for site-specific conditions (i.e., depth to water, soils and geology, disposal options, etc.); and 5) prejudice against the small mom and pop operators the Fund was designed to help perform corrective action. TASTP stated that traditionally, the TCEQ has pre-approved a lump-sum, all-inclusive $3,500 for mobilization, equipment, and personnel for 8-hour MDPE contractor services for any location in Texas and maintains that that amount is adequate to cover contractor costs for large RPs with multiple locations, but inadequate to cover small mom and pop type RPs with one location who must then bear additional contractor costs that exceed pre-approved amounts. TASTP proposed that MDPE costs be based on location and proposes a new format for MDPE in the proposed RCSs that provides additional items/activities and increasing amounts for currently proposed items/activities. For example, TASTP's proposed format included $3,250 for equipment and personnel for an 8-hour day and an additional $325 per hour for additional hours up to 7 days for the same mobilization. TASTP stated that TCEQ often requests that vacuum readings be taken at nearby wells, that additional equipment and personnel costs are needed to address this issue, and gave suggested amounts. TASTP stated that the proposed amounts in the RCSs for the 24-hour, 72-hour, and 7-day events are woefully inadequate for personnel and equipment. TASTP stated that the allowance for security guards and fencing is a good idea but an experienced operator must be present or readily available. TASTP maintained that an extension of its suggested hourly rates and per diem are more representative of the longer duration events than the costs currently proposed in the RCSs.

Chapman commented, concerning Activity 02, Phase-Separated Hydrocarbon Recovery (i.e., mobile dual-phase extraction), that the stakeholder's committee spent a great deal of time working on the guidelines and that will bring lots of stability to the group. The field personnel costs need to be looked at because the proposed rules do not give any specifications as to what the personnel costs are for the field, it just says "field costs." Chapman also commented that the notes also do not specify where those monies go. For example, for a 24-hour event there isn't an MDPE vendor in the state who's worth having on your site that's going to conduct a 24-hour event for equipment cost only. Chapman commented that there needs to be personnel cost and that it would like to see a greater definition to avoid problems, to avoid change orders, and to avoid necessary headaches. Chapman also commented that in reference to Activity 2, Note 7, regarding mobilization and de-mobilization, the agency needs to give some time on both sides for the field contractors because it takes a little longer to set up site than 24 hours and a little longer than that to break it down. Chapman stated that the agency should give at least 26 hours.

The commission responds that in an attempt to impart a greater degree of consistency and predictability into the process by which MDPE technologies are addressed, the agency is incorporating allowable amounts for those technologies into the RCSs. Those technologies have to date, only been addressed by the agency on a case-by-case basis. The commission further responds that costs and applicable line item amounts with respect to MDPE were arrived at as a result of a number of meetings and teleconferences with stakeholders and MDPE providers, are reflective of consensus agreement among the participants of those meetings, and are also reflective of charges observed by the agency for this activity in reimbursement applications and in the agency's State Lead Remediation Program. The commission recognizes the concerns of the commenters, however, and has made the following changes in the RCSs to address those concerns: 1) for the 8-hour event, SF hours have been increased from 9.5 hours to 10 hours and combined allowable costs for Field Personnel-MDPE and Equipment-MDPE have been increased from $3,000 to $3,200; 2) for the 24-hour event, the allowance for two technicians for 25 hours each has been replaced with an allowance for an SF and a technician for 27 hours each and combined allowable costs for Field Personnel-MDPE and Equipment-MDPE have been increased from $5,110 to $6,200; and 3) for the 72-hour event, SF hours have been increased from 11 hours to 20 hours, technician (T-II) hours have been increased from 26 hours to 28 hours, and combined allowable costs for Field Personnel-MDPE and Equipment-MDPE have been increased from $7,650 to $8,750. In addition, the proposed hourly rate for security personnel has been increased from $20 per hour to $30 per hour. For the 7-day event, SF hours have been increased from 12 hours to 16 hours and combined allowable costs for Field Personnel-MDPE and Equipment-MDPE have been decreased from $16,820 to $15,550; however, the increase in the hourly rate for security personnel counteracts that decrease for this extended event.

Meridian, with regard to Activity 04 (Site Assessment), requested that the current proposed language allowing up to $500 for licenses/permits associated with obtaining off-site access from municipalities or government agencies be modified to include landowners who are requesting payment for their legal costs associated with providing the off-site access agreement.

The commission responds that the $500 amount is in addition to $320 per property otherwise provided in the proposed RCSs and specifically addresses the additional cost of municipal permits. No changes are therefore considered necessary and none have been made with respect to this comment.

Ranger, with regard to Activity 04 (Site Assessment), stated that separate travel for site visits should be allowed for any corrective action proposal that involves off-site drilling activities.

The commission responds that current rules and this rulemaking allow for as much travel as is necessary to perform eligible remedial activities. No change is therefore considered necessary and none has been made in response to this comment.

ICE, with regard to Activity 04 (Site Assessment), stated that in the case of work scopes requiring bidding, the workplan cost proposal amount of $195 is still inadequate.

The commission agrees with ICE's comment and responds that the RCSs have been amended at Activity 04, Part A, Section 1; at Activity 09, Parts A1, A2, A3, and A4, Section 1 of each part; and at Activity 11, Part A, Section 1 to add "Workplan and Cost Proposal with Bidding" at $355.

ICE, with regard to Activity 04 (Site Assessment), requested that the unit cost allowance of $300 for determining well elevations in a Site/Monitoring Well Survey be increased to allow use of a surveying firm.

The commission responds that the proposed RCSs already address that issue at Activity 04, Note 2, which allows the submission of quotes to be submitted with regard to contracting with a licensed surveyor. No change has therefore been made in response to this comment.

Meridian, with regard to proposed rule requirements for bidding addressed at Activity 09, Note 2 of the RCSs stated that the requirement to obtain three bids for any remediation equipment costs exceeding $1,000 sets the amount for the requirement too low and suggested that an amount of $5,000 should be used.

The commission responds that the current requirement of $1,000 is considered appropriate because many of the items routinely utilized in remediation systems are priced between the $1,000 and $5,000 range, and setting the bid minimum higher than $1,000 would not assure the best use of the funds in the PSTR Account. No change has therefore been made with respect to this comment.

Activity 10 (Operation, Monitoring & Performance), Note 9 of the proposed RCSs allows (for sites which have been approved for annual OMP activity) a claim for reimbursement to be filed after the initial six months of the activity is completed. Bordeaux suggested that the initial period prior to filing for reimbursement be changed from six months to three months.

Ranger, with regard to Activity 10 (Operation, Monitoring & Performance), stated that claims should be allowed to be submitted on a quarterly basis as operation and maintenance activities are typically performed on a weekly basis and attendant bills can be very significant.

The commission responds that although the current language in this rulemaking already contains a relaxation of agency requirements, the commission agrees with the commenters and has changed rule language at Activity 10, Note 9 to allow claims for reimbursement to be filed quarterly instead of every six months.

With regard to Appendix A, Part 1 (Professional Personnel/Labor Rates), SEI stated that labor rates are low, having remained unchanged since 1997, and requested that they be increased to reflect interim increases in cost of living, wages, and employee promotions.

With regard to Appendix A, Part 1 (Professional Personnel/Labor Rates), Ranger stated that labor rates are low, having remained unchanged since the inception of the reimbursement program and do not reflect the increased cost of living since that time. Ranger recommended increases in the hourly rate for Staff and Field Engineer/Geologist/Hydrogeologist, Technician I - III, and Clerical.

The commission responds that the agency's experience in the reimbursement program indicates that current labor rates continue to be fair and although no changes to labor rates in this rule are being made, the agency has made other changes such as increasing total allowable personnel hours for some activities that increases the amount that can be reimbursed for labor for that activity. The commission considers the rates to be appropriate and no changes have been made in response to these comments.

With regard to Appendix A, Part 2 (Laboratory Analysis Costs), TAI provided reasoning and recommended that increases be made in several areas of the proposed RCSs.

With regard to Appendix A, Part 2 (Laboratory Analysis Costs), Xenco provided reasoning and recommended that increases be made in several areas of the proposed RCSs with regard to lab analysis costs. Xenco also suggested revisions including additional application of rush rates and additional line items with regard to analytical methods.

The commission responds that the proposed costs and applicable line items, with respect to lab analysis, were arrived at as a result of a number of meetings and teleconferences with stakeholders and laboratory representatives and are reflective of past and current market rates observed by the agency in reimbursement applications and in the agency's State Lead Remediation Program. The commission, therefore, feels that the rates are appropriate without change.

With regard to Appendix A, Part 3 (Drilling, Well Installation and Direct Push Technology Costs), Note 5, Bordeaux suggested that more flexibility should be applied with regard to the requirement for three bids for drilling in areas where it may be difficult to obtain bids from three separate drillers.

The commission agrees and points out that although the requested flexibility had been addressed in the current rulemaking at Activity 09, Note 3 of the proposed RCSs, the following additional clarification has been provided by adding a reference to Activity 09, Note 3 in Activity 09, Note 5, and by adding language similar to that of Activity 09, Note 3, as follows: 1) in the second paragraph of the Introductory Requirements; 2) in Appendix A, Part 3, Notes 1 and 5; 3) in Appendix A, Part 5, Note 1; and 4) in Appendix A, Part 7, Note 3.

With regard to Appendix A, Part 3 (Drilling, Well Installation and Direct Push Technology Costs), Ranger recommended using reimbursable unit rates in lieu of bidding, but stated that if bidding is required, an additional several hours of PM time should be approved to allow gathering requested bids.

The commission points out that bidding requirements have been expanded in this rulemaking to help hold down overall costs, not further increase them, and that no change is being made with respect to this comment.

With regard to Appendix A, Part 4 (Travel Costs), Bordeaux suggested that more flexibility should be applied to the issue of per diem versus travel time.

With regard to Appendix A, Part 4 (Travel Costs), Ranger recommended, due to record high gasoline prices, that the mileage rate be increased to $.50 per mile.

With regard to Appendix A, Part 4 (Travel Costs), ICE recommended that the mileage rate be increased to $.37 per mile or higher as it better reflects the actual costs of owning and operating a work vehicle.

With regard to Appendix A, Part 4 (Travel Costs), Meridian questioned why two options have been included for the mileage rate and recommended using the OMGST rate.

The commission responds that, as stated in the preamble to this rulemaking, the rate per mile for mileage is increased from $.31 to $.35, as mileage rate is to be the lower of either the applicable Internal Revenue Service rate per mile or the applicable OMGST rate per mile at the time the activity was performed, rounded to the next highest cent. As of August 1, 2003, that rate was $.35

per mile. The current language regarding travel costs in general, is considered fair and appropriate without change.

With regard to Appendix A, Part 7 (Soils and Wastewater Management Costs), Ranger recommended that the truck rate, which is proposed to be reduced, be left the same or increased, due to high gasoline prices.

The commission responds that, as stated in the preamble to this rulemaking, this reduction reflects the agency's experience that average hourly reimbursed rates for this service have decreased, and also points out that it might be unwise to react to short-term fluctuations in fuel pricing. No change in the proposed rate is therefore considered necessary.

With regard to Appendix A, Part 8 (Report Generation Costs), Ranger stated that, with respect to MDPE Reports, clarification is needed as to whether stated amounts are per event or per multiple events and further stated that if these costs are per multiple event, they are significantly inadequate and should be increased.

The commission responds that the specified amounts apply on a "per event" basis and that the RCSs language has been amended to specify that point.

With regard to Appendix A, Part 8 (Report Generation Costs), Ranger stated that the proposed cost of $765 for an updated assessment report form is insufficient if the report contains both soil and groundwater data and recommends it be raised to $1,200.

The commission disagrees and points out that the amount was determined as a result of meetings and teleconferences with stakeholders and industry representatives. No changes have therefore been made as a result of this comment.

With regard to Appendix A, Part 8 (Report Generation Costs), Ranger stated that the agency did not include costs for the preparation of Recovery Well Installation Field Activity Reports (FARs) and recommended that allowance for these reports be made in the range of $485 to $750.

The commission responds that Appendix A, Part 8, Note 3 has been amended to include Recovery Well Installation FARs in the "Report Generation - Miscellaneous" section of Part 8, which allows an amount of $485.

SUBCHAPTER A. GENERAL PROVISIONS

30 TAC §§334.2, 334.5, 334.7 - 334.10, 334.12

STATUTORY AUTHORITY

The amendments are adopted under TWC, §5.103, which provides the commission authority to adopt any rules necessary to carry out its powers and duties under this code and other laws of this state and to adopt rules repealing any statement of general applicability that interprets law or policy; §5.105, which authorizes the commission to establish and approve all general policy of the commission by rule; and §26.011, which requires the commission to control the quality of water by rule. The amended sections are also adopted under TWC, §26.345, which provides the commission authority to develop a regulatory program and to adopt rules regarding USTs; §26.351, which directs the commission to adopt rules establishing the requirements for taking corrective action in response to a release from a UST or an AST; and §26.3573, which allows the commission to use funds from the PST remediation account to reimburse an eligible owner or operator or insurer for the expenses of corrective action or to pay the claim of a contractor hired by an eligible owner or operator to perform corrective action.

§334.2. Definitions.

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

(1) Abandonment in-place--A method of permanent removal of an underground storage tank from service where the tank is left in the ground after appropriate preparation and filling with an acceptable solid inert material in accordance with the requirements of §334.55 of this title (relating to Permanent Removal from Service).

(2) Abatement--The process of reducing in sufficient degree or intensity the source of the release or impacted area, and potential fire, explosion, or vapor hazards, such that immediate threats to human health no longer exist. This includes the removal, as necessary, of all regulated substances from any confirmed or suspected release source (including associated aboveground or underground tanks, individual tank compartments, or associated piping) and the removal of phase-separated regulated substances from the impacted area.

(3) Aboveground release--Any release to the surface of the land or to surface water, including, but not limited to, releases from the aboveground portion of an underground storage tank (UST) system and releases associated with overfills and transfer operations during the dispensing, delivering, or removal of regulated substances into or out of a UST system.

(4) Aboveground storage tank (AST)--A non-vehicular device, (including any associated piping), that is made of non-earthen materials; located on or above the surface of the ground, or on or above the surface of the floor of a structure below ground, such as mineworking, basement, or vault; and designed to contain an accumulation of petroleum products.

(5) ACT--A trademark of the former Association for Composite Tanks, now a licensed trademark of the Steel Tank Institute.

(6) Action level--The concentration of constituents of any substance or product listed in §334.1(a)(1) of this title (relating to Purpose and Applicability) in the soil or water at which corrective action will be required.

(7) Allowable cost--As defined by, §334.308 of this title (relating to Allowable Costs and Restrictions on Allowable Costs).

(8) Ancillary equipment--Any devices that are used to distribute, meter, or control the flow of petroleum substances or hazardous substances into or out of an underground storage tank (UST), including, but not limited to, piping, fittings, flanges, valves, and pumps.

(9) ANSI--American National Standards Institute, a nationally recognized organization which provides certifications and standards for consumer products and services.

(10) API--American Petroleum Institute, a nationally recognized organization which provides certifications and standards for petroleum equipment and services.

(11) Appropriate regional office--The agency's regional field office which has jurisdiction for conducting authorized agency regulatory activities in the area where a particular underground storage tank system or aboveground storage tank system is located.

(12) ASTM--American Society of Testing and Materials, a nationally recognized organization which provides certifications and standards for products and services.

(13) Backfill--The volume of materials or soils surrounding the underground storage tank bounded by the ground surface, walls, and floor of the tank pit.

(14) Below-ground release--Any release to the subsurface of the land or to groundwater, including, but not limited to, releases from the below-ground portions of an underground storage tank (UST) system and releases associated with overfills and transfer operations during the dispensing, delivering, or removal of regulated substances into or out of a UST system.

(15) Beneath the surface of the ground--Beneath the ground surface or otherwise covered with materials so that visual inspection is precluded.

(16) Cathodic protection--A technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell, normally by means of either the attachment of galvanic anodes or the application of impressed current.

(17) CERCLA--The federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended.

(18) Change-in-service--A method of permanent removal from service involving the permanent conversion of a regulated underground storage tank to a tank which is not regulated under this chapter, where all regulated substances are properly removed by emptying and cleaning, and the tank is left in the ground for the storage of materials other than regulated substances.

(19) Closure letter--A letter issued by the agency which states that, based on the information available, the agency agrees that corrective action has been completed for the referenced release in accordance with agency requirements. .

(20) Commingled--A combination or mixture of a petroleum product and a substance other than a petroleum product (excluding soil and/or water).

(21) Common carrier--With respect to delivery prohibitions, a person (as defined in this section) who physically delivers a regulated substance into an underground storage tank directly from a cargo tank which is affixed or mounted to a self-propelled, towable, or pushable vehicle (e.g., wagon, truck, trailer, railcar, aircraft, boat, or barge).

(22) Composite tank--A single-wall or double-wall steel tank, to which a fiberglass-reinforced plastic laminate or cladding has been factory-applied to the external surface of the outer tank wall.

(23) Consumptive use--(With respect to heating oil) the utilization and consumption of heating oil on the premises where stored.

(24) Corporate Fiduciary--An entity chartered by the Banking Department of Texas, the Savings and Loan Department of Texas, the United States comptroller of the currency, or the director of the United States Office of Thrift Supervision that acts as a receiver, conservator, guardian, executor, administrator, trustee, or fiduciary of real or personal property.

(25) Corrective action--Any assessment, monitoring, and remedial activities undertaken to investigate the extent of, and to remediate, contamination.

(26) Corrective action plan (or remedial action plan)--A detailed plan developed to address site remediation of soil, groundwater, or surface water contamination that provides for required protection of human health, safety, and the environment. The selection of the most effective and efficient remedial method will be dictated by the nature and location of the release, the site soils, hydrogeological conditions, and the required degree of remediation. The remedial method selection should take into consideration such factors as cost, time, and state compliance requirements with each method. The title of any report which contains a corrective action plan must include the designation "remedial action plan."

(27) Corrosion specialist--A person who, by reason of a thorough knowledge of the physical sciences and the principals of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks, and who is either:

(A) certified as a corrosion specialist or a cathodic protection specialist by NACE International; or

(B) licensed as a professional engineer by the Texas Board of Professional Engineers in a branch of engineering that includes education and experience in corrosion control of buried or submerged metal piping systems and metal tanks.

(28) Corrosion technician--A person who can demonstrate an understanding of the principals of soil resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements related to corrosion protection and control on buried or submerged metal tanks and metal piping systems; who is qualified by appropriate training and experience to engage in the practice of inspection and testing for corrosion protection and control on such systems, including the inspection and testing of all common types of cathodic protection systems; and who is either:

(A) certified by NACE International as a corrosion technician, corrosion technologist, or senior corrosion technologist;

(B) employed under the direct supervision of a corrosion specialist (as defined in this section), where the corrosion specialist maintains responsible control and oversight over all corrosion testing and inspection activities; or

(C) certified as a cathodic protection tester, in a manner satisfactory to the agency, by either NACE International or the Steel Tank Institute (STI).

(29) Date installation is complete--The date any regulated substance is initially placed in an underground storage tank or the date any petroleum product is initially placed in an aboveground storage tank.

(30) Dielectric material--A material that does not conduct direct electrical current, as related to coatings, bushings, and other equipment and materials used with underground storage tank systems.

(31) Electrical equipment--Underground equipment which contains dielectric fluid which is necessary for the operation of equipment such as transformers and buried electrical cable.

(32) Emergency generator--A standby electrical generating system powered by an internal combustion engine (including a turbine), where such system is designed to supply temporary electrical service only when service from the normal or primary electrical source is disrupted. Such systems include, but are not necessarily limited to, those providing emergency electrical service for hospitals, life support systems, and other medical service facilities; telephone and electrical utilities; heating, lighting, ventilation, security, elevator, fire control, and other essential building operations systems; uninterruptible power systems; essential air conditioning and refrigeration; and motors, machinery, and controls used for other essential or critical purposes.

(33) Excavation zone--The space containing the underground storage tank (UST) system and backfill material, which is bounded by the ground surface and the walls and floor of the pit and trenches into which the UST system is placed at the time of installation.

(34) Existing underground storage tank (UST) system--A UST system which is used or designed to contain an accumulation of regulated substances for which installation either had commenced prior to December 22, 1988, or had been completed on or prior to December 22, 1988. Installation will be considered to have commenced if the owner or operator had obtained all federal, state, and local approvals or permits necessary to begin physical construction at the site or installation of the tank system, and if either a continuous on-site physical construction or installation program had begun or the owner or operator had entered into contractual obligations (which could not be canceled or modified without substantial loss) which required that the physical construction at the site or installation of the tank system was to be completed within a reasonable time.

(35) External release detection--A method of release detection which includes equipment or procedures designed to effectively monitor or measure for the presence of regulated substances in the excavation zone, soil, or other media outside of a single-wall or double-wall underground storage tank system.

(36) Facility--The site, tract, or other defined area where one or more underground storage tank systems or one or more aboveground storage tank systems are located.

(37) Farm--A tract or tracts of land (including all associated structures and improvements) which are principally devoted to the raising of agricultural or other types of crops, domestic or other types of animals, or fish for the production of food, fiber, or other products or for other useful purposes, including fish hatcheries, rangeland, and plant nurseries with growing operations, but not including timber-growing land and operations dedicated primarily to recreational, aesthetic, or other non-agricultural activities (e.g., golf courses and parks).

(38) Farm tank--A tank located on a farm where the stored regulated substance is or will be utilized directly in the farm activities.

(39) Field-constructed tank--A tank which is not factory-assembled, and which is principally constructed, fabricated, or assembled at the same facility where the tank is subsequently placed into service.

(40) Flow-through process tank--A tank through which regulated substances flow in a steady, variable, recurring, or intermittent manner during, and as an integral part of, a production process (such as petroleum refining, chemical production, and industrial manufacturing), but specifically excluding any tank used for the static storage of regulated substances prior to their introduction into the production process and any tank used for the static storage of regulated substances which are products or by-products of the production process.

(41) Free-product (or non-aqueous phase liquid)--A regulated substance in its free-flowing non-aqueous liquid phase at standard conditions of temperature and pressure (i.e., that portion of the product not dissolved in water or adhering to soil).

(42) Gathering lines--Any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

(43) Hazardous substance--Any substance defined or listed in the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), §101(14) (42 United States Code, §§9601, *et seq.*), and which is not regulated as a hazardous waste under the federal Solid Waste Disposal Act, Subtitle C (42 United States Code, §§6921, *et seq*.).

(44) Hazardous substance underground storage tank (UST) system--A UST system that contains an accumulation of either a hazardous substance, a mixture of two or more hazardous substances, or a mixture of one or more petroleum substances with one or more hazardous substances, and which does not meet the definition of a petroleum UST system in this section.

(45) Heating oil--A petroleum substance which is typically used in the operation of heating, boiler, or furnace equipment and which either is one of the following seven technical grades of fuel oil: Number 1, Number 2, Number 4-light, Number 4-heavy, Number 5-light, Number 5-heavy, and Number 6; is a residual fuel oil derivative of the refining process (such as Navy Special and Bunker C residual fuel oils); or is another fuel (such as kerosene or diesel) used for heating purposes as a substitute for one of the fuel oils or residual fuel oil derivatives listed in this paragraph.

(46) Hydraulic fluid--Any regulated substance that is normally used in a hydraulic lift system.

(47) Hydraulic lift tank--A tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air and hydraulic fluid to operate lifts, elevators, or other similar devices.

(48) Impressed current system--A method of cathodic protection where a rectifier is used to convert alternating current to direct current, where the current then flows in a controlled electrically connected circuit to non-sacrificial anodes, then through the surrounding soil or backfill to the protected metallic structure or component, and back to the rectifier.

(49) In operation--The description of an in-service underground storage tank which is currently being used on a regular basis for its intended purpose.

(50) In service--The status of an underground storage tank (UST) beginning at the time that regulated substances are first placed into the tank and continuing until the tank is permanently removed from service by means of either removal from the ground, abandonment in-place, or change-in-service. An in-service UST may or may not contain regulated substances, and may be either in operation or out of operation at any specific time.

(51) Installer--A person who participates in or supervises the installation, repair, or removal of underground storage tanks.

(52) Inventory control--Techniques used to identify a loss of product that are based on volumetric measurements in the tank and reconciliation of those measurements with product delivery and withdrawal records.

(53) Jacketed tank--A factory-constructed tank consisting of a single-wall or double-wall steel internal (or primary) tank that is completely enclosed in an external secondary-containment jacket made of noncorrodible material, and which is designed so that releases of stored substances from the internal tank can be contained and monitored within a liquid-tight interstitial space between the internal tank and the external jacket.

(54) Lender--A state or national bank; a state or federal savings bank; a credit union; a state or federal savings and loan association; a state or federal government agency that customarily provides financing; or an entity that is registered with the Office of Consumer Credit Commissioner under Chapter 7, Title 79, Revised Statutes (Texas Civil Statutes, Article 5069-7.01, *et seq.*) if the entity is regularly engaged in the business of extending credit and if extending credit represents the majority of the entity's total business activity.

(55) Liquid trap--A collection device (such as a sump, well cellar, and other trap) which is used in association with oil and gas production, gathering, and extraction operations (including gas production plants) for the purpose of collecting oil, water, and other liquids, and which either may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

(56) Leaking petroleum storage tank (LPST) site--A site at which a confirmed release of a petroleum substance from an underground storage tank or aboveground storage tank has occurred. Petroleum substance contamination which results from multiple sources may be deemed as one LPST site by the agency.

(57) Maintenance--The normal and routine operational upkeep of underground storage tank systems necessary for the prevention of releases of stored regulated substances.

(58) Monitoring well--An artificial excavation constructed to measure or monitor the quantity or movement of substances, elements, chemicals, or fluids below the surface of the ground. The term does not include any monitoring well which is used in conjunction with the production of oil, gas, or any other minerals.

(59) Motor fuel--A petroleum substance which is typically used for the operation of internal combustion engines (including stationary engines and engines used in motor vehicles, aircraft, and marine vessels), and which is one of the following types of fuels: motor gasoline, aviation gasoline, Number 1 diesel fuel, Number 2 diesel fuel, or gasohol.

(60) NACE--NACE International (formerly National Association of Corrosion Engineers), a nationally recognized organization which provides certifications and standards for corrosion protection services.

(61) New underground storage tank (UST) system--A UST system which is used or designed to contain an accumulation of regulated substances for which installation commenced after December 22, 1988; or an underground storage system which is converted from the storage of materials other than regulated substances to the storage of regulated substances after December 22, 1988.

(62) NFPA--National Fire Protection Association, a nationally recognized organization which provides certifications and standards for fire protection equipment and services.

(63) Non-aqueous phase liquid (NAPL)--See "Free product (or non-aqueous phase liquid)" as defined in this section.

(64) Non-commercial purposes--(With respect to motor fuel) all purposes except resale.

(65) Noncorrodible material--A material used in the construction, maintenance, or upgrading of any component of an underground storage tank (UST) system which is designed to retain its physical and chemical properties without significant deterioration or failure for the operational life of the UST system when placed in contact with (and subjected to the resulting electrical and chemical forces associated with) any surrounding soil, backfill, or groundwater, any connected components constructed of dissimilar material, or the stored regulated substance.

(66) Observation well--A monitoring well or other vertical tubular structure which is constructed, installed, or placed within any portion of an underground storage tank excavation zone (including the tank hole and piping trench), and which is designed or used for the observation or monitoring of groundwater, or for the observation, monitoring, recovery, or withdrawal of either released regulated substances (in liquid or vapor phase) or groundwater contaminated by such released regulated substances.

(67) Occurrence--An incident, including continuous or repeated exposure to conditions, which results in a release from an underground storage tank or aboveground storage tank or tank system.

(68) On the premises where stored--(With respect to heating oil) refers to the consumptive use of heating oil on the same property or site where the heating oil is stored.

(69) Operational life--The actual or anticipated service life of an underground storage tank system, which begins when regulated substances are first placed into the tank system and which continues until the tank system is permanently removed from service by means of either removal from the ground, abandonment in-place, or change-in-service.

(70) Operator--Any person in day-to-day control of, and having responsibility for, the daily operation of the underground storage tank system or the aboveground storage tank system, as applicable.

(71) Out of operation--The description of an in-service underground storage tank which is not currently being used on a regular basis for its intended purpose.

(72) Overfill--A release that occurs when an underground storage tank system is filled beyond its capacity, thereby resulting in a discharge of a regulated substance to the surface or subsurface environment.

(73) Owner--Any person who holds legal possession or ownership of an interest in an underground storage tank system or an aboveground storage tank. For the purposes of this chapter, if the actual ownership of a UST system or a AST is uncertain, unknown, or in dispute, the fee simple owner of the surface estate of the tract on which the UST system or the AST is located is considered the UST system or AST owner unless that person can demonstrate by appropriate documentation, including a deed reservation, invoice, bill of sale, or by other legally acceptable means that the UST system or AST is owned by another person. A person who has registered as an owner of a UST system or AST with the commission under §334.7 of this title (relating to Registration for Underground Storage Tanks (USTs) and UST Systems) (or a preceding rule section concerning tank registration) after September 1, 1987, shall be considered the UST system owner and/or AST owner until such time as documentation demonstrates to the executive director's satisfaction that the legal interest in the UST system or AST was transferred to a different person subsequent to the date of the tank registration. This definition is subject to the limitations found in TWC, §26.3514, Limits on Liability of Lender; §26.3515, Limits on Liability of Corporate Fiduciary; and §25.3516, Limits on Liability of Taxing Unit.

(74) PEI--Petroleum Equipment Institute, a nationally recognized organization which provides certifications and standards for petroleum equipment and services.

(75) Permanent removal from service--The termination of the use and the operational life of an underground storage tank by means of either removal from the ground, abandonment in-place, or change-in-service.

(76) Person--An individual, trust, firm, joint-stock company, corporation, government corporation, partnership, association, state, municipality, commission, political subdivision of a state, an interstate body, a consortium, joint venture, commercial entity, or the United States government.

(77) Petroleum marketing facilities--All facilities at which a petroleum substance is produced or refined and all facilities from

which a petroleum substance is sold or transferred to other petroleum substance marketers or to the public.

(78) Petroleum marketing firms--All firms owning petroleum marketing facilities. Firms owning other types of facilities with underground storage tanks as well as petroleum marketing facilities are considered to be petroleum marketing firms.

(79) Petroleum product--A petroleum substance obtained from distilling and processing crude oil that is liquid at standard conditions of temperature and pressure, and that is capable of being used as a fuel for the propulsion of a motor vehicle or aircraft, including, but not limited to, motor gasoline, gasohol, other alcohol blended fuels, aviation gasoline, kerosene, distillate fuel oil, and Number 1 and Number 2 diesel. The term does not include naphtha-type jet fuel, kerosene-type jet fuel, or a petroleum product destined for use in chemical manufacturing or feedstock of that manufacturing.

(80) Petroleum storage tank--

(A) Any one or combination of aboveground storage tanks that contain petroleum products and that are regulated by the commission; or

(B) Any one or combination of underground storage tanks and all connecting underground pipes that contain petroleum products and that are regulated by the commission.

(81) Petroleum substance--A crude oil or any refined or unrefined fraction or derivative of crude oil which is liquid at standard conditions of temperature and pressure (except for any substance regulated as a hazardous waste under the federal Solid Waste Disposal Act, Subtitle C (42 United States Code, §§6921, *et seq*.)). For the purposes of this chapter, a petroleum substance is limited to one or a combination of the substances or mixtures in the following list:

(A) basic petroleum substances--crude oils, crude oil fractions, petroleum feedstocks, and petroleum fractions;

(B) motor fuels--(see definition for "Motor fuel" in this section);

(C) aviation gasolines--(e.g., Grade 80, Grade 100, and Grade 100-LL);

(D) aviation jet fuels--(e.g., Jet A, Jet A-1, Jet B, JP-4, JP-5, and JP-8);

(E) distillate fuel oils--(e.g., Number 1-D, Number 1, Number 2-D, and Number 2);

(F) residual fuel oils--(e.g., Number 4-D, Number 4-light, Number 4, Number 5-light, Number 5-heavy, and Number 6);

(G) gas-turbine fuel oils--(e.g., Grade O-GT, Grade 1-GT, Grade 2-GT, Grade 3-GT, and Grade 4-GT);

(H) illuminating oils--(e.g., kerosene, mineral seal oil, long-time burning oils, 300 oil, and mineral colza oil);

(I) solvents--(e.g., Stoddard solvent, petroleum spirits, mineral spirits, petroleum ether, varnish makers' and painters' naphthas, petroleum extender oils, and commercial hexane);

(J) lubricants--automotive and industrial lubricants;

(K) building materials--(e.g., liquid asphalt and dust-laying oils);

(L) insulating and waterproofing materials--(e.g., transformer oils and cable oils); or

(M) used oils--(see definition for "Used oil" in this section).

(82) Petroleum underground storage tank (UST) system--A UST system that contains, has contained, or will contain a petroleum substance (as defined in this section), a mixture of two or more petroleum substances, or a mixture of one or more petroleum substances with very small amounts of one or more hazardous substances. In order for a UST system containing a mixture of petroleum substances with small amounts of hazardous substances to be classified as a petroleum UST system, the hazardous substance must be at such a dilute concentration that the overall release detectability, effectiveness of corrective action, and toxicity of the basic petroleum substance is not altered to any significant degree.

(83) Pipeline facilities (including gathering lines)--New and existing pipeline rights-of-way, including any equipment, facilities, or buildings therein which are used in the transportation or associated treatment (during transportation) of gas or hazardous liquids (which include petroleum and other liquids as designated by the Secretary of the United States Department of Transportation), and which are regulated under the federal Natural Gas Pipeline Safety Act of 1968 (49 United States Code App. 1671, *et seq*.); the federal Hazardous Liquid Pipeline Safety Act of 1979 (49 United States Code App. 2001, *et seq*.); or (for intrastate pipeline facilities) the Texas Natural Resources Code, Chapters 111 or 117, or Texas Civil Statutes, Articles 6053-1 and 6053-2.

(84) Piping--All underground pipes in an underground storage tank system, including valves, elbows, joints, flanges, flexible connectors, and other fittings attached to a tank system through which regulated substances flow or in which regulated substances are contained or stored.

(85) Piping trench--The portion of the excavation zone at an underground storage tank facility which contains the piping system and associated backfill materials.

(86) Pressurized piping--Product or delivery piping in an underground storage tank system which typically operates at greater than atmospheric pressure.

(87) Professional engineer--A person who is currently duly licensed by the Texas Board of Professional Engineers to engage in the practice of engineering in the State of Texas.

(88) Professional geoscientist--A person who is currently duly licensed by the Texas Board of Professional Geoscientists to engage in the public practice of geoscience in the State of Texas.

(89) Qualified personnel--Persons who possess the appropriate competence, skills, and ability (as demonstrated by sufficient education, training, experience, and/or, when applicable, any required certification or licensing) to perform a specific activity in a timely and complete manner consistent with the applicable regulatory requirements and generally accepted industry standards for such activity.

(90) Radioactive materials--Radioactive substances or radioactive waste materials (e.g., high-level radioactive wastes and low-level radioactive cooling waters) which are classified as hazardous substances under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), §101(14), 42 United States Code, §§9601, *et seq*., except for radioactive materials regulated as a hazardous waste under the federal Solid Waste Disposal Act, Subtitle C, 42 United States Code, §§6921, *et seq*.

(91) Regulated substance--An element, compound, mixture, solution, or substance that, when released into the environment, may present substantial danger to the public health, welfare, or the environment. For the purposes of this chapter, a regulated substance is limited to any hazardous substance (as defined in this section), any petroleum substance (as defined in this section), any mixture of two

or more hazardous substances and/or petroleum substances, and any other substance designated by the commission to be regulated under the provisions of this chapter.

(92) Release--Any spilling including overfills, leaking, emitting, discharging, escaping, leaching, or disposing from an underground storage tank or aboveground storage tank into groundwater, surface water, or subsurface soils.

(93) Release detection--The process of determining whether a release of a regulated substance is occurring, or has occurred, from an underground storage tank system.

(94) Repair--The restoration, renovation, or mending of a damaged or malfunctioning tank or underground storage tank system component.

(95) Residential tank--A tank located on property used primarily for dwelling purposes.

(96) Retail service station--A facility where flammable liquids used as motor fuels are stored and dispensed from fixed equipment into the fuel tanks of motor vehicles and where such dispensing is an act of retail sale.

(97) Risk-based corrective action--Site assessment or site remediation, the timing, type, and degree of which is determined according to case-by-case consideration of actual or potential risk to public health from environmental exposure to a regulated substance released from a leaking underground storage tank or aboveground storage tank.

(98) Secondary containment--A containment method by which a secondary wall, jacket, or barrier is installed around the primary storage vessel (e.g., tank or piping) in a manner designed to prevent a release from migrating beyond the secondary wall or barrier before the release can be detected. Secondary containment systems include, but are not limited to: double-wall tank and/or piping systems, impervious liners, jackets, containment boots, sumps, or vaults surrounding a primary (single-wall) tank and/or piping system.

(99) Septic tank--A water-tight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer.

(100) Spill--A release of a regulated substance which results during the filling, placement, or transfer of regulated substances into an underground storage tank (UST) or an aboveground storage tank (AST), or during the transfer or removal of regulated substances from a UST system or an AST.

(101) Standard conditions of temperature and pressure--A temperature of 60 degrees Fahrenheit and an atmospheric pressure of 14.7 pounds per square inch absolute.

(102) STI--Steel Tank Institute, a nationally recognized organization which provides certifications and standards for steel tanks.

(103) Stormwater collection system--The piping, pumps, conduits, and any other equipment necessary to collect and transport surface water runoff resulting from precipitation to and from retention areas and into natural or man-made drainage channels.

(104) Suction piping--Product or delivery piping in an underground storage tank system which typically operates below atmospheric pressure.

(105) Sump--Any man-made pit or reservoir that meets the definition of a tank (including any connected troughs or trenches) that serves to collect and temporarily store regulated substances.

(106) Surface impoundment--A natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials (but possibly lined with man-made materials) that is designed to hold an accumulation of regulated substances.

(107) Tank--A stationary device (generally exclusive of any associated ancillary equipment) designed or used to contain an accumulation of regulated substances which is constructed of a non-earthen material (e.g., concrete, steel, or plastic) that provides structural support.

(108) Tank hole--The portion of the excavation zone at an underground storage tank facility which contains the tanks and associated backfill materials.

(109) Tank system--An underground storage tank system.

(110) Temporary removal from service--The procedure by which an underground storage tank system may be temporarily taken out of operation without being permanently removed from service.

(111) Tightness test (or tightness testing)--A procedure for testing and analyzing a tank or piping system to determine whether the system(s) is capable of preventing the inadvertent release of a stored substance into the environment.

(112) UL--Underwriters Laboratories, Inc., a nationally recognized organization which provides certifications and standards for consumer products and services.

(113) Underground area--An underground room, basement, cellar, shaft, or vault, which provides enough space for physical inspection of the exterior of a tank or tank system situated on or above the surface of the floor.

(114) Underground storage tank--Any one or combination of underground tanks and any connecting underground pipes used to contain an accumulation of regulated substances, the volume of which, including the volume of the connecting underground pipes, is 10% or more beneath the surface of the ground.

(115) Underground storage tank system--An underground storage tank, all associated underground piping and underground ancillary equipment, spill and overfill prevention equipment, release detection equipment, corrosion protection system, secondary containment equipment (as applicable), and all other related systems and equipment.

(116) Unsaturated zone--The subsurface zone containing water under pressure less than that of the atmosphere (including water held by capillary forces within the soil) and containing air or gases generally under atmospheric pressure. This zone is bounded at the top by the ground surface and at the bottom by the upper surface of the zone of saturation (i.e., the water table).

(117) Upgrading--The addition, improvement, retrofitting, or renovation of an existing underground storage tank system with equipment or components as required to meet the corrosion protection, spill and overfill prevention, and release detection requirements of this chapter.

(118) Used oil--Any oil or similar petroleum substance that has been refined from crude oil, used for its designed or intended purposes, and contaminated as a result of such use by physical or chemical impurities; and including spent motor vehicle and aircraft lubricating oils (e.g., car and truck engine oil, transmission fluid, and brake fluid), spent industrial oils (e.g., compressor, turbine, bearing, hydraulic, metalworking, gear, electrical, and refrigerator oils), and spent industrial process oils.

(119) UST--An underground storage tank (as defined in this section).

(120) UST system--An underground storage tank system (as defined in this section).

(121) Vent lines--All pipes including valves, elbows, joints, flanges, flexible connectors, and other fittings attached to a tank system, which are intended to convey the vapors emitted from a regulated substance stored in an underground storage tank to the atmosphere.

(122) Wastewater collection system--The piping, pumps, conduits, and any other equipment necessary to collect and transport domestic, commercial, or industrial wastewater to and from any facilities or areas where treatment of such wastewater is designated to occur.

(123) Wastewater treatment tank--A tank that is designed to receive and treat an influent wastewater through physical, chemical, or biological methods.

§334.10. Reporting and Recordkeeping.

(a) Reporting. Owners and operators of underground storage tank (UST) systems must assure that all reporting and filing requirements in this chapter are met, including the following (as applicable):

(1) construction notification, in accordance with §334.6 of this title (relating to Construction Notification for Underground Storage Tanks (USTs) and UST Systems);

(2) application for approval of any proposed UST system in the Edwards Aquifer recharge or transition zones, in accordance with §334.6(a)(2) of this title and Chapter 213 of this title (relating to Edwards Aquifer);

(3) registration of UST systems and changes in information, in accordance with §334.7 of this title (relating to Registration for Underground Storage Tanks (USTs) and UST Systems);

(4) certification of construction activities, financial assurance, and compliance self-certification in accordance with §334.8 of this title (relating to Certification for Underground Storage Tanks (USTs) and UST Systems);

(5) request for approval of any variance or alternative procedure, in accordance with §334.43 of this title (relating to Variances and Alternative Procedures);

(6) documentation of release determination or site assessment conducted when a UST system is permanently removed from service, in accordance with §334.55(a)(6) of this title (relating to Permanent Removal from Service);

(7) payment of UST fees, in accordance with Subchapter B of this chapter (relating to Underground Storage Tank Fees);

(8) reports, plans, and certifications related to suspected and confirmed releases of regulated substances, including:

(A) release reports and notifications, in accordance with §334.72 of this title (relating to Reporting of Suspected Releases), §334.75 of this title (relating to Reporting and Cleanup of Surface Spills and Overfills), and §334.76 of this title (relating to Initial Response to Releases);

(B) report and certification of site check methods, in accordance with §334.74(c) of this title (relating to Release Investigation and Confirmation Steps);

(C) initial abatement report, in accordance with §334.77(b) of this title (relating to Initial Abatement Measures and Site Check);

(D) initial site assessment report, in accordance with §334.78(b) of this title (relating to Site Assessment);

(E) non-aqueous phase liquid removal report, in accordance with §334.79(d) of this title (relating to Removal of Non-Aqueous Phase Liquids (NAPLs));

(F) soil and groundwater contamination information, in accordance with §334.80(b) of this title (relating to Investigation for Soil and Groundwater Cleanup);

(G) corrective action plan, in accordance with §334.81 of this title (relating to Corrective Action Plan);

(H) notification of cleanup initiation, in accordance with §334.81(e) of this title;

(I) certification of compliance with corrective action plan, in accordance with §334.81(g) of this title; and

(J) public notices related to corrective action plans, in accordance with §334.82(b) of this title (relating to Public Participation);

(9) notifications and reports relating to financial assurance requirements, in accordance with Chapter 37, Subchapter I of this title (relating to Financial Assurance for Petroleum Underground Storage Tank Systems); and

(10) any other reports, filings, notifications, or other submittals required by this chapter, or otherwise required by the agency to demonstrate compliance with the provisions of this chapter. When agency requirements specify documents that must be prepared by, or prepared under, the supervision of a duly licensed professional engineer, a duly licensed professional geoscientist, or a duly licensed professional surveyor, those documents must be prepared in accordance with all requirements of statute and rule applicable to that respective professional.

(b) Recordkeeping.

(1) General recordkeeping requirements.

(A) Owners and operators of UST systems are responsible for developing and maintaining all records required by the provisions of this chapter.

(B) Except as provided in subparagraphs (C) and (D) of this paragraph, legible copies of all required records pertaining to a UST system must be maintained in a secure location on the premises of the UST facility, must be immediately accessible for reference and use by the UST system operator, and must be immediately available for inspection upon request by agency personnel.

(C) Except as provided in clause (v) of this subparagraph, in the event that copies of the required records cannot reasonably be maintained on the premises of the UST facility, then such records may be maintained at a readily accessible alternate site, provided that the following conditions are met.

(i) If the UST system is in operation, the records must be readily accessible for reference and use by the UST system operator.

(ii) The records must be readily accessible and available for inspection upon request by agency personnel.

(iii) The owner or operator must provide the following information (in writing) to the agency's central office and to the agency's appropriate regional office:

(I) the specific location where the required records are maintained; and

(II) the name, address, and telephone number of the authorized custodian of such records.

(iv) The filing of the written information required in clause (iii) of this subparagraph must be accomplished no later than October 29, 1989, 30 days after a UST installation or replacement has been completed, or 30 days after the UST records are moved to an alternate site, whichever is later or applicable, as provided in §334.7(d) of this title.

(v) The conditional authorization otherwise allowed under this subparagraph for records maintenance at an alternative, off-premises location is not applicable to the UST delivery certificate (or temporary delivery authorization, if applicable) issued by the agency under §334.8(c) of this title. This UST delivery certificate must be maintained on the premises of all facilities with regulated USTs, must be posted by the UST system operator, and must be visible to the person(s) performing deliveries to the UST system.

(D) For UST systems which have been permanently removed from service in accordance with the applicable provisions of §334.55 of this title, the facility owner may submit the appropriate records required by this chapter to the agency in lieu of maintaining the records on the premises or at an alternative site, provided that the following conditions are met:

(i) the facility is no longer operated in a manner that requires the underground storage of regulated substances, and all UST systems at the facility have been permanently removed from service;

(ii) the facility owner must provide written justification adequate to explain why such records cannot be maintained on the premises of the UST facility or at a readily accessible alternative site; and

(iii) the records must be submitted at one time in one package for each UST facility, and the records must be appropriately labeled with the UST facility location information and the UST facility identification number.

(2) Required records and documents. Owners and operators of UST systems must assure that all recordkeeping requirements in this chapter are met, including the following records and documentation (as applicable).

(A) Legible copies of the following general records must be maintained for the operational life of the UST system:

(i) original and amended registration documents, in accordance with §334.7 of this title;

(ii) original and amended certifications for UST installations and financial assurance, in accordance with §334.8 of this title;

(iii) notification to UST purchaser, in accordance with §334.9 of this title (relating to Seller's Disclosure).

(B) Legible copies of applicable records and documents related to technical standards for UST systems must be maintained in accordance with the following provisions:

(i) application documents and the agency's approval letter for any variances or alternative procedures, in accordance with §334.43 of this title;

(ii) records demonstrating compliance with technical standards and installation standards for new UST systems, in accordance with §334.45(f) of this title (relating to Technical Standards for New Underground Storage Tank Systems) and §334.46(i) of this title (relating to Installation Standards for New Underground Storage Tank Systems);

(iii) records demonstrating compliance with the minimum upgrading requirements for existing UST systems, in accordance with §334.47(d) of this title (relating to Technical Standards for Existing Underground Storage Tank Systems);

(iv) operation and maintenance records, in accordance with §334.48(g) of this title (relating to General Operating and Management Requirements);

(v) corrosion protection records, in accordance with §334.49(e) of this title (relating to Corrosion Protection);

(vi) release detection records, in accordance with §334.50(e) of this title (relating to Release Detection);

(vii) spill and overfill control records, in accordance with §334.51(c) of this title (relating to Spill and Overfill Prevention and Control);

(viii) records for repairs and relining of a UST system, in accordance with §334.52(d) of this title (relating to Underground Storage Tank System Repairs and Relining);

(ix) records for reuse of used tanks, in accordance with §334.53(c) of this title (relating to Reuse of Used Tanks);

(x) records for temporary removal of UST systems from service, in accordance with §334.54(f)(4) of this title (relating to Temporary Removal from Service);

(xi) records for permanent removal of UST systems from service, in accordance with §334.55(f) of this title.

(C) Legible copies of all required financial assurance records must be maintained in accordance with the applicable provisions of Chapter 37, Subchapter I of this title.

(D) Legible copies of previous and current registration and self-certification forms required to be filed annually with the agency under §334.8(c) of this title, as well as UST delivery certificates, must be maintained for at least five years from the original date of submittal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. TECHNICAL STANDARDS

30 TAC §§334.46, 334.50, 334.55, 334.56

STATUTORY AUTHORITY

The amendments are adopted under TWC, §5.103, which provides the commission authority to adopt any rules necessary to carry out its powers and duties under this code and other laws of this state and to adopt rules repealing any statement of general

applicability that interprets law or policy; §5.105, which authorizes the commission to establish and approve all general policy of the commission by rule; and §26.011, which requires the commission to control the quality of water by rule. The amended sections are also adopted under TWC, §26.345, which provides the commission authority to develop a regulatory program and to adopt rules regarding USTs; §26.351, which directs the commission to adopt rules establishing the requirements for taking corrective action in response to a release from a UST or an AST; and §26.3573, which allows the commission to use funds from the PST remediation account to reimburse an eligible owner or operator or insurer for the expenses of corrective action or to pay the claim of a contractor hired by an eligible owner or operator to perform corrective action.

§334.50. Release Detection.

(a) General requirements.

(1) Owners and operators of new and existing underground storage tank (UST) systems shall provide a method, or combination of methods, of release detection which shall be:

(A) capable of detecting a release from any portion of the UST system which contains regulated substances including the tanks, piping, and other underground ancillary equipment;

(B) installed, calibrated, operated, maintained, utilized, and interpreted (as applicable) in accordance with the manufacturer's and/or methodology provider's specifications and instructions consistent with the other requirements of this section, and by personnel possessing the necessary experience, training, and competence to accomplish such requirements; and

(C) capable of meeting the particular performance requirements of such method (or methods) as specifically prescribed in this section, based on the performance claims by the equipment manufacturer or methodology provider/vendor, as verified by third-party evaluation conducted by a qualified independent testing organization, using applicable United States Environmental Protection Agency protocol, provided that the following additional requirements shall also be met.

(i) Any performance claims, together with their bases or methods of determination including the summary portion of the independent third-party evaluation, shall be obtained by the owner and/or operator from the equipment manufacturer, methodology provider, or installer and shall be in writing.

(ii) When any of the following release detection methods are used on or after December 22, 1990 (except for methods permanently installed and in operation prior to that date), such method shall be capable of detecting the particular release rate or quantity specified for that method such that the probability of detection shall be at least 95% and the probability of false alarm shall be no greater than 5.0%:

(I) tank tightness testing, as prescribed in subsection (d)(1)(A) of this section;

(II) automatic tank gauging, as prescribed in subsection (d)(4) of this section;

(III) automatic line leak detectors for piping, as prescribed in subsection (b)(2)(A)(i) of this section;

(IV) piping tightness testing, as prescribed in subsection (b)(2)(A)(ii)(I) of this section;

(V) electronic leak monitoring systems for piping, as prescribed in subsection (b)(2)(A)(ii)(III) of this section; and

(VI) statistical inventory reconciliation (SIR), as prescribed in subsection (d)(9) of this section.

(2) When a release detection method operated in accordance with the particular performance standards for that method indicates that a release either has or may have occurred, the owners and operators shall comply with the applicable release reporting, investigation, and corrective action requirements in Subchapter D of this chapter (relating to Release Reporting and Corrective Action).

(3) Owners and operators of all UST systems shall comply with the release detection requirements of this section in accordance with the applicable schedules in §334.44 of this title (relating to Implementation Schedules).

(4) As prescribed in §334.47(a)(2) of this title (relating to Technical Standards for Existing Underground Storage Tank Systems), any existing UST system that cannot be equipped or monitored with a method of release detection that meets the requirements of this section shall be permanently removed from service in accordance with the applicable procedures in §334.55 of this title (relating to Permanent Removal from Service) no later than 60 days after the implementation date for release detection as prescribed by the applicable schedules in §334.44 of this title.

(5) Any owner or operator who plans to install a release detection method for a UST system shall comply with the applicable construction notification requirements in §334.6 of this title (relating to Construction Notification for Underground Storage Tanks (USTs) and UST Systems), and upon completion of the installation of such method shall also comply with the applicable registration and certification requirements of §334.7 of this title (relating to Registration for Underground Storage Tanks (USTs) and UST Systems) and §334.8 of this title (relating to Certification for Underground Storage Tanks (USTs) and UST Systems).

(6) Any equipment installed or used for conducting release detection for a UST system shall be listed, approved, designed, and operated in accordance with standards developed by a nationally recognized association or independent testing laboratory (e.g., UL) for such installation or use, as specified in §334.42(d) of this title (relating to General Standards).

(7) For a UST system to be placed temporarily out-of-service, the owner or operator must comply with the requirements of §334.54(c) of this title (relating to Temporary Removal from Service).

(b) Release detection requirements for all UST systems. Owners and operators of all UST systems shall ensure that release detection equipment or procedures are provided in accordance with the following requirements.

(1) Release detection requirements for tanks.

(A) Except as provided in subparagraphs (B) and (C) of this paragraph and in subsection (d)(9) of this section, all tanks shall be monitored in a manner which will detect a release at a frequency of at least once every month (not to exceed 35 days between each monitoring) by using one or more of the release detection methods described in subsection (d)(4) - (10) of this section).

(B) A combination of tank tightness testing and inventory control in accordance with subsection (d)(1) of this section may be used as an acceptable release detection method for tanks only until December 22, 1998, and the required frequency of the tank tightness test shall be based on the following criteria.

(i) A tank tightness test shall be conducted at least once each year for any tank in an existing UST system which is not

being operated in violation of the upgrading or replacement schedule in §334.44(b) of this title, but has not yet been either:

(I) replaced with a UST system meeting the applicable technical and installation standards in §334.45 of this title (relating to Technical Standards for New Underground Storage Tank Systems) and §334.46 of this title (relating to Installation Standards for New Underground Storage Tank Systems); or

(II) retrofitted or equipped in accordance with the minimum upgrading requirements applicable to existing UST systems in §334.47 of this title.

(ii) A tank tightness test shall be conducted at least once every five years for any tank in a UST system which has been either:

(I) installed in accordance with the applicable technical standards for new UST systems in §334.45 and §334.46 of this title; or

(II) retrofitted or equipped in accordance with the minimum upgrading requirements applicable to existing UST systems in §334.47 of this title.

(C) The manual tank gauging method of release detection, as prescribed in subsection (d)(2) of this section, may be used as the sole release detection system only for a petroleum substance tank with a nominal capacity of 1,000 gallons or less. The monthly tank gauging method of release detection, as prescribed in subsection (d)(3) of this section, may be used as the sole release detection system only for emergency generator tanks.

(D) In addition to the requirements in subparagraphs (A) - (C) of this paragraph, any tank in a hazardous substance UST system shall also be equipped with a secondary containment system and related release detection equipment, as prescribed in subsection (c) of this section.

(2) Release detection for piping. Piping in a UST system shall be monitored in a manner which will detect a release from any portion of the piping system, in accordance with the following requirements.

(A) Requirements for pressurized piping. UST system piping that conveys regulated substances under pressure shall be in compliance with the following requirements.

(i) Each separate pressurized line shall be equipped with an automatic line leak detector meeting the following requirements.

(ii) In addition to the required line leak detector prescribed in clause (i) of this subparagraph, each pressurized line shall also be tested or monitored for releases in accordance with at least one of the following methods.

(I) The piping may be tested at least once per year by means of a piping tightness test conducted in accordance with a code or standard of practice developed by a nationally recognized association or independent testing laboratory. Any such piping tightness test shall be capable of detecting any release from the piping system of 0.1 gallons per hour when the piping pressure is at 150% of normal operating pressure.

(II) The line leak detector shall be capable of alerting the UST system operator of any release within one hour of occurrence either by shutting off the flow of regulated substances, or by substantially restricting the flow of regulated substances.

(III) The line leak detector shall be tested at least once per year for performance and operational reliability and shall be properly calibrated and maintained, in accordance with the manufacturer's specifications and recommended procedures.

(ii) In addition to the required line leak detector prescribed in clause (i) of this subparagraph, each pressurized line shall also be tested or monitored for releases in accordance with at least one of the following methods.

(I) The piping may be tested at least once per year by means of a piping tightness test conducted in accordance with a code or standard of practice developed by a nationally recognized association or independent testing laboratory. Any such piping tightness test shall be capable of detecting any release from the piping system of 0.1 gallons per hour when the piping pressure is at 150% of normal operating pressure.

(II) Except as provided in subsection (d)(9) of this section, the piping may be monitored for releases at least once every month (not to exceed 35 days between each monitoring) by using one or more of the release detection methods prescribed in subsection (d)(5) - (10) of this section.

(III) The piping may be monitored for releases at least once every month (not to exceed 35 days between each monitoring) by means of an electronic leak monitoring system capable of detecting any release from the piping system of 0.2 gallons per hour at normal operating pressure.

(B) Requirements for suction piping and gravity flow piping.

(i) Except as provided in clause (ii) of this subparagraph, each separate line in a UST piping system that conveys regulated substances either under suction or by gravity flow shall meet at least one of the following requirements.

(I) Each separate line may be tested at least once every three years by means of a positive or negative pressure tightness test applicable to underground product piping and conducted in accordance with a code or standard of practice developed by a nationally recognized association or independent testing laboratory. Any such piping test shall be capable of detecting any release from the piping system of 0.1 gallons per hour.

(II) Each line may be monitored for releases at least once every month (not to exceed 35 days between each monitoring) by using one or more of the release detection methods prescribed in subsection (d)(5) - (10) of this section.

(ii) No release detection methods are required to be installed or applied for any piping system that conveys regulated substances under suction when such suction piping system is designed and constructed in accordance with the following standards:

(I) the below-grade piping operates at less than atmospheric pressure;

(II) the below-grade piping is sloped so that all the contents of the pipe will drain back into the storage tank if the suction is released;

(III) only one check valve is included in each suction line;

(IV) the check valve is located aboveground, directly below and as close as practical to the suction pump; and

(V) verification that the requirements under subclauses (I) - (IV) of this clause have been met can be provided in the form of:

(-a-) signed as-built drawings or plans provided by the installer or by a professional engineer who is duly licensed to practice in Texas; or

(-b-) signed written documentation provided by a UST contractor who is properly registered with the agency, by a UST installer who is properly licensed with the agency, or by a professional engineer who is duly licensed to practice in Texas.

(C) Monitoring secondary containment. In addition to the requirements in subparagraphs (A) and (B) of this paragraph, all piping in a hazardous substance UST system shall also be equipped with a secondary containment system and related release detection equipment, as prescribed in subsection (c) of this section.

(c) Additional release detection requirements for hazardous substance UST systems. In addition to the release detection requirements for all UST systems prescribed in subsections (a) and (b) of this section, owners and operators of all hazardous substance UST systems shall also assure compliance with the following additional requirements.

(1) All new hazardous substance UST systems shall be in compliance with the requirements of paragraph (3) of this subsection for the entire operational life of the system.

(2) All existing hazardous substance UST systems shall be brought into compliance with the requirements of paragraph (3) of this subsection no later than December 22, 1998.

(3) Secondary containment and monitoring.

(A) All hazardous substance UST systems (including tanks and piping) shall be equipped with a secondary containment system which shall be designed, constructed, installed, and maintained in accordance with §334.45(d) and §334.46(f) of this title.

(B) All hazardous substance UST systems (including tanks and piping) shall include one or more of the release detection methods or equipment prescribed in subsection (d)(7) - (10) of this section, which shall be capable of monitoring the space between the primary tank and piping walls and the secondary containment wall or barrier.

(d) Allowable methods of release detection. Tanks in a UST system may be monitored for releases using one or more of the methods included in paragraphs (2) - (10) of this subsection. Piping in a UST system may be monitored for releases using one or more of the methods included in paragraphs (5) - (10) of this subsection. Any method of release detection for tanks and/or piping in this section shall be allowable only when installed (or applied), operated, calibrated, and maintained in accordance with the particular requirements specified for such method in this subsection.

(1) Tank tightness testing and inventory control. A combination of tank tightness testing and inventory control may be used as a tank release detection method only until December 22, 1998, subject to the following conditions and requirements.

(A) Tank tightness test. Any tank tightness test shall be conducted in conformance with the following standards.

(i) The tank tightness test shall be conducted in accordance with a code or standard of practice developed by a nationally recognized association or independent testing laboratory.

(ii) The tank tightness test shall be performed by qualified personnel who possess the requisite experience, training, and competence to conduct the test properly, who are present at the facility and who maintain responsible oversight throughout the entire testing procedure, and who have been certified by the manufacturer or developer of the testing equipment as being qualified to perform the test. The tank tightness test shall be conducted in strict accordance with the testing procedures developed by the system manufacturer or developer.

(iii) The tank tightness test shall be capable of detecting a release of 0.1 gallons per hour from any portion of the tank which contains regulated substances.

(iv) The tank tightness test shall be performed in a manner that will account for the effects of vapor pockets, thermal expansion or contraction of the stored substance, temperature of the stored substance, temperature stratification, evaporation or condensation, groundwater elevation, pressure variations within the system, tank end deflection, tank deformation, and any other factors that could affect the accuracy of the test procedures.

(B) Inventory control. All inventory control procedures shall be in conformance with the following requirements.

(i) All inventory control procedures shall be in accordance with a code or standard of practice developed by a nationally recognized association or independent testing laboratory.

(ii) Reconciliation of detailed inventory control records shall be conducted at least once each month, and shall be sufficiently accurate to detect a release as small as the sum of 1.0% of the total substance flow-through for the month plus 130 gallons.

(iii) The operator shall assure that the following additional procedures and requirements are followed.

(I) Inventory volume measurement for regulated substance inputs, withdrawals, and the amount still remaining in the tank shall be recorded each operating day.

(II) The equipment used shall be capable of measuring the level of stored substance over the full range of the tank's height to the nearest 1/8 inch.

(III) Substance dispensing shall be metered and recorded within an accuracy of six or less cubic inches for every five gallons of product withdrawn.

(IV) The measurement of any water level in the bottom of the tank shall be made to the nearest 1/8 inch at least once a month, and appropriate adjustments to the inventory records shall be made.

(2) Manual tank gauging. Manual tank gauging may be used as a tank release detection method, subject to the following limitations and requirements.

(A) Manual tank gauging in accordance with this subparagraph may be used as the sole method of tank release detection only for petroleum substance tanks having a nominal capacity of 1,000 gallons or less.

(B) The use of manual tank gauging shall not be considered an acceptable method for meeting the release detection requirements of this section for any tanks with a nominal capacity greater than 1,000 gallons.

(C) When used for compliance with the release detection requirements of this section, the procedures and requirements in the following clauses shall be applicable.

(i) For purposes of this subparagraph only, the following definitions are applicable.

(I) Level measurement--The average of two consecutive liquid level readings from a tank gauge, measuring stick, or other measuring equipment.

(II) Gauging period--A weekly period during which no substance is added to or removed from the tank. The duration of the gauging period is dependant upon tank volume and diameter, as specified in clause (v) of this subparagraph.

(III) Weekly deviation--The variation between the level measurements taken at the beginning and the end of one gauging period, converted to and expressed as gallons.

(IV) Monthly deviation--The arithmetic average of four consecutive weekly deviations, expressed as gallons.

(ii) Any measuring equipment shall be capable of measuring the level of stored substance over the full range of the tank's height to the nearest 1/8 inch.

(iii) Separate liquid level measurements in the tank shall be taken weekly at the beginning and the ending of the gauging period, and the weekly deviation shall be determined from such level measurements.

(iv) Once each month, after four consecutive weekly deviations are determined, a monthly deviation shall be calculated.

(v) For the purposes of the manual tank gauging method of release detection, a release shall be indicated when either the weekly deviation or the monthly deviation exceeds the maximum allowable standards indicated in the following subclauses:

(I) for a tank with a capacity of 550 gallons or less (any tank diameter): minimum duration of gauging period = 36 hours; weekly standard = ten gallons; monthly standard = five gallons;

(II) for a tank with a capacity of 551 gallons to 1,000 gallons (when tank diameter is 64 inches): minimum duration of gauging period = 44 hours; weekly standard = nine gallons; monthly standard = four gallons;

(III) for a tank with a capacity of 551 gallons to 1,000 gallons (when tank diameter is 48 inches): minimum duration of gauging period = 58 hours; weekly standard = 12 gallons; monthly standard = six gallons.

(vi) When either the weekly standard or the monthly standard is exceeded and a suspected release is thereby indicated, the owner or operator shall comply with the applicable release reporting, investigation, and corrective action requirements of Subchapter D of this chapter.

(3) Monthly tank gauging. Monthly tank gauging may be used as a tank release detection method, subject to the following limitations and requirements.

(A) Monthly tank gauging in accordance with this paragraph may be used as the sole method of tank release detection only for emergency generator tanks.

(B) The use of monthly tank gauging shall not be considered an acceptable method for meeting the release detection requirements of this section for any tanks other than emergency generator tanks.

(C) When used for compliance with the release detection requirements of this section, the procedures and requirements in the following clauses shall be applicable.

(i) For purposes of this paragraph only, the following definitions are applicable.

(I) Level measurement--The average of two consecutive liquid level readings from a tank gauge, measuring stick, or other manual or automatic measuring equipment.

(II) Gauging period--A period of at least 36 hours during which no substance is added to or removed from the tank.

(III) Monthly deviation--The variation between the level measurements taken at the beginning and the end of one gauging period, converted to and expressed as gallons.

(ii) Any measuring equipment (whether operated manually or automatically) shall be capable of measuring the level of a stored substance over the full range of the tank's height to the nearest 1/8 inch.

(iii) Separate liquid level measurements in the tank shall be taken at least once monthly at the beginning and the ending of the gauging period, and the monthly deviation shall be determined from such level measurements.

(iv) For the purposes of the monthly tank gauging method of release detection, a release shall be indicated when the monthly deviation exceeds the maximum allowable standards indicated in the following subclauses:

(I) for a tank with a capacity of 550 gallons or less: monthly standard = five gallons;

(II) for a tank with a capacity of 551 gallons to 1,000 gallons: monthly standard = seven gallons;

(III) for a tank with a capacity of 1,001 gallons to 2,000 gallons: monthly standard = 13 gallons;

(IV) for a tank with a capacity greater than 2,000 gallons: monthly standard = 1.0% of the total tank capacity.

(v) When the monthly standard is exceeded and a suspected release is thereby indicated, the owner or operator shall comply with the applicable release reporting, investigation, and corrective action requirements of Subchapter D of this chapter.

(4) Automatic tank gauging and inventory control.

(A) A combination of automatic tank gauging and inventory control may be used as a tank release detection method, subject to the following requirements.

(i) Inventory control procedures shall be in compliance with paragraph (1)(B) of this subsection.

(ii) The automatic tank gauging equipment shall be capable of:

(I) automatically monitoring the in-tank liquid levels, conducting automatic tests for substance loss, and collecting data for inventory control purposes; and

(II) performing an automatic test for substance loss that can detect a release of 0.2 gallon per hour from any portion of the tank which contains regulated substances.

(B) For emergency generator tanks only, automatic tank gauging may be used as a tank release detection method, provided that the automatic tank gauging equipment shall be capable of:

(i) automatically monitoring the in-tank liquid levels;

(ii) conducting continuous automatic tests for substance loss during the periods when the emergency generator engine is not in operation; and

(iii) performing an automatic test for substance loss that can detect a release of 0.2 gallon per hour from any portion of the tank which contains regulated substances.

(5) Vapor monitoring. Equipment and procedures designed to test or monitor for the presence of vapors from the regulated substance (or from a related tracer substance) in the soil gas of the backfilled excavation zone may be used, subject to the following limitations and requirements.

(A) The bedding and backfill materials in the excavation zone shall be sufficiently porous to allow vapors from any released regulated substance (or related tracer substance) to rapidly diffuse through the excavation zone (e.g., gravel, sand, crushed rock).

(B) The stored regulated substance, or any tracer substance placed in the tank system, shall be sufficiently volatile so that, in the event of a substance release from the UST system, vapors will develop to a level that can be readily detected by the monitoring devices located in the excavation zone.

(C) The capability of the monitoring device to detect vapors from the stored regulated substance shall not be adversely affected by the presence of any groundwater, rainfall, and/or soil moisture in a manner that would allow a release to remain undetected for more than one month (not to exceed 35 days).

(D) Any preexisting background contamination in the excavation zone shall not interfere with the capability of the vapor monitoring equipment to detect releases from the UST system.

(E) The vapor monitoring equipment shall be designed to detect vapors from either the stored regulated substance, a component or components of the stored substance, or a tracer substance placed in the UST system, and shall be capable of detecting any significant increase in vapor concentration above preexisting background levels.

(F) Prior to installation of any vapor monitoring equipment, the site of the UST system (within the excavation zone) shall be assessed by qualified personnel to:

(i) ensure that the requirements in subparagraphs (A) - (D) of this paragraph have been met; and

(ii) determine the appropriate number and positioning of any monitor wells and/or observation wells, so that releases into the excavation zone from any part of the UST system can be detected within one month of the release (not to exceed 35 days).

(G) All monitoring wells and observation wells shall be designed and installed in accordance with the requirements of §334.46(g) of this title.

(6) Groundwater monitoring. Equipment or procedures designed to test or monitor for the presence of regulated substances floating on, or dissolved in, the groundwater in the excavation zone may be used, subject to the following limitations and requirements.

(A) The stored regulated substance shall be immiscible in water and shall have a specific gravity of less than one.

(B) The natural groundwater level shall never be more than 20 feet (vertically) from the ground surface, and the hydraulic conductivity of the soils or backfill between all parts of the UST system and the monitoring points shall not be less than 0.01 centimeters per second (i.e., the soils or backfill shall consist of gravels, coarse to medium sands, or other similarly permeable material).

(C) Any automatic monitoring devices that are employed shall be capable of detecting the presence of at least 1/8 inch of free product on top of the groundwater in the monitoring well or observation well. Any manual monitoring method shall be capable of detecting a visible sheen or other accumulation of regulated substances in, or on, the groundwater in the monitoring well or observation well.

(D) Any preexisting background contamination in the monitored zone shall not interfere with the capability of the groundwater monitoring equipment or methodology to detect releases from the UST system, and the groundwater monitoring equipment or methodology shall be capable of detecting any significant increase above preexisting background levels in the amount of regulated substance floating on, or dissolved in, the groundwater.

(E) Prior to installation of any groundwater monitoring equipment, the site of the UST system (within and immediately below the excavation zone) shall be assessed by qualified personnel to:

(i) ensure compliance with the requirements of subparagraphs (A) and (B) of this paragraph; and

(ii) determine the appropriate number and positioning of any monitoring wells and/or observation wells, so that releases from any part of the UST system can be detected within one month (not to exceed 35 days) of the release.

(F) All monitoring wells and observation wells shall be designed, installed, and maintained in accordance with the requirements in §334.46(g) of this title.

(7) Interstitial monitoring for double-wall UST systems. Equipment designed to test or monitor for the presence of regulated substance vapors or liquids in the interstitial space between the inner (primary) and outer (secondary) walls of a double-wall UST system may be used, subject to the following conditions and requirements.

(A) Any double-wall UST system using this method of release detection shall be designed, constructed, and installed in accordance with the applicable technical and installation requirements in §334.45(d) and §334.46(f) of this title.

(B) The sampling, testing, or monitoring method shall be capable of detecting any release of stored regulated substances from any portion of the primary tank or piping within one month (not to exceed 35 days) of the release.

(C) The sampling, testing, or monitoring method shall be capable of detecting a breach or failure in the primary wall and the entrance of groundwater into the interstitial space due to a breach in the secondary wall of the double-wall tank or piping system within one month (not to exceed 35 days) of such breach or failure (whether or not a stored regulated substance has been released into the environment).

(8) Monitoring of UST systems with secondary containment barriers. Equipment designed to test or monitor for the presence of regulated substances (liquids or vapors) in the excavation zone between the UST system and an impermeable secondary containment barrier immediately around the UST system may be used, subject to the following conditions and requirements.

(A) Any secondary containment barrier or liner system at a UST system using this method of release detection shall be designed, constructed, and installed in accordance with the applicable technical and installation requirements in §334.45(d) and §334.46(f) of this title.

(B) The sampling, testing, or monitoring method shall be capable of detecting any release of stored regulated substance from any portion of the UST system into the excavation zone between the UST system and the secondary containment barrier within one month (not to exceed 35 days) of the release.

(C) The sampling, testing, or monitoring method shall be designed and installed in a manner that will ensure that groundwater, soil moisture, and rainfall will not render the method inoperative where a release could remain undetected for more than one month (not to exceed 35 days).

(D) Prior to installation of any secondary containment release monitoring equipment, the site of the UST system shall be assessed by qualified personnel to:

(i) ensure that the secondary containment barrier will be positioned above the groundwater level and outside the designated 25-year flood plain, unless the barrier and the monitoring equipment are designed for use under such conditions; and

(ii) determine the appropriate number and positioning of any observation wells.

(E) All observation wells shall be designed and installed in accordance with the requirements in §334.46(g) of this title.

(9) Statistical inventory reconciliation (SIR) and inventory control.

(A) A combination of SIR and inventory control may be used as a release detection method for UST system tanks and lines, subject to the following requirements.

(i) Inventory control procedures must be in compliance with paragraph (1)(B) of this subsection.

(ii) The SIR methodology as utilized by its provider or vendor, or by its vendor-authorized franchisee or licensee or representative must analyze inventory control records in a manner which can detect a release of 0.2 gallons per hour from any part of the UST system.

(iii) The UST system owner and/or operator must take appropriate steps to assure that they receive a monthly analysis report from the entity which actually performs the SIR analysis (either the SIR provider/vendor or the provider/vendor-authorized franchisee or licensee or representative) in no more than 15 calendar days following the last day of the calendar month for which the analysis is performed. This analysis report must, at minimum:

(I) state the name of the SIR provider/vendor and the name and version of the SIR methodology which was utilized for the analysis as they are listed in the independent third-party evaluation of that methodology;

(II) state the name of the company and the individual (or the name of the individual if no company affiliation) who performed the analysis, if it was performed by a provider/vendor-authorized franchisee or licensee or representative;

(III) state the name and address of the facility at which analysis is performed and provide a description of each UST system for which analysis has been performed;

(IV) quantitatively state in gallons per hour for each UST system being monitored: the leak threshold for the month analyzed, and the minimum detectable leak rate for the month analyzed, and the indicated leak rate for the month analyzed;

(V) qualitatively state one of the following for each UST system being monitored: "pass," or "fail," or "inconclusive."

(iv) Any UST system analysis report result other than "pass" must be reported to the agency by the UST system owner or operator as a suspected release in accordance with §334.72 of this title (relating to Reporting of Suspected Releases).

(v) Any UST system analysis report result of "inconclusive" which has not been investigated and quantified as a "pass" (in the form of a replacement UST system analysis report meeting the requirements of clause (iii) of this subparagraph) must be reported to the agency as a suspected release within 72 hours of the time of receipt of the inconclusive analysis report result by the UST system owner or operator.

(B) At least once per calendar quarter, the SIR provider/vendor must select at random, at least one of the individual UST system analyses performed by each of its authorized franchisees or licensees or representatives during that period and audit that analysis to assure that provider/vendor standards are being maintained with regard to the acceptability of inventory control record data, the acceptability of analysis procedures, and the accuracy of analysis results. The written result of that audit must be provided to the authorized franchisee or licensee or representative and to the owner and/or operator of the audited UST system(s) by the SIR provider/vendor during that calendar quarter. In addition, within 30 days following each calendar quarter, the SIR provider/vendor must provide to the agency a list containing the name and address of each of its authorized franchisees or licensees or representatives which specifies for each one, the name and address of each facility at which one or more UST system audits were performed during the previous calendar quarter.

(10) Alternative release detection method. Any other release detection method, or combination of methods, may be used if such method has been reviewed and determined by the agency to be capable of detecting a release from any portion of the UST system in a manner that is no less protective of human health and safety and the environment than the methods described in paragraphs (1) - (8) of this subsection, in accordance with the provisions of §334.43 of this title (relating to Variances and Alternative Procedures).

(e) Release detection records.

(1) Owners and operators shall maintain the release detection records required in this subsection in accordance with the requirements in §334.10(b) of this title (relating to Reporting and Recordkeeping).

(2) Owners and operators shall maintain records adequate to demonstrate compliance with the release detection requirements in this section, and in accordance with the following minimum requirements.

(A) All appropriate installation records related to the release detection system, as listed in §334.46(i) of this title, shall be maintained for as long as the release detection system is used.

(B) All written performance claims pertaining to any release detection system used, and documentation of the manner in which such claims have been justified, verified, or tested by the equipment manufacturer, methodology provider/vendor, or independent third-party evaluator shall be maintained for as long as the release detection system is used.

(C) Records of the results of all manual and/or automatic methods of sampling, testing, or monitoring for releases (including tank tightness tests) shall be maintained for at least five years after the sampling, testing, or monitoring is conducted.

(D) Records and calculations related to inventory control reconciliation shall be maintained for at least five years from the date of reconciliation.

(E) Written documentation of all service, calibration, maintenance, and repair of release detection equipment permanently located on-site shall be maintained for at least five years after the work

is completed. Any schedules of required calibration and maintenance provided by the release detection equipment manufacturer shall be retained for as long as the release detection system is used.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER H. REIMBURSEMENT PROGRAM

30 TAC §§334.302, 334.306 - 334.310, 334.313 - 334.315, 334.322

STATUTORY AUTHORITY

The amendments are adopted under TWC, §5.103, which provides the commission authority to adopt any rules necessary to carry out its powers and duties under this code and other laws of this state and to adopt rules repealing any statement of general applicability that interprets law or policy; §5.105, which authorizes the commission to establish and approve all general policy of the commission by rule; and §26.011, which requires the commission to control the quality of water by rule. The amended sections are also adopted under TWC, §26.345, which provides the commission authority to develop a regulatory program and to adopt rules regarding USTs; §26.351, which directs the commission to adopt rules establishing the requirements for taking corrective action in response to a release from a UST or an AST; and §26.3573, which allows the commission to use funds from the PST remediation account to reimburse an eligible owner or operator or insurer for the expenses of corrective action or to pay the claim of a contractor hired by an eligible owner or operator to perform corrective action.

§334.302. General Conditions and Limitations Regarding Reimbursement; Assignments.

(a) To be considered for reimbursement under this subchapter, corrective action must be performed either as provided in subsection (b) of this section or in response to a release which:

(1) results in contamination which penetrates beyond the excavation zone of the tank system and which is above action levels determined by the agency;

(2) is ultimately confirmed by the agency, either before or after corrective action commences, provided that it shall be the burden of the person claiming monies under this subchapter to show both that a release which is eligible for reimbursement occurred and the expenses claimed are allowable and reimbursable; and

(3) the confirmed release was initially discovered and reported to the agency on or before December 22, 1998.

(b) Subsection (a) of this section does not apply if the corrective action is specifically required by an order of the commission, or a written request or confirmation by the agency, and the release was initially discovered and reported to the agency on or before December 22, 1998.

(c) No payments shall be made by the agency under this subchapter for:

(1) the owner/operator contribution described in §334.312 of this title (relating to Owner/Operator Contribution), which the agency may apportion in the case of multiple claimants as provided in §334.314(f) of this title (relating to Fund Payment Report);

(2) any expenses for corrective action which exceed $1 million per occurrence;

(3) any expenses relating to compensation for bodily injury or property damage;

(4) any expenses for corrective action incurred for confirmed releases initially discovered and reported to the agency after December 22, 1998;

(5) any expenses related to corrective action performed after September 1, 2005;

(6) any expenses related to corrective action contained in a reimbursement claim filed with the agency after March 1, 2006;

(7) any expenses on or after September 1, 2006; or

(8) payments to an owner and/or operator, who acts as his own prime contractor or consultant, in the form of markup of amounts paid to subcontractors (see Appendix A Note 1 in "Part 9: Markup" or in excess of the limitation listed in Note 5 in "Part 1: Professional Personnel/Labor Rates" and/or in excess of the limitation listed in Note 2 in "Part 8: Report Generation Costs" of §334.560 of this title (relating to Reimbursable Cost Specifications).

(d) No expenses for which reimbursement is claimed under this subchapter and no expenses which are to be applied to the owner/operator contribution shall be subject to reimbursement or applied to the owner/operator contribution unless the following conditions have been met.

(1) An application for reimbursement must be filed by the owner or operator of a petroleum storage tank or his/her duly authorized agent, as required by §334.304 of this title (relating to Who May File Application).

(2) Unless otherwise approved by the agency, a certification affidavit as provided in the application for reimbursement must be signed by all of the following: owner or operator of a petroleum storage tank, the application preparer, and the prime contractor and/or the prime corrective action specialist, as defined in §334.322 of this title (relating to Subchapter H Definitions).

(3) The application has been filed within the time prescribed in §334.303 of this title (relating to When to File Application).

(4) The person seeking reimbursement must be an eligible owner or operator, as defined in §334.322 and §334.310 of this title (relating to Subchapter H Definitions and Requirements for Eligibility, respectively) or they must be authorized through an assignment by an eligible owner or eligible operator to receive such payment under subsections (i) - (k) of this section.

(5) The expenses for which reimbursement is sought, and those which are to be applied to the owner/operator contribution must be allowable costs, as defined in §334.308 of this title (relating to Allowable Costs and Restrictions on Allowable Costs).

(6) The allowable costs for which reimbursement is sought and those which are to be applied to the owner/operator contribution must be reimbursable, as defined in §334.309 of this title (relating to Reimbursable Costs).

(7) An application for reimbursement has been filed in accordance with this subchapter which contains the information required by this subchapter.

(e) For purposes of this subchapter only, the persons listed in §334.310 of this title may be eligible owners or operators, provided that they meet the other criteria prescribed by this subchapter.

(f) All claims for assistance and reimbursement filed under this subchapter are subject to the availability of funds in the petroleum storage tank remediation fund.

(g) Nothing in this subchapter shall affect the liability or responsibility of an owner or operator of an underground or aboveground storage tank to take corrective action in response to a release in accordance with applicable law.

(h) Nothing in this subchapter shall be construed to create an entitlement to monies in the petroleum storage tank remediation account or any other fund, and the commission reserves the right to amend or repeal without limitation any of the provisions of this subchapter, including provisions regarding eligibility and allowable costs.

(i) Payment made to persons other than the eligible owner or operator may only be made subject to subsections (j) and (k) of this section and may only be made to assignees duly authorized to receive payment on behalf of an eligible owner or operator except as provided by §334.306(f) of this title (relating to Form and Contents of Application).

(j) Authorization for an assignee to receive payment on behalf of an eligible owner or operator must be in writing and signed by the eligible owner or operator who is requesting payment. The authorization must clearly describe what funds the assignee is authorized to receive. If the agency determines that the authorization is not clear as to the disposition of funds to which the eligible owner or operator is entitled, the agency may withhold payment and request written clarification from the eligible owner or operator. The agency may limit the number of assignees who may receive payments for any one occurrence. Notwithstanding any review made or limitations imposed by the agency under this section, neither the State of Texas, nor the agency shall be responsible for ensuring that payment is made to the parties as contemplated by the authorization. It is the responsibility of the eligible owner or operator and the assignee requesting payment to ensure that the agency is supplied with information sufficient to make the proper payments. The right to receive payment under this subchapter is not transferable for any purpose and only the people authorized to receive payment under this section are entitled to do so.

(k) No payment of funds will be made to any person other than the eligible owner or operator under this subchapter, except as follows:

(1) the person assigned the right to accept payment on behalf of an eligible owner or operator. Such assignees are limited to the following:

(A) a Prime Corrective Action Specialist, properly registered under Subchapter J of this chapter (relating to Leaking Petroleum Storage Tank Corrective Action Specialist Registration and Project Manager Licensing), hired by the owner or operator to perform corrective action activities at the leaking petroleum storage tank site in question who also holds a lienhold interest on the real estate or fixture that is attached to the real estate where the release occurred and on which the claim for payment is based; or

(B) a person who has insured the owner or operator of petroleum storage tanks for pollution liability on or after July 17, 1990, and who has paid claims on that policy for remediation costs for which the tank owner may be reimbursed under this subchapter; or

(C) any other person who holds legal or equitable title to the property where the release occurred and on which the claim for payment is based; and

(2) the type of ownership interest required under paragraph (1)(A) and (C) of this subsection is an interest in the surface estate of the property.

§334.306. Form and Contents of Application.

(a) An application for reimbursement filed in accordance with this subchapter shall be on a form approved or provided by the agency.

(b) The application must contain the following:

(1) the name, address, telephone number, and signature of all of the following: the applicant, the application preparer, and the prime contractor and/or prime corrective action specialist required by §334.302 of this title (relating to General Conditions and Limitations Regarding Reimbursement), unless otherwise approved by the agency;

(2) the name, address, and telephone number of:

(A) each owner and operator of the tanks;

(B) the facility owner; and

(C) the owner of the land on which the tank system is located;

(3) the address and zip code of the facility where the release occurred;

(4) the location of the facility at which the corrective action was performed or is to be performed, identified with sufficient clarity and detail to enable a person unfamiliar with the site to locate it and reach it by automobile;

(5) any information required by the agency under §334.307 of this title (relating to Technical Information Required), if not already submitted to the agency;

(6) legible copies of contractor and subcontractor invoices and any other documents required by the executive director to provide a description of:

(A) any work performed;

(B) who performed the work;

(C) where the work was performed;

(D) the dates the work was performed;

(E) the unit cost, using the same breakdown of individual activities as are listed in this subchapter and Subchapter M of this chapter (relating to Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program); and

(F) the total amount paid, or ensured to be paid through the posting of a payment bond;

(7) certification on the designated agency form, either that the amounts described in §334.309(c) of this title (relating to Reimbursable Costs) have been paid in full by the claimant, or have been ensured to be paid in full though the posting of a payment bond in the amount not yet paid in full by the claimant. The certification must include:

(A) for reimbursement(s) to a claimant who is an eligible owner or operator, or an insurer under §334.302(k)(1)(B) of this

title, a certification as to payment of the claimant's prime contractor; or

(B) for reimbursement(s) to a claimant who is an assignee contractor described in §334.302(k)(1)(A) of this title, a certification as to payment of the claimant's subcontractors;

(8) if the agency is being requested to honor a reimbursement assignment under §334.302(i) - (k) of this title, the application must include a complete assignment document as described in §334.302(i) - (k) of this title;

(9) if any combination of the owner or operator or the persons performing corrective action activities at, or for, the leaking petroleum storage tank site in question are related parties as the term is defined in §334.322 of this title (relating to Subchapter H Definitions), the application must contain a full description of all such relationships including applicable documentation; and

(10) any other information which the agency may reasonably require.

(c) An application may be filed at the following times:

(1) after the completion of a phase or pre-approved activity; or

(2) at points during the corrective action process agreed to by the agency and the applicant.

(d) The agency may require the applicant to supplement information already submitted or return the application if the information is not sufficient to review the application.

(e) The applicant must update his application with any information not yet submitted to the agency before processing or payment of claims at any stage begins.

(f) A subcontractor may submit information to the agency to assert a claim that the subcontractor has performed pre-approved work and has not been fully paid for the work. To be considered for direct reimbursement by the commission under this subchapter, each of the following requirements must be met:

(1) the subcontractor requesting to be directly reimbursed by the agency shall have performed work for a person eligible for reimbursement in accordance with §334.310 of this title (relating to Requirements for Eligibility) and performed such work as a subcontractor to a prime corrective action specialist retained by the eligible owner or operator;

(2) a Fund Payment Report that contains the charges for which the subcontractor has not been paid has been issued in accordance with §334.314 of this title (relating to Fund Payment Report);

(3) the prime corrective action specialist has failed to pay the subcontractor, due to insolvency subject to the limitations of 11 United States Code, §365(e)(1), the amount reflected on the Fund Payment Report;

(4) the commission has not paid for the work performed in the Fund Payment Report or the commission has successfully recovered the money paid for the work performed in the Fund Payment Report in accordance with §334.318 of this title (relating to Recovery of Costs) and Texas Water Code, §26.355; and

(5) the subcontractor has filed within 120 days of the effective date of this subchapter the following:

(A) written notice to the agency of the amounts owed on each specific Fund Payment Report that the prime corrective action specialist has failed to pay; and

(B) an affidavit by the subcontractor stating that the prime corrective action specialist has failed to pay the amount being requested by the subcontractor.

(g) For purposes of this subchapter, the following are the phases of corrective action:

(1) initial abatement measures and emergency actions phase;

(2) preliminary site assessment phase;

(3) comprehensive site assessment phase;

(4) risk assessment and remediation planning phase;

(5) remediation phase;

(6) post-remediation monitoring phase; and

(7) site closure.

§334.309. Reimbursable Costs.

(a) The agency will utilize the reimbursable cost specifications, as outlined in §334.560 of this title (relating to Reimbursable Cost Specifications), to evaluate the reimbursability of claims related to the cleanup of leaking petroleum storage tank sites.

(b) No cost shall be reimbursed unless it is also an allowable cost under §334.308 of this title (relating to Allowable Costs and Restrictions on Allowable Costs).

(c) For reimbursements appropriate to be made under this subchapter, the amount reimbursed will be the lower of the invoiced amount or the line-item amount (adjusted for scope of work) for that activity specified in Subchapter M of this chapter (relating to Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program). An exception to this subsection is made for items under Subchapter M of this chapter requiring bidding, where reimbursements requests are processed as described in Subchapter M of this chapter. For those activities that require pre-approval under §334.310(f) of this title (relating to Requirements for Eligibility), the agency may also, at its discretion, limit the amount reimbursed to the pre-approved amount.

(d) A cost is not reimbursable if a contractor fails to pay its subcontractors for subcontracted work or if there is a failure to perform the work claimed as technically required. The audit of reimbursable costs is addressed in §§334.530 - 334.535 of this title (relating to Purpose and Applicability of the Subchapter, Cooperation with Audit; False Submittals, Payments, Audits, Notice of Overpayment, and Objections to the Notice of Overpayment and Formal Petition for Hearing).

§334.313. Review of Application.

(a) An application for reimbursement or supplemented application filed under this subchapter shall be subject to review by the agency:

(1) to determine if the information which is required to be submitted under this subchapter has been filed with the agency, utilizing the following procedure:

(A) an application submitted will be reviewed by the staff for completeness. To be considered complete, an application must contain the following information:

(i) a completed application form, which has been provided or approved by the agency, containing the information required under §334.306(a) and (b)(1) - (4) of this title (relating to Form and Contents of Application);

(ii) legible copies as required under §334.306(b)(6) of this title and by certification of payment as required under §334.306(b) (7) of this title;

(iii) copies of pre-approval documentation and technical information requested in the application form, provided or approved by the agency, under §334.306(b)(5) of this title and §334.307(a) of this title (relating to Technical Information Required); and

(iv) an Application Checklist, provided with the application form, verifying that the applicant and application preparer have reviewed the application for completeness;

(B) if it is determined that an otherwise complete application contains any costs which required prior agency approval prior to implementation as required by §334.310(f) of this title (relating to Requirements for Eligibility), and such prior approval was not obtained, the applicant will be notified in a fund payment report that those costs will not be forwarded for further review until such time as the agency completes reviews of applications with pre-approved costs as allowed under subsection (d) of this section;

(C) if it has been determined that an otherwise complete application contains costs for a corrective action activity which the agency determines to have been performed improperly, the applicant will be notified in a fund payment report that those costs are denied as not allowable under §334.308(g)(22) of this title (relating to Allowable Costs and Restrictions on Allowable Costs); and

(D) the received date of the application is considered to be the date which the complete application was received by the agency, or the date which the required additional information was received by the agency; and

(2) to examine the substance of the application, including, without limitation:

(A) the cost effectiveness and fiscal merits of the corrective action taken at the facility; and

(B) the technical merits of the corrective action taken at the facility.

(b) If, during review, the agency determines that additional information is required to assess the validity of the claim under Subchapters H and M of this chapter (relating to Reimbursement Program; and Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program), it may either:

(1) require the applicant to provide such additional information. Further review of the application will be postponed until such information is received by the agency. The received date for the complete claim will be considered the date on which the agency received such additional required information; or

(2) issue the fund payment report, but withhold payment of those portions of the claim for which additional information has been requested.

(c) An application for reimbursement or supplemental application filed under this subchapter shall be subject to audit by the agency.

(d) The executive director may not consider, process, or pay a claim for reimbursement for corrective action work begun after September 1, 1993, and without prior agency approval until all claims for reimbursement for corrective action work pre-approved by the agency have been considered, processed, and paid.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406462
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Effective date: November 18, 2004
Proposal publication date: April 30, 2004
For further information, please call: (512) 239-0348

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SUBCHAPTER L. OVERPAYMENT PREVENTION

30 TAC §§334.530 - 334.535

STATUTORY AUTHORITY

The amendments are adopted under TWC, §5.103, which provides the commission authority to adopt any rules necessary to carry out its powers and duties under this code and other laws of this state and to adopt rules repealing any statement of general applicability that interprets law or policy; §5.105, which authorizes the commission to establish and approve all general policy of the commission by rule; and §26.011, which requires the commission to control the quality of water by rule. The amended sections are also adopted under TWC, §26.345, which provides the commission authority to develop a regulatory program and to adopt rules regarding USTs; §26.351, which directs the commission to adopt rules establishing the requirements for taking corrective action in response to a release from a UST or an AST; and §26.3573, which allows the commission to use funds from the PST remediation account to reimburse an eligible owner or operator or insurer for the expenses of corrective action or to pay the claim of a contractor hired by an eligible owner or operator to perform corrective action.

§334.531. Cooperation with Audit; False Submittals.

(a) The party who has entered into a contract with the agency in accordance with this chapter to perform corrective action work, eligible owner or operator, and any party who received reimbursement under §334.302(k) of this title (relating to General Conditions and Limitations Regarding Reimbursement), any Registered Corrective Action Specialist, and any contractor or subcontractor whose invoices or other documents are submitted, or are required to be submitted, with the Application for Reimbursement shall cooperate fully with any audit or investigation by the agency regarding the work performed, the costs charged, and/or amounts paid and shall provide copies of all documents relating to an audited claim to the agency on request and at no charge.

(b) If the documentation or information requested by the agency under subsection (a) of this section to support an audited claim is not provided, the unsupported portion of the claim will be the subject of a Notice of Overpayment under §334.534 of this title (relating to Notice of Overpayment).

(c) No person shall knowingly submit false information to the agency as part of any materials required to be submitted under this subchapter.

§334.533. Audits.

(a) Audits of claims and associated documents will be conducted in accordance with auditing standards as provided by Texas Water Code, §26.35735. Such audits may occur prior to or after claims have been paid. Such audits may include an investigation into whether activities performed and/or the amounts claimed were:

(1) eligible to be paid as provided by Texas Water Code, §26.3573, and allowable under Subchapters H and M of this chapter (relating to Reimbursement Program; and Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program);

(2) reimbursable under Subchapter H of this chapter, §334.560 of this title (relating to Reimbursable Cost Specifications), and §334.309 of this title (relating to Reimbursable Cost) (for work performed on or after June 6, 1993), or reasonable (for work performed prior to June 6, 1993); and

(3) actual costs in §334.306(b)(6) of this title (relating to Form and Contents of Application). For the purposes of this subchapter, actual cost is the actual amount paid for actual work performed, net of any discounts, offsets, or other reductions to the amount paid. Actual cost includes associated overhead and reasonable profit.

(b) An audit may also include an investigation into whether, and by what means, the amounts claimed have been paid in full by the claimant to the person(s) who actually performed the corrective action work for the claimed amount. The investigation may include a review of any and all documents relating to the payment of any amounts claimed, including those of any subcontractors who performed any of the corrective action work. Upon conclusion of the audit, any amounts the audit reveals have not been actually paid to the person(s) performing the corrective action work, rather than evidenced only by a promise to pay, must be included in the Notice of Overpayment issued under §334.534 of this title (relating to Notice of Overpayment).

§334.534. Notice of Overpayment.

(a) If the agency conducts an audit or investigation and concludes that payment of a claim was for an amount which exceeded the amount provided for under this chapter, the agency shall prepare a notice of overpayment. The notice of overpayment shall briefly summarize the findings of the audit and identify the amounts which were overpaid. If the executive director determines that the overpayment was the result of incorrect, incomplete, or inaccurate documentation submitted by the claimant, then the executive director may include in the notice of overpayment a charge for the claimant to pay interest, calculated at New York Prime, plus two points, dating from the date of overpayment by the Texas Commission on Environmental Quality (TCEQ), or its predecessor agency, to the date of repayment to the TCEQ. Interest shall be calculated each month using the interest rate determined on the first business day of each month.

(b) The notice of overpayment will be delivered to the claimant (either the party who contracted directly with the TCEQ for corrective action work, the eligible owner or operator, or the party assigned the reimbursement right under §334.302(i) - (k) of this title (relating to General Conditions and Limitations Regarding Reimbursements; Assignments).

(c) Upon receipt of a notice of overpayment, the recipient shall submit a check returning the amount of overpayment to the TCEQ.

(d) All checks rendered to return overpayments shall be made out to "The State of Texas-Petroleum Storage Tank Remediation Account" and mailed to the address specified on the notice of overpayment.

§334.535. Objections to the Notice of Overpayment and Formal Petition for Hearing.

(a) If any person receiving the notice of overpayment disputes any portion of the amount to be repaid to the commission, he or she must, within 30 days of receipt of the notice of overpayment, file a petition for hearing with the chief clerk in the manner prescribed generally by this title for filing petitions with the commission and shall serve a copy of the petition on the executive director.

(b) The petition must assert which funds the party is entitled to retain, and why such funds represent claims paid under the requirements of this chapter. At hearing, the petitioner must prove that the audited claims or portions of claims were for amounts paid under the requirements of this chapter.

(c) If a person does not object to a notice of overpayment, in whole or in part, as prescribed by this section, then all objections to the notice are waived.

(d) Any amount not specifically disputed in accordance with this section must be returned within 30 days of receipt of the notice of overpayment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406463
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
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Proposal publication date: April 30, 2004
For further information, please call: (512) 239-0348

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SUBCHAPTER M. REIMBURSABLE COST SPECIFICATIONS FOR THE PETROLEUM STORAGE TANK REIMBURSEMENT PROGRAM

30 TAC §334.560

(Editor's Note: In accordance with Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figure in 30 TAC §334.560 is not included in the print version of the Texas Register. The figure is available in the on-line issue of the November 12, 2004, issue of the Texas Register.)

STATUTORY AUTHORITY

The amendment is adopted under TWC, §5.103, which provides the commission authority to adopt any rules necessary to carry out its powers and duties under this code and other laws of this state and to adopt rules repealing any statement of general applicability that interprets law or policy; §5.105, which authorizes the commission to establish and approve all general policy of the commission by rule; and §26.011, which requires the commission to control the quality of water by rule. The amended section is also adopted under TWC, §26.345, which provides the commission authority to develop a regulatory program and to adopt rules regarding USTs; §26.351, which directs the commission to adopt rules establishing the requirements for taking corrective action in response to a release from a UST or an AST; and

§26.3573, which allows the commission to use funds from the PST remediation account to reimburse an eligible owner or operator or insurer for the expenses of corrective action or to pay the claim of a contractor hired by an eligible owner or operator to perform corrective action.

§334.560. Reimbursable Cost Specifications.

The following Reimbursable Cost Specifications for the Petroleum Storage Tank Reimbursement Program are in effect as of November 18, 2004.
Figure: 30 TAC §334.560

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Effective date: November 18, 2004
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For further information, please call: (512) 239-0348

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER O. STATE SALES AND USE TAX

34 TAC §3.284

The Comptroller of Public Accounts adopts an amendment to §3.284, concerning drugs, medicines, medical equipment, and devices, without changes to the proposed text as published in the August 6, 2004, issue of the *Texas Register* (29 TexReg 7647).

The adopted amendment clarifies in subsection (d)(9) that the exemption provided for intravenous systems is for those systems used in the treatment of humans. The adopted amendment in subsection (d)(11)(A) also clarifies and explains the documentation requirements that sellers must ascertain when an individual purchases a therapeutic appliance or device under a prescription from a licensed practitioner of the healing arts. The other changes in the adopted amendment are for the purpose of clarity.

No comments were received regarding adoption of the amendment.

This amendment is adopted under Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2.

The amendment implements Tax Code, §151.313.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406495
Martin Cherry
Chief Deputy General Counsel
Comptroller of Public Accounts
Effective date: November 21, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 475-0387

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SUBCHAPTER GG. INSURANCE TAX

34 TAC §3.832

The Comptroller of Public Accounts adopts an amendment to §3.832, concerning assessment for the Office of Public Insurance Counsel (OPIC) under Article 1.35B, Insurance Code, without changes to the proposed text as published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7927).

The amendment changes subsection (a) to include county mutual insurance companies for the OPIC assessment (Insurance Code, §912.002(b)) and subsection (c) to add language for clarity.

No comments were received regarding adoption of the amendment.

This amendment is adopted under Tax Code, §111.002 which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2.

The amendment implements Texas Insurance Code, §912.002(b).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2004.

TRD-200406496
Martin Cherry
Chief Deputy General Counsel
Comptroller of Public Accounts
Effective date: November 21, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 475-0387

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 12. TEXAS BOARD OF OCCUPATIONAL THERAPY EXAMINERS

CHAPTER 362. DEFINITIONS

40 TAC §362.1

The Texas Board of Occupational Therapy Examiners adopts amendments to §362.1, concerning Definitions, without changes to the proposed text as published in the August 6, 2004, issue of *Texas Register* (29 TexReg 7660) and will not be republished.

The section was amended to add current clarification of the rules.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Occupational Therapy Practice Act, Title 3, Subchapter H, Chapter 456, Occupations Code, which provides the Texas Board of Occupational Therapy Examiners with the authority to adopt rules consistent with this Act to carry out its duties in administering this Act.

Title 3, Subchapter H, Chapter 454 of the Occupations Code is affected by this amended section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 26, 2004.

TRD-200406424
John Maline
Executive Director
Texas Board of Occupational Therapy Examiners
Effective date: November 15, 2004
Proposal publication date: August 6, 2004
For further information, please call: (512) 305-6900

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 3. PUBLIC INFORMATION
SUBCHAPTER B. ACCESS TO OFFICIAL RECORDS

43 TAC §3.12, §3.13

The Texas Department of Transportation (department) adopts amendments to §3.12 and §3.13, concerning access to official records. The amendments to §3.13 are adopted with changes to the proposed text as published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7954). The amendments to §3.12 are adopted without changes to the proposed text as published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7954) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

Government Code, §552.230 and §552.262, authorize each agency to promulgate rules of procedure for the inspection and copying of public information and to specify the charges the agency will make. Government Code, §552.262, also provides that the rules adopted by the Texas Building and Procurement Commission (TBPC) be used by each agency when determining charges for providing copies of public information.

TBPC adopted revised costs to copies, codified in Title 1, Texas Administrative Code, §111.61 et seq., effective February 11, 2004.

Section 3.12(f) is amended to remove the requirement that a certification regarding repetitious or redundant requests must be signed by the General Counsel, Director of Public Information, or the district engineer, or division director. The amendment allows the department official who is responsible for the information to sign the certification. Since the number of redundant requests has increased, this change will facilitate the sending of the certification letters to the requestors in a more timely manner.

The amendments to §3.13 reflect the charges adopted by TBPC. The amendments establish charges to recover the full cost of providing copies of, or access to, public records, and include charges for new types of media.

Subsection (a) is amended as shown in the revised graphic. The charge for standard-size paper copies and paper copies produced on a high-resolution color copier remains the same, but is clarified to read that the cost is for the side that has recorded information. A category of specialty paper/media such as mylar blueline, blueprint, continuous or roll plot, is added at actual cost. This category covers all specialty paper and so the following specific categories of paper are deleted: paper copy (11 inches x 17 inches) from microfilmed construction plans, paper copy (22 inches x 34 inches) from original construction plans (copy-flo continuous print or Xerox 5080 or 2080 print), paper copy (11, 18, 22, 24, or 36 inches wide) of plan, schematic, cross-section or other roll plot, Vellum copies (11 1/2, 22, 34, or 36 inches wide) of plan, schematic, cross-section or other roll plot, Diazo prints (11 inches x 17 inches and 22 inches x 34 inches), Mylar copies (18, 22, 24, or 36 inches wide) of plan, schematic, cross-section or other roll plot. The charge for photographic prints is changed from $3.89 per square foot to actual cost. The size distinctions of 4mm, 8mm, and 9-track for computer magnetic tape are eliminated and the costs ($13.50, $12.00, $11.00 each respectively) are actual costs. The cost for data cartridges is actual costs instead of the current cost of $17.50 for 2000 series, $20.00 for 3000 series, $25.00 for 6000 series, $35.00 for 9000 series, and $20.00 for the 600A for each. The cost for a tape cartridge is actual cost instead of $38.00 for each 25 OMB and $45.00 for each 525MB. The following additional categories of media are added: rewritable CD (CD-RW) at $1.00 each, non-rewritable CD (CD-R) at $1.00 each, JAZ drive and other electronic media at actual cost. The cost for a digital video disc has been changed from the proposal. The charge was proposed as $1.00 each. However, this was in error. The TBPC charge is $3.00 each and the department does not have approval from TBPC to vary this cost.

The computer resource per minute charges are clarified as per CPU minute for the mainframe or the mid-size/mini and per clock hour for the client/server, and PC or LAN. The programming charge is changed from $26.00 per hour to $28.50 per clock hour.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission

with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: Government Code, §552.230 and §552.262.

§3.13. Cost of Copies of Official Records.

(a) Standard costs. The following table lists charges for copies and related services.
Figure: 43 TAC §3.13(a)

(b) Personnel and overhead charge. A personnel charge of $15 per hour plus an overhead charge of 20% of the personnel charge will be added to the costs of any request involving:

(1) more than 50 pages;

(2) copying of information located in two or more buildings that are not physically connected with each other;

(3) copying of information located in a remote storage facility;

(4) retrieval of information that is older than five years and will require more than five hours to make available for inspection; or

(5) retrieval of information that will completely fill six or more archival boxes and will require more than five hours to make available for inspection.

(c) Document inspection. If editing of confidential information is required in order to obtain access to a record for inspection, the department may charge for the cost of making copies to edit.

(d) Estimated charges.

(1) If a request will result in the imposition of a charge that exceeds $40, the department will provide the requestor:

(A) an itemized statement detailing all estimated charges; and

(B) an identification of any less costly alternative that is available.

(2) If a less costly alternative is specified, the itemized statement will inform the requestor of the need to contact the department regarding the alternative and will inform the requestor:

(A) that the request will be considered to be automatically withdrawn if the requestor does not, within 10 days of the date of the notice and in writing, accept the charges or modify the request; and

(B) that the requestor may respond by mail, in person, by facsimile transmission, or by electronic mail.

(3) If, before the requested information is made available, it is determined that actual charges will exceed the charges identified in paragraph (1) of this subsection by 20% or more, the department will send the requestor an updated itemized statement detailing all estimated charges that will be imposed.

(4) If an itemized or updated itemized statement is provided under paragraphs (1) or (3) of this subsection and the requestor does not accept the estimated charges in writing or modify the request in writing within 10 days of the date of the notice, the request will be considered to have been withdrawn by the requestor.

(5) Actual charges will not exceed the estimated charges in the itemized statement provided under paragraph (1) of this subsection by more than 20%, or if an updated itemized statement is provided under paragraph (3) of this subsection, actual charges will not exceed the estimated charges in the updated itemized statement.

(e) Payment.

(1) Payment of charges is due prior to release of copies of records.

(2) Upon release of copies of records, the department will provide to the requestor a statement describing all charges, including the amount of time required for retrieval and copying, when personnel and overhead charges are included. The statement will be signed by an authorized employee with that employee's name typed or printed below the signature.

(f) Waiver.

(1) When an employee files an internal employee grievance, the department will provide copies of relevant records free of charge to an official party to the proceeding. The department's General Counsel will determine which records are relevant under this subsection.

(2) The department may waive or reduce the fees charged under subsections (a) and (b) of this section if the executive director, the district engineer with jurisdiction over the records, or the division director with jurisdiction over the records determines a waiver to be in the public interest because providing the records primarily benefits the general public or because the records can be produced at a minimal expense to the public.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406472
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: November 18, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 463-8630

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CHAPTER 9. CONTRACT MANAGEMENT
SUBCHAPTER G. CONTRACTOR SANCTIONS

The Texas Department of Transportation (department) adopts amendments to §§9.102-9.105, the repeal of §§9.106-9.110, and new §9.106, concerning contractor sanctions. Sections 9.102-9.105, 9.106, and 9.106-9.110 are adopted without changes to the proposed text as published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7955) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS, REPEALS, AND NEW SECTION

The department's contractor sanction rules set forth the circumstances under which state highway improvement contractors may be sanctioned and the procedures that must be followed. The Texas Transportation Commission (commission) previously adopted §§9.100-9.110 to specify the process by which the department will administer and manage contractor sanctions associated with highway improvement contracts.

Sections 9.102(a), (b) and (c) are revised to provide the department's executive director the authority to apply sanctions to contractors performing on any highway improvement contracts as deemed appropriate. At present, the department's executive director possesses the authority to issue sanctions associated with maintenance contracts while the commission issues sanctions associated with construction contracts. However, §9.17 of this chapter (relating to Qualification of Bidders) makes no distinction between maintenance and construction contracts. This revision will, therefore, better conform to existing contractor prequalification requirements and provide uniformity in the application of sanctions on all highway improvement contracts.

Section 9.103(b) is revised to provide that final orders regarding sanctions subsequent to the receipt of a petition for a hearing will be issued by the commission. This revision provides clarification regarding procedures associated with an appeal of the initial sanction determination rendered by the executive director.

To maintain flexibility in the sanction process, §9.103(c) is added to afford the commission the authority to reduce, eliminate, or modify those sanctions that it imposes when it is in the public interest to do so.

Sections 9.104 is revised to provide conformity with new §9.106 and the repeal of §§9.107-9.110.

Sections 9.105(a) and (b) are revised to afford the executive director the authority to suspend a contractor in those instances where the contractor is notified of debarment. This provides conformity with the revisions to §9.102(a), (b) and (c).

Section 9.106 is repealed and simultaneously adopted as new §9.106 to provide four distinct sanction levels applicable to highway improvement contracts, regardless of the reason for the sanction. In accordance with revisions to §9.104(d) and (e), the determination of the appropriate sanction level is at the discretion of the executive director, including the imposition of consecutive sanctions in the event of multiple contractor violations. New §9.106 will serve to further protect the integrity of the competitive bid process by providing the executive director the flexibility to impose the appropriate sanction level in instances of consecutive contractor violations for various reasons.

New §9.106(a) affords the executive director the authority to issue sanctions and provides conformity with the revisions to §9.102(a), (b) and (c). In addition, paragraphs (5) and (6) are added to §9.106(a) to provide that a contractor's failure to execute a highway improvement contract after a bid is awarded or honor a bid guaranty submitted in accordance with §9.14 of this title (relating to Submittal of Proposal) are additional grounds for contractor sanctions.

As a result of the revisions to §§9.102-9.106, the remaining sections of this subchapter are no longer needed. Therefore, §9.107 (relating to Failure to Honor a Bid Guaranty), §9.108 (relating to Failure to Execute a Contract), §9.109 (relating to Notice of Debarment in Other Jurisdictions), and §9.110 (relating to Performance Default) are repealed.

COMMENTS

No comments were received on the proposed amendments, repeals and new section.

43 TAC §§9.102 - 9.106

STATUTORY AUTHORITY

The amendments and new section are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: None.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406473
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: November 18, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 463-8630

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43 TAC §§9.106 - 9.110

STATUTORY AUTHORITY The repealed sections are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: None.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406474
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: November 18, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 463-8630

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CHAPTER 21. RIGHT OF WAY
SUBCHAPTER K. CONTROL OF SIGNS ALONG RURAL ROADS

43 TAC §21.441

The Texas Department of Transportation (department) adopts amendments to §21.441, concerning permit for erection of off-premise sign. The amendments to §21.441 are adopted without changes to the proposed text as published in the August 13, 2004, issue of the *Texas Register* (29 TexReg 7958) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

Transportation Code, §394.021, allows outdoor advertisers to erect off-premise signs on state rural roads if there is a commercial or industrial activity within 800 feet of the sign site. Section

21.441, the rule implementing Transportation Code, §394.021, requires that two such activities be within 800 feet of the sign site. This conflict has caused confusion in enforcing sign regulations statewide. Amending the rule will bring it into conformity with the statute.

Section 21.441(b)(3)(A) is amended to require that one commercial or industrial activity instead of two be within 800 feet of the sign site.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department and more specifically, Transportation Code, Chapter 394, which authorizes the department to carry out the provisions of the those laws governing outdoor advertising on state rural roads.

CROSS REFERENCE TO STATUTE: Transportation Code, §394.021.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 29, 2004.

TRD-200406475
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: November 18, 2004
Proposal publication date: August 13, 2004
For further information, please call: (512) 463-8630

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TEXAS DEPARTMENT OF INSURANCE

Notification Pursuant to the Insurance Code, Chapter 5, Subchapter L

As required by the Insurance Code, Article 5.96 and 5.97, the ***Texas Register*** publishes notice of proposed actions by the Texas Department of Insurance. Notice of action proposed under Article 5.96 must be published in the ***Texas Register*** not later than the 30th day before the proposal is adopted. Notice of action proposed under Article 5.97 must be published in the ***Texas Register*** not later than the 10th day before the proposal is adopted. The Administrative Procedure Act, Government Code, Chapters 2001 and 2002, does not apply to department action under Articles 5.96 and 5.97.

The complete text of the proposal summarized here may be examined in the offices of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78701.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Administrative Procedure Act.

Texas Department of Insurance

Final Action on Rules

EXEMPT FILING NOTIFICATION PURSUANT TO THE INSURANCE CODE CHAPTER 5, SUBCHAPTER L, ARTICLE 5.96 ADOPTION OF NEW AND/OR ADJUSTED 2003 and 2004 MODEL PRIVATE PASSENGER AUTOMOBILE PHYSICAL DAMAGE RATING SYMBOLS FOR THE TEXAS AUTOMOBILE RULES AND RATING MANUAL

The Commissioner of Insurance adopts amendments proposed by Staff to the Texas Automobile Rules and Rating Manual (the Manual). The amendments consist of new and/or adjusted 2003 and 2004 model Private Passenger Automobile Physical Damage Rating Symbols and revised identification information. Staff's petition (Ref. No. A-0904-15-I) was published in the September 24, 2004 issue of the *Texas Register* (29 TexReg 9209).

The new and/or adjusted symbols for the Manual's Symbols and Identification Section reflect data compiled on damageability, repairability, and other relevant loss factors for the 2003 and 2004 model year of the listed vehicles. The amendments as adopted by the Commissioner of Insurance are shown in exhibits on file with the Chief Clerk under Ref. No. A-0904-15-I, which are incorporated by reference into Commissioner's Order No. 04-1051.

The Commissioner of Insurance has jurisdiction over this matter pursuant to Insurance Code Articles 5.10, 5.96, 5.98 and 5.101.

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that the Manual is amended as described herein, and the amendments are adopted to become effective on the 60th day after publication of the notification of the Commissioner's action in the *Texas Register*.

TRD-200406574
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: November 2, 2004

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REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Proposed Rule Review

Texas State Board of Medical Examiners

Title 22, Part 9

The Texas State Board of Medical Examiners proposes to review Chapter 166 (§§166.1-166.6), concerning Physician Registration, pursuant to the Texas Government Code, §2001.039.

The agency's reason for adopting the rules contained in this chapter continues to exist.

Comments on the proposed review may be submitted to Colleen Klein, P.O. Box 2018, Austin, Texas 78768-2018.

TRD-200406571
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: November 2, 2004

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Adopted Rule Review

Texas Public Finance Authority

Title 34, Part 10

The Texas Public Finance Authority adopts the review of Chapters 221 and 225, pursuant to the requirements of Government Code, §2001.039. Notice of the proposed rule review was published in the August 6, 2004, issue of the *Texas Register* (29 TexReg 7743).

No comments were received concerning the proposed rule review.

The Authority has completed the review of Chapters 221 and 225 and has determined that the reasons for adopting the chapters continue to exist. However, certain sections of Chapter 221 and all sections of Chapter 225 require revisions. Proposed amendments to §§221.2, 221.3, 221.6, and 225.1, 225.3, 225.5, and 225.7 are published in the Proposed Rules section of this issue of the *Texas Register*.

This concludes the review of Chapters 221 and 225.

TRD-200406476
Kimberly Edwards
Executive Director
Texas Public Finance Authority
Filed: October 29, 2004

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TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 22 TAC §7.4

Figure: 22 TAC §7.10(b)

Fee Description	Architects	Landscape Architects	Interior Designers
Exam Application	$100	$100	$100
Examination	981	***	**
Registration by Examination - Resident	155	*355	*355
Registration by Examination - Nonresident	180	*380	*380
Reciprocal Application	150	150	150
Reciprocal Registration	*400	*400	*400
Active Renewal - Resident	*310	*310	*310
Active Renewal - Nonresident	*400	*400	*400
Active Renewal 1-90 days late - Resident	*465	*465	*465
Active Renewal 91-365 days late - Resident	*620	*620	*620
Active Renewal 1-90 days late - Nonresident	*600	*600	*600
Active Renewal 91-365 days late - Nonresident	*800	*800	*800
Emeritus Renewal - Resident	50	N/A	N/A
Emeritus Renewal- Nonresident	183	N/A	N/A
Emeritus Renewal 1-90 days late - Resident	75	N/A	N/A
Emeritus Renewal 91-365 days late - Resident	100	N/A	N/A
Emeritus Renewal 1-90 days late - Nonresident	274.50	N/A	N/A
Emeritus Renewal 91-365 days late - Nonresident	366	N/A	N/A
Inactive Renewal - Resident	50	50	50
Inactive Renewal - Nonresident	125	125	125
Inactive Renewal 1-90 days late - Resident	75	75	75
Inactive Renewal 91-365 days late - Resident	100	100	100
Inactive Renewal 1-90 days late - Nonresident	187.50	187.50	187.50
Inactive Renewal 91-365 days late - Nonresident	250	250	250
Reciprocal Reinstatement	620	620	620
Change in Status - Resident	65	65	65
Change in Status - Nonresident	95	95	95
Reinstatement - Resident	685	685	685
Reinstatement - Nonresident	775	775	775
Certificate of Standing - Resident	30	30	30
Certificate of Standing - Nonresident	40	40	40
Replacement or Duplicate Wall Certificate - Resident	80	80	80
Replacement of Duplicate Wall Certificate - Nonresident	90	90	90
Duplicate Pocket Card	15	15	15
Reopen Fee for closed candidate files	25	25	25
Examination - Administrative Fee	-	40	-
Examination - Record Maintenance	25	25	25
Returned Check Fee	25	25	25
Application by Prior Examination	-	-	100
Administrative Fee for 1.5 Hour LARE Review	-	22	-
Administrative Fee for 1 Hour LARE Review	-	17	-

*These fees include a $200 professional fee required by the State of Texas and deposited with the State Comptroller of Public Accounts into the General Revenue Fund. The fee for initial architectural registration by examination does not include the $200 professional fee. Under the statute, the professional fee is imposed only upon each renewal of architectural registration.
**NCIDQ fee: October 2004 - $675; April 2005 - $695; October 2005 - $695
***LARE fee: June 2004 - $430 (2 sections only); August 2004 - $500 (remaining 3 sections) (Total exam - June/August 2004 - $930); December 2004 - $470 (2 sections only); March 2005 - $525 (estimate for remaining 3 sections) (Total exam - December 2004/March 2005 - $995); June 2005 - $470 (2 sections only); August 2005 - $525 (estimate for remaining 3 sections) (Total exam - June/August 2005 - $995); December 2005 - $490 (2 sections only)

Figure: 28 TAC §11.1403

NOTICE OF SPECIAL TOLL-FREE COMPAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623 [~~1-800-228-1570~~]

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency [~~dependence~~] treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL [~~EXPECIAL~~] PARA QUEJAS PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS [~~PISQUITRICOS~~] O DE DEPENDENCIA QUIMICA EN UN [~~US~~] HOSPITAL GENERAL, LLAME A:

1-800-832-0623 [~~1-800-228-1570~~]

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

The entire notice shall be in at [~~a~~] least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice shall be in the same type as the rest of the newsletter or mailing. Paragraphs 1-3 of the English notice and paragraphs 1-3 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in [a] capital letters. A final print of the mailing shall be submitted to the HMO Division [~~Unit~~] of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

Figure: 28 TAC §11.1804(b)

Additional Statutory Deposit Required

Type of HMO	
Basic Service MCO	$150,000
Limited Service MCO	$100,000
Single Service MCO	$ 75,000

	[~~Reduction in Net Worth~~]	[~~Reduction in Statutory Deposit~~]
[~~Type of HMO~~]	[~~$500,000~~]	[~~$250,000~~]
[~~Basic Service MCO~~]	[~~$300,000~~]	[~~$190,000~~]
[~~Limited Service MCO~~]	[~~$300,000~~]	[~~$190,000~~]
[~~Single Service MCO~~]	[~~$125,000~~]	[~~$125,000~~]

If and only if a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in subsection (c)(2)(B) in this section and if the MCO participates solely in the section 1115 waiver expansion program controlled and as defined by the State Medicaid Office for Texas, and is determined by the commissioner to be such an MCO, then [~~the $1.5 million figure required by §11.1802(a)(1) of this title (relating to Minimum Surplus or Net Worth) is reduced to $500,000 and~~] the $400,000 [~~$500,000~~] figure required by §11.1803(a)(1) [~~§11.1803(b)(1)~~] of this title (relating to Statutory Deposits) is reduced to $100,000 [~~$100,00~~]. [~~Provided, however, if the requirements of HMOs mandated by the Insurance Code Article 20A.13 §(b)(i) and §(b)(j) are increased by the Texas Legislature, then the reductions provided in this section shall increase to the levels required by the Texas Legislature upon the effective date provided in any such amendment.~~]

Figure: 43 TAC §3.13(a)

Service Rendered	Charge
Standard-size paper copies (up to 8 1/2 inches x 14 inches)	$ .10 per page (Each side that has recorded information is considered a single page)
Paper copies produced on high-resolution color copier	$ .65 per page (Each side that has recorded information is considered a single page)
Charges for certified copies	Charges as applicable, plus $1.00 for sealed certification page
Nonstandard-size paper copy	$ .50 per page
Paper copy from microfilm or microfiche: standard size	$ .10 per page
Specialty paper/media (e.g.: Mylar blueline, blueprint, continuous or roll plot)	Actual cost
Title and registration verification (record search)	$2.30
Title history	$5.75
Online access to motor vehicle records database	$23.00 per month plus $ .12 per record entry
Motor vehicle registration and title database	$5,000 plus $ .38 per 1,000 records copied to tape
Weekly updates to motor vehicle registration and title database -- tape provided by the department	$135.00
Batch inquiry to motor vehicle records database	$23.00 per computer run plus $ .12 per record searched
Texas Highways Magazine mailing list	(See charges under 43 TAC §23.28)
Duplicate forms: --microfilm roll, 16mm --microfilm roll, 35mm --microfiche --microfilm jackets	Actual cost (current Texas State Library charge; contact TxDOT Records Management for cost and assistance).
Photographic prints	Actual cost
Diskettes	$1.00 each
Computer magnetic tape	Actual cost
Data cartridge	Actual cost
Tape cartridge	Actual cost
Rewritable CD (CD-RW)	$1.00 each
Non-rewritable CD (CD-R)	$1.00 each
Digital video disc	$3.00 each
JAZ drive	Actual cost
Other electronic media	Actual cost
VHS video cassette	$2.50 each
Audio cassette	$1.00 each
Other, including miscellaneous supplies, postage and shipping	Actual cost
Remote document retrieval charges	Actual cost

Service Rendered	Charge
Computer resource charge (mainframe; prorated to actual time used; charges not assessed for printout time)	$10.00 per CPU minute
Computer resource charge (mid-size/mini; prorated to actual time used; charges not assessed for printout time)	$1.50 per CPU minute
Computer resource charge (client/server; prorated to actual time used; charges not assessed for printout time)	$2.20 per clock hour
Computer resource charge (PC or LAN prorated to actual time used; charges not assessed for printout time)	$1.00 per clock hour
Programming (time charge; to be prorated to actual time used)	$28.50 per clock hour
Outside/Contracted Services	Actual Cost

Publication	Charge
County general highway maps (charges based on the sheet as a unit for all department maps); Colored maps available in selected counties only	Actual cost: Contact Map Sales at (512) 486-5014
Official department state map: (3 x 3 feet: 1 inch = 22 miles)	Actual cost: Contact Map Sales at (512) 486-5014
Traffic maps: Half scale (18 x 25 inches) only	Actual cost: Contact Map Sales at (512) 486-5014
State outline maps	Actual cost: Contact Map Sales at (512) 486-5014
Division manuals and subscription services (also available on an annual fee basis are subscription services to provide administrative documents pertaining to appraisal work and utility adjustment work performed for and by the department)	Charges based on cost of printing: Contact Publications Sales at (512) 302-0985

Figure: 43 TAC §21.40(f)(1)(A)

Minimum Depth of Cover by Voltage

Voltage	Minimum Depth of Cover
22,000 or less	30 inches
22,001 to 40,000	36 inches
40,001 and greater	42 inches

Figure: 43 TAC §21.41(c)

Horizontal Clearances[1]					
Location	Functional Classification	Design Speed (mph)	Avg. Daily Traffic[2]	Horizontal Clearance Width (ft) [3, 4, 5] Minimum	Desirable
Rural	Freeways	All	All	30	
Rural	Arterial	All	0 - 750	10	16
			750 - 1500	16	30
			>1500	30	-
Rural	Collector	≥50	All	Use above rural arterial criteria.	
		≤45	All	10	-
Rural	Local	All	All	10	-
Suburban	All	All	<8,000	10[6]	10[6]
Suburban	All	All	8,000 - 12,000	10[6]	20[6]
Suburban	All	All	12,000 - 16,000	10[6]	25[6]
Suburban	All	All	>16,000	20[6]	30[6]
Urban	Freeways	All	All	30	
Urban	All (curbed)	≥50	All	Use above suburban criteria insofar as available border width permits.	
Urban	All (curbed)	≤45	All	1.5 from curb face	3.0
Urban	All (uncurbed)	≥50	All	Use above suburban criteria.	
Urban	All (uncurbed)	≤45	All	10	-

[1] Because of the need for specific placement to assist traffic operations, devices such as traffic signal supports, railroad signal/warning device supports, and controller cabinets are excluded from horizontal clearance requirements, but must be located outside of the prescribed horizontal clearances or protected by a barrier.

[2] Average ADT over project life, i.e., 0.5 (present ADT and future ADT). Use total ADT on two-way highways and directional ADT on one-way highways.

[3] Without barrier or other safety treatment of appurtenances.

[4] Measured from edge of travel lane for all cut sections and for all fill sections where side slopes are 6:1 or flatter. Where fill slopes are steeper then 6:1, it is desirable to provide a hazard-free area beyond the toe of slope.

[5] Desirable, rather than minimum, values should be used where feasible.

[6] Purchase of 5 feet or less of additional right of way strictly for satisfying horizontal clearance provisions is not required.

[7] 16 feet for ramps.

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for these activities extends 30 days from the date published on the Coastal Coordination Council web site. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of October 21, 2004, through October 28, 2004. The public comment period for these projects will close at 5:00 p.m. on November 12, 2004.

FEDERAL AGENCY ACTIONS:

Applicant: Texas Gulf & Harbor, Ltd.; Location: The project is located adjacent to Corpus Christi Bay and State Highway 361, approximately 3 miles south of Port Aransas, Nueces County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Port Aransas, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 14; Easting: 684538 (POB) & 686904 (POE); Northing: 3071258 (POB) & 3074676 (POE). Project Description: The applicant proposes to develop an approximate 835-acre tract of land for a destination resort complex that will include residential housing, retail establishments, a marina, channels and a golf course. The proposed work will result in the filling of 16.9 acres of jurisdictional areas, maintenance dredging of an entrance channel, and the excavation of 46.3 acres of jurisdictional areas and the conversion of 78.7 acres of uplands into manmade canals, channels and expansion of the existing basin. CCC Project No.: 05-0013-F1; Type of Application: U.S.A.C.E. permit application #23357 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act.

Applicant: Karam Ali Mohammed; Location: The project is located in wetlands adjacent to Dickinson Bayou, at the intersection of 146 and Avenue R, in San Leon, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Texas City, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 307980; Northing: 3262070. Project Description: The applicant requests an After-the-Fact Permit application for the mechanized land clearing and discharge of fill material into 1.35 acres of wetlands on a 15-acre tract to develop a commercial development. The fill material that was placed outside of the 1.35-acre project site will be removed and the area will be restored to pre-existing conditions. To compensate for the impacts to 1.35 acres of wetlands, the applicant will construct 2.70 acres of wetlands from adjacent uplands. The applicant will excavate uplands to the elevation of the existing marsh and allow the site to revegetate naturally. Standard monitoring and success criteria will be incorporated into the mitigation plan. CCC Project No.: 05-0023-F1; Type of Application: U.S.A.C.E. permit application #23331 is being evaluated under §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act.

Applicant: M&M Development Company; Location: The project is located in waters of the U.S., including wetlands adjacent to and within Dickinson Bayou, on a 49-acre tract, on Hughes Road approximately 0.7 mile east of Interstate 45, in Galveston County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Dickinson, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 300005; Northing: 3260062. Project Description: The applicant requests an After-the-Fact permit to retain fill material placed into 2.017 acres of gilgai wetlands, 0.86 acre of an open water tributary, and 0.13 acre of fringe wetlands located along Dickinson Bayou. Additionally, the applicant proposes to excavate 0.251 acre of open water in Dickinson Bayou. The project purpose is to construct a residential subdivision, including in-line vegetated detention basins, called the Reserves. The detention basins will be constructed by excavating 0.86 acre of an unnamed tributary to Dickinson Bayou and adjacent uplands. The basins will be graded to create 1.93 acre of open water areas, 1.15 acre of wetland fringe, and 1.21 acre of riparian buffer. The applicant proposes to retain the fill material placed in 2.017 acre of adjacent wetlands to develop the subdivision. These wetlands are gilgai-type so the acreage was estimated based on the percent. Along the Dickinson Bayou shoreline, the applicant proposes to retain fill material placed in 0.21 acre of fringe wetlands located within a small cove. Additionally, the applicant proposes to construct a bulkhead around the cove and excavate 0.251 acre of open water to allow for boat access. To compensate for the impacts to 3.26 acres of waters of the U.S., the applicant proposes an onsite compensatory mitigation plan and an offsite preservation mitigation plan. The applicant will construct 1.15 acre of freshwater fringe wetlands and 1.21 acre of riparian buffer within the Reserves. Additionally, the applicant proposes to construct a bulkhead in uplands along the Dickinson Bayou shoreline. The 5-foot transition between the bulkhead and the bayou will be excavated to create 0.14 acre of tidal wetlands along the shoreline. The applicant will also enhance 0.30 acre of riparian area along the east side of the cove. The applicant's offsite mitigation plan involves the preservation of a 9.59-acre forested tract adjacent to Dickinson Bayou. A conservation easement on the property will be established and held by an approved land trust. CCC Project No.: 05-0024-F1 Type of Application: U.S.A.C.E. permit application #23567 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act.

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above may be obtained from Ms. Gwen Spriggs, Council Administrative Coordinator, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or gwen.spriggs@glo.state.tx.us. Comments should be sent to Ms. Spriggs at the above address or by fax at 512/475-0680.

TRD-200406585
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: November 3, 2004

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Comptroller of Public Accounts

Notice of Revision to Plan of Operation

Texas Treasury Safekeeping Trust Company Plan of Operation

Plan of Operation: Pursuant to Chapter 404, Subchapter G, §404.103(g), Texas Government Code, the Texas Treasury Safekeeping Trust Company (Trust Company) has developed and adopted a revised Plan of Operation for the purchase of certain goods and services using best value methods. Pursuant to §404.103(g), the Trust Company shall make all purchases of goods and services using purchasing methods that ensure the best value to the Trust Company and its participants.

Copies: On November 12, 2004, the Trust Company (agency 930) made the complete revised Plan of Operation available electronically on the Texas Marketplace, http://esbd/tbpc.state.tx.us/1380/sagency.cfm. Hard copies of the Plan of Operation may also be requested from the contact named in the paragraph below.

Questions: Questions concerning the revised Plan of Operation may be submitted via facsimile or e-mail to Pamela Smith, Deputy General Counsel for Contracts, General Counsel Division, Comptroller of Public Accounts, 111 E. 17th St., ROOM G-24, Austin, Texas, 78774; facsimile: (512) 475-0973; e-mail: pamela.smith@cpa.state.tx.us. On December 15, 2004 or as soon thereafter as practical, the Trust Company shall post on the Texas Marketplace answers to written questions concerning the Plan of Operation that are received via such facsimile or e-mail before 5:00 pm, CZT, December 13, 2004.

TRD-200406599
Pamela Smith
Deputy General Counsel, Contracts
Comptroller of Public Accounts
Filed: November 3, 2004

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in Sections 303.003 and 303.009, Tex. Fin. Code.

The weekly ceiling as prescribed by Sections 303.003 and 303.009 for the period of 11/08/04 -- 11/14/04 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit thru $250,000.

The weekly ceiling as prescribed by Sections 303.003 and 303.09 for the period of 11/08/04 -- 11/14/04 is 18% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

TRD-200406573
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: November 2, 2004

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East Texas Council of Governments

Request for Proposals

The East Texas Council of Governments (ETCOG), as administrative unit for the East Texas Workforce Development Board, is soliciting proposals for increasing the quality of child care in the East Texas Workforce Development Area (WDA).

The total funds available are $100,000. Counties that comprise the East Texas WDA are Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt, and Wood.

Funds will be awarded to community agencies, including child care providers and educational institutions, for innovative projects that will enhance, improve and increase the quality of direct child care provided to the children in this region. The proposer is encouraged to use their own initiative and creativity to propose methods to enhance the quality of infant, toddler and school age child care in addition to the services required by the Board. Significant consideration will be given to proposals that are designed to provide services or activities to the broadest range and/or largest number of child care providers in the region.

Requests for Proposals will not be released prior to October 28, 2004. The anticipated deadline for receipt of proposals will be November 23, 2004.

Persons or organizations wanting to receive a Request for Proposals (RFP) package should request by letter, email or by fax. Request letters should be addressed to Paul Macaluso, Regional Planner, Workforce Development Programs, East Texas Council of Governments, 3800 Stone Road, Kilgore, Texas 75662 or email to paul.macaluso@twc.state.tx.us or fax at 903-983-1440, Attention: Paul Macaluso.

Questions concerning the RFP process should be addressed by email or fax to Gary Allen, Section Chief, Planning and Board Support or Paul Macaluso, Regional Planner at gary.allen@twc.state.tx.us or paul.macaluso@twc.state.tx.us or fax at 903-983-1440.

TRD-200406447
Glynn Knight
Executive Director
East Texas Council of Governments
Filed: October 27, 2004

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Texas Commission on Environmental Quality

Notice of District Petition

Notices mailed October 27, 2004

TCEQ Internal Control No. 07132004-D01; Airport/288 Associates Limited (Petitioner) filed a petition for creation of Harris County Municipal Utility District No. 404 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative

Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there is only one lienholder, Old Standard Life Insurance Company, on the property to be included in the proposed District; (3) the proposed District will contain approximately 209.636 acres located within Harris County, Texas; and (4) the proposed District is within the corporate limits of the City of Houston, Texas, and is not within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. The Petitioner has provided the TCEQ with a certificate evidencing the consent of Old Standard Life Insurance Company to the creation of the proposed District. By Ordinance No. 2004-349, effective May 4, 2004, the City of Houston, Texas, gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, provide, maintain, repair, improve, and operate a waterworks and sanitary sewer system for residential, industrial and commercial purposes; (2) construct, acquire, improve, extend, maintain, and operate works, improvements, facilities, plants, equipment, and appliances helpful or necessary to provide more adequate drainage for the property in the proposed District; and (3) control, abate and amend local storm waters or other harmful excesses of water, as more particularly described in an engineer's report filed simultaneously with the filing of the petition; and (4) purchase, construct, acquire, improve, maintain, and operate additional facilities, systems, plants, park and recreational facilities, roadway system and a fire department and fire-fighting services and enterprises consistent with the purposes for which the District is created and permitted under State law. According to the petition, the Petitioners have conducted a preliminary investigation to determine the cost of the project, and from the information available at the time, the cost of the project is estimated to be approximately $8,512,000.

TCEQ Internal Control No. 10042004-D16; Wynne/Jackson West Tract LP (Petitioner) filed a petition for Kaufman County Municipal Utility District No. 2 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there is one lienholder, West Foundation, on the property to be included in the proposed District; (3) the proposed District will contain approximately 314.329 acres located within Kaufman County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Dallas, Texas. The Petitioner has also provided the TCEQ with a certificate evidencing the consent of West Foundation to the creation of the proposed District. By Resolution No. 04-2332, effective August 11, 2004, the City of Dallas gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain and operate a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, improve, extend, maintain and operate works, improvements, facilities, plants, equipment and appliances helpful or necessary to provide more adequate drainage for the property in the proposed District; (3) control, abate and amend local storm waters or other harmful excesses of waters, as more particularly described in an engineer's report filed simultaneously with the filing of the petition; and (4) purchase, construct, acquire, improve, maintain, and operate any additional facilities, systems, plants and enterprises consistent with the purposes for which the District is created. According to the petition, the Petitioners estimate that the cost of the project will be approximately $16,770,000.

TCEQ Internal Control No. 10042004-D17; Wynne/Jackson West Tract LP (Petitioner) filed a petition for Kaufman County Municipal Utility District No. 3 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there is one lienholder, West Foundation, on the property to be included in the proposed District; (3) the proposed District will contain approximately 279.667 acres located within Kaufman County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Dallas, Texas. The Petitioner has also provided the TCEQ with a certificate evidencing the consent of West Foundation to the creation of the proposed District. By Resolution No. 04-2332, effective August 11, 2004, the City of Dallas gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain and operate a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, improve, extend, maintain and operate works, improvements, facilities, plants, equipment and appliances helpful or necessary to provide more adequate drainage for the property in the proposed District; (3) control, abate and amend local storm waters or other harmful excesses of waters, as more particularly described in an engineer's report filed simultaneously with the filing of the petition; and (4) purchase, construct, acquire, improve, maintain, and operate any additional facilities, systems, plants and enterprises consistent with the purposes for which the District is created. According to the petition, the Petitioners estimate that the cost of the project will be approximately $10,280,000.

TCEQ Internal Control No. 10042004-D18; Wynne/Jackson West Tract LP (Petitioner) filed a petition for Kaufman County Municipal Utility District No. 4 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there is one lienholder, West Foundation, on the property to be included in the proposed District; (3) the proposed District will contain approximately 331.588 acres located within Kaufman County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Dallas, Texas. The Petitioner has also provided the TCEQ with a certificate evidencing the consent of West Foundation to the creation of the proposed District. By Resolution No. 04-2332, effective August 11, 2004, the City of Dallas gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain and operate a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, improve, extend, maintain and operate works, improvements, facilities, plants, equipment and appliances helpful or necessary to provide more adequate drainage for the property in the proposed District; (3) control, abate and amend local storm waters or other harmful excesses of waters, as more particularly described in an engineer's report filed simultaneously with the filing of the petition; and (4) purchase, construct, acquire, improve, maintain, and operate any additional facilities, systems, plants and enterprises consistent with the purposes for which the District is created. According to the petition, the Petitioners estimate that the cost of the project will be approximately $13,190,000.

INFORMATION SECTION

The TCEQ may grant a contested case hearing on a petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed district's boundaries. You may also submit your proposed adjustments to the petition which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below.

The Executive Director may approve a petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of the notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court.

Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, the same address. For additional information, individual members of the general public may contact the Office of Public Assistance, at 1-800-687- 4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200406588
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 3, 2004

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Notice of Public Hearing--30 TAC Chapter 37, Financial Assurance, and Chapter 337, Dry Cleaner Environmental Response

The Texas Commission on Environmental Quality will conduct a public hearing to receive testimony concerning revisions to 30 TAC Chapter 37, concerning Financial Assurance, new Subchapter W, Financial Assurance for Dry Cleaning Facilities, and new Chapter 337, Dry Cleaner Environmental Response, under the requirements of Texas Health and Safety Code, §382.017 and Texas Government Code, Subchapter B, Chapter 2001.

The purpose of the proposed rules is to implement House Bill (HB) 1366, 78th Legislature, 2003. HB 1366 amends the Texas Health and Safety Code (THSC) by adding a new Chapter 374. HB 1366 requires rules to be adopted that are necessary to administer and enforce the new chapter. Specifically, these proposed rules set forth procedures for administering and enforcing THSC, §374.105, which requires owners of certain dry cleaning facilities to furnish a bond or other financial assurance to the commission.

A public hearing on this proposal will be held in Austin on December 6, 2004 at 10:00 a.m. at the Texas Commission on Environmental Quality in Building E, Room 201S, located at 12100 Park 35 Circle. The hearing will be structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. There will be no open discussion during the hearing; however, an agency staff member will be available to discuss the proposal 30 minutes prior to the hearing and will answer questions before and after the hearing.

Persons with disabilities who have special communication or other accommodation needs who are planning to attend the hearing should contact the Office of Environmental Policy, Analysis, and Assessment at (512) 239-4900. Requests should be made as far in advance as possible.

Comments may be submitted to Lola Brown, MC 205, Office of Environmental Policy, Analysis, and Assessment, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or by fax to (512) 239-4808. All comments should reference Rule Project Number 2003-047-337-WS. Comments must be received by 5:00 p.m., December 13, 2004. Copies of the proposed rules can be obtained from the commission's Web site at *http://www.tnrcc.state.tx.us/oprd/rules/propadop.html*. For further information, please contact Michael Bame, Policy and Regulations Division, (512) 239-5658.

TRD-200406459
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: October 29, 2004

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Notice of Water Quality Applications

The following notices were issued during the period of October 26, 2004 through October 29, 2004.

The following require the applicants to publish notice in the newspaper. The public comment period, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P O Box 13087, Austin Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THIS NOTICE

TOWN OF BAYSIDE has applied for a renewal of TPDES Permit No. WQ0013892001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 64,200 gallons per day. The facility is located between Autry Road and Vega Road approximately 1.1 miles southwest of the intersection of 3rd Street and State Route 136 in Refugio County, Texas.

CMH PARKS INC. has applied for a renewal of TPDES Permit No. 12849-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 75,000 gallons per day. The facility is located approximately 1.0 mile north of the intersection of Farm-to- Market Road 518 and Suburban Gardens Road and approximately 2.3 miles west-northwest of the City of Pearland in Brazoria County, Texas.

EOLA WATER SUPPLY CORPORATION has applied for a major amendment to Permit No. 14053-001 to authorize a decrease in the monitoring frequency for Biochemical Oxygen Demand (5-day) from once/week to once/month. The current permit authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 25,000 gallons per day via evaporation with a total surface area of 8.18 acres and a total capacity of 8.18 acre-feet for storage which will remain the same. This permit will not authorize a discharge of pollutants into waters in the State. The facility and disposal site are located approximately 600 feet north of State Highway 765 and approximately 2,000 feet northeast of the intersection of State Highway 765 and State Highway 381 in Concho County, Texas.

FAULKEY GULLY MUNICIPAL UTILITY DISTRICT has applied for a major amendment to TPDES Permit No. 11832-001 to authorize an increase in the discharge of treated domestic wastewater from a daily average flow not to exceed 950,000 gallons per day to an annual average flow not to exceed 1,420,000 gallons per day. The proposed amendment requests to lower the existing permitted flow from 950,000 gallons per day to 900,000 gallons per day. The application also includes a request for a temporary variance to the existing water quality standards to allow time for the TNRCC to adopt a site specific standard for Faulkey Gully in Segment No. 1009 for incorporation into 30 TAC §§307.10 Appendix D. The variance would authorize a three-year period in which the Commission will consider a recommended site specific standard for Faulkey Gully and determine whether to adopt the standard or require the existing water quality standards to remain in effect. The facility is located at 15503 Hermitage Oak, north of Malcomson Road and west of Farm- to-Market Road 149 in Harris County, Texas.

FORT BEND COUNTY MUNICIPAL UTILITY DISTRICT 116 c/o Allen, Boone & Humphries, L.L.P. has applied for a renewal of TPDES Permit No. 13976-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 500,000 gallons per day. The facility is located along the west side of Crabb River Road approximately 4,200 feet south of U.S. Highway 59 in Fort Bend County, Texas.

CITY OF FULSHEAR has applied for a major amendment to TPDES Permit No. WQ0013314001 to authorize an increase in the discharge of treated domestic wastewater from a daily average flow not to exceed 75,000 gallons per day to a daily average flow not to exceed 100,000 gallons per day. The facility is located on a tract of land bounded by Farm to Market Road 1093 and Sante Fe Pacific Railway, approximately 1,000 feet west southwest of the intersection of Farm to Market Road 1093 and Farm to Market Road 359, in the City of Fulshear in Fort Bend County, Texas. are high aquatic life uses, public water supply and contact recreation.

MATAGORDA COUNTY WATER CONTROL AND IMPROVEMENT DISTRICT NO. 6 has applied for a renewal of TPDES Permit No. 10663-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 193,000 gallons per day. The facility is located approximately 3000 feet east of the intersection of State Highway 35 and Farm-to-Market Road 2540 in Matagorda County, Texas.

MCMULLEN COUNTY WATER CONTROL AND IMPROVEMENT DISTRICT NO. 1 AND MCMULLEN COUNTY have applied for a renewal of TCEQ Permit No. 13543-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 96,000 gallons per day. The facility is located adjacent to the west side of State Highway 16 and immediately south of the intersection of State Highway 16 and Farm-to-Market Road 72 in McMullen County, Texas.

THE SALVATION ARMY has applied for a major amendment to TCEQ Permit No. 13904-001 to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 50,000 gallons per day. The proposed amendment requests to dispose portion of the effluent via evaporation and use the water of Lake Whaley, a receiving body of water, for irrigation. The current permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 150,000 gallons per day via evaporation. The facility is located on the southern portion of Camp Hoblitzelle, approximately 1.5 miles south of the intersection of Farm-to-Market Road 875 and Farm-to-Market Road 685, south of the town of Midlothian in Ellis County, Texas.

SCHENECTADY INTERNATIONAL INC. which operates an alkyl phenol/petrochemical plant, has applied for a major amendment to TPDES Permit No. WQ0001961000 to authorize the discharge of wastewater from the production of 2, 4 xylenol via Outfall 101 and to authorize less stringent effluent limitations for pH at Outfall 101. The current permit authorizes the discharge of utility wastewater, storm water run off, and previously monitored effluents (monitored at Outfall 101) at a daily average flow not to exceed 1,400,000 gallons per day via Outfall 001; and process wastewater and storm water at a daily average flow not to exceed 100,000 gallons per day via Outfall 101.

THE CITY OF SEMINOLE has applied for a renewal of TPDES Permit No. 10278-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 900,000 gallons per day. This application was submitted to the TCEQ on July 15, 2004. The facility is located adjacent to and south of U.S. Highway 180, approximately 1.5 miles east of the intersection of U.S. Highways 180 and 385 in Gaines County, Texas.

SILVERLEAF RESORTS INC. has applied for a renewal of TPDES Permit No. 13417-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 200,000 gallons per day. The facility is located approximately 0.5 mile northwest of the intersection of League Line Road and White Oak Drive on Lake Conroe in Montgomery County, Texas.

SOUTH CENTRAL CALHOUN COUNTY WATER CONTROL AND IMPROVEMENT DISTRICT NO. 1 has applied for a renewal of TPDES Permit No. 13774-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 75,000 gallons per day. The facility is located 0.8 mile northeast of the intersection of State Highway 316 and Farm-to- Market Road 2760 on the south corner of the intersection of Blackburn Avenue Bay/Chocolate Bay in Calhoun County, Texas.

TOWER OAK BEND WATER SUPPLY CORPORATION has applied for a renewal of TPDES Permit No. 11986-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 50,000 gallons per day. The facility is located approximately one mile east of Jones Road and 1,000 feet north of Cypress-North Houston Road in Harris County, Texas.

UNITED STATES DEPARTMENT OF AGRICULTURE has applied for a renewal of TPDES Permit No. 12263-005, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 19,525 gallons per day. This application was submitted to the TCEQ on June 16, 2004. The facility is located in the Angelina National Forest, approximately 5.8 miles southeast of the intersection of State Highway 63 and Farm-to-Market Road 2743 near the Caney Creek Recreation Area, on the north side of Forest Service Road 336 and approximately 1,000 feet from Sam Rayburn Reservoir in Angelina County, Texas.

TRD-200406587
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 3, 2004

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Notice of Water Rights Application

Notices mailed October 28 through November 2, 2004.

CERTIFICATE OF ADJUDICATION NO. 14-5476; The Lower Colorado River Authority (LCRA), P.O. Box 220, Austin, Texas, 78767-0220, seeks an extension of time for commencement and completion

of construction of a reservoir authorized by Certificate of Adjudication No. 14-5476, pursuant to Texas Water Code 11.145, and Texas Commission on Environmental Quality Rules 30 Texas Administrative Code (TAC) 295.1, et seq. Certificate of Adjudication No. 14-5476 authorizes the owner to maintain two existing dams and reservoirs on the Colorado River, Colorado River Basin, in Matagorda County for industrial (hydroelectric generation) and agricultural (irrigation) purposes. Lane City Dam has a capacity of 305 acre-feet. With the modifications that have already been completed, Bay City Dam now has a capacity of 1,560 acre-feet. The Certificate included a requirement that the modifications of Bay City Dam were to commence by November 18, 1994, and be completed by November 20, 1995. There were subsequently two extensions of time for completion issued by the TCEQ authorizing additional time to complete modifications to the Bay City Dam, with the currently authorized completion date of August 20, 2004. The LCRA seeks to extend the deadline to complete the remaining modification to add hydroelectric generating facilities to the Bay City Dam and repairs to September 1, 2009. The applicant has indicated that they require this time extension in order to ensure that they are able to make a final determination of the cost- effectiveness of adding the hydroelectric-generating facilities to the Bay City Dam and using the electricity either in its irrigation districts or to serve its wholesale load in Central Texas. All costs involved cannot be verified until the Public Utilities Commission and the Electric Reliability Council of Texas determine the value of the electric output of the Bay City Dam. Review and approval of the rules determining said value is expected to conclude by November 2005, after which time the LCRA will be able to review the cost-effectiveness of the Bay City Dam hydroelectric facilities. The commission will review the application as submitted by the applicant and may or may not grant the application as requested. The application was received on August 12, 2004, and additional fees and information were received on October 4, 2004. The application was determined to be administratively complete and filed with the Office of the Chief Clerk on October 7, 2004. Written public comments and requests for a public meeting should be received in the Office of Chief Clerk, at the address provided in the information section below, within 30 days of the date of newspaper publication of the notice.

WATER USE PERMIT NO. 5259; Public Utilities Board of Brownsville, P.O. Box 3270, Brownsville, Texas 78523-3270, applicant, seeks an extension of time for commencement and completion of construction of a dam and reservoir authorized by Water Use Permit No. 5279, pursuant to Texas Water Code (TWC) 11.145, and Texas Commission on Environmental Quality Rules 30 Texas Administrative Code (TAC) 295.1, et seq. Water Use Permit No. 5259 authorizes the Permittee to construct and maintain a dam creating a reservoir on the Rio Grande and impound therein not to exceed 6,000 acre-feet of water. Permittee is also authorized to divert and use water from the storage in the reservoir pursuant to its existing water rights authorized by Certificate of Adjudication No. 23-865 and Water Use Permit No. 1838 (Application No. 1980). The permit included time limitations that construction of the dam and reservoir commence by September 29, 2002 and be completed by September 29, 2005. There was an extension of time granted by order dated September 9, 2002 to commence construction by September 29, 2004 and complete construction by September 29, 2007. Applicant seeks to extend the time limitations to commence construction by September 29, 2007 and to complete construction by September 29, 2009. The applicant has indicated that it requires a time extension in order to obtain both federal and international authorizations and approval for the project. These approvals have taken more time than was anticipated. The Commission will review the application as submitted by the applicant and may or may not grant the application as requested. The application was received on September 24, 2004. The application was determined to be administratively complete and filed with the Office of the Chief Clerk on October 7, 2004. Written public comments and requests for a public meeting should be received in the Office of Chief Clerk, at the address provided in the information section below, within 30 days of the date of newspaper publication of the notice.

PROPOSED PERMIT NO. 5848; Arkema, Inc. (Sulfox Process Unit), P.O. Box 1427, Beaumont, Texas, 77704-1427, has applied to the Texas Commission on Environmental Quality (TCEQ) for a Temporary Water Use Permit pursuant to Texas Water Code 11.138, and Texas Commission on Environmental Quality Rules 30 TAC 295.1, et seq. Applicant seeks a temporary water use permit to divert and use not to exceed 800 acre-feet of water within a period of one year from an oxbow, tributary to the Neches River, Neches River Basin located in the vicinity of 2810 Gulf States Road, approximately 9 miles north of the town of Nederland, Texas, at Latitude 30.058 N, Longitude 92.057 W, at a maximum diversion rate of 4.456 cfs (2,000 gpm) for industrial purposes in Jefferson County. The Commission will review the application as submitted by the applicant and may or may not grant the application as requested. The application was received on June 1, 2004. Additional information and fees were received on August 4 and September 3, 2004. The application was declared administratively complete and filed with the Office of the Chief Clerk on September 14, 2004. Written public comments and requests for a public meeting should be received in the Office of Chief Clerk, at the address provided in the information section below, by November 23, 2004.

Information Section

A public meeting is intended for the taking of public comment, and is not a contested case hearing. A public meeting will be held if the Executive Director determines that there is a significant degree of public interest in an application.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any: (2) applicant's name and permit number; (3) the statement "[I/we] request a contested case hearing;" and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the TCEQ Office of the Chief Clerk at the address provided in the information section below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200406586

LaDonna Castañuela

Chief Clerk

Texas Commission on Environmental Quality

Filed: November 3, 2004

Department of Family and Protective Services

Request for Proposal--Community Based Child Abuse Prevention (formerly known as Community Based Family Resource and Support Program)

The Texas Department of Family and Protective Services (DFPS), Division of Prevention and Early Intervention, is soliciting proposals for Community Based Child Abuse Prevention services. DFPS anticipates funding between five and seven contracts under this procurement. **The Request for Proposal (RFP) will be released on or about November 2, 2004, and will be posted on the State Internet Site at http://www.marketplace.state.tx.us/ on the date of its release.**

Brief Description of Services: The purpose of this RFP is to solicit contractors who will create, develop, and maintain Community Partnerships for Strengthening Families.

The intent of this procurement is to purchase services that are comprehensive, collaborative, innovative, and capable of affecting substantial change at the community level. It calls for the meaningful participation of parents and community members in the design, implementation, and evaluation of programs and services related to child abuse prevention.

Eligible Offerors: Eligible offerors include private nonprofit and for-profit corporations, cities, counties, state agencies/entities, partnerships, and individuals. Historically Underutilized Businesses (HUBs), Minority Businesses and Women's Enterprises, and Small Businesses are encouraged to apply.

Deadline for Proposals, Term of Contract, and Amount of Award: Proposals will be **due November 24, 2004, at 12 Noon**. It is anticipated that the maximum available funds for services purchased under this RFP for the contract period of January 1, 2005, through August 31, 2005, will be $1,395,175. DFPS anticipates funding between five and seven contracts under this procurement. Offerors may apply for an eight- month prorated reimbursable funding amount between $75,000 and $115,000.

Limitations: The funding allocated for the contract resulting from this RFP is dependent on Legislative appropriation. Funding is not guaranteed at the maximum level, or at any level. DFPS reserves the right to reject any and all offers received in response to this RFP and to cancel this RFP if it is deemed in the best interest of DFPS. DFPS also reserves the right to re-procure this service.

If no acceptable responses are received, or no contract is entered into as a result of this procurement, DFPS reserves the right to procure by non-competitive means in accordance with the law but without further notice to potential vendors.

Contact Person: Potential offerors may obtain a copy of the RFP on or about November 2, 2004. It is preferred that requests for the RFP be submitted in writing (by mail or fax) to: Sundee McKnight; Mail Code Y-956; Texas Department of Family and Protective Services; P.O. Box 149030; Austin, Texas 78714-9030; Fax: 512-821-4767.

TRD-200406579
Gerry Williams
Acting General Counsel
Department of Family and Protective Services
Filed: November 2, 2004

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Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
League City	Filter Flow Technology Inc	L05835	League City	00	10/26/04
Longview	Diagnostic Clinic of Longview PA	L05817	Longview	00	10/21/04
Stephenville	Caporal Industries LTD	L05837	Stephenville	00	10/26/04
Throughout Tx	Capitan Corporation	L05824	Midland	00	10/14/04

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Alice	Christus Spohn Health System Corporation DBA Christus Spohn Hospital Alice	L02390	Alice	36	10/25/04
Arlington	Physician Reliance Network Inc DBA Texas Cancer Center Arlington	L05116	Arlington	09	10/15/04
Austin	Applied Genetics Inc	L04806	Austin	07	10/22/04
Austin	Capital Cardiovascular Consultants	L05590	Austin	06	10/18/04
Austin	Seton Medical Center	L02896	Austin	76	10/21/04
Bay City	Equistar Chemicals LP	L03938	Bay City	17	10/14/04
Beaumont	Health South Diagnostic Center of Texas LP DBA Health South Diagnostic Center of Beaumont	L03888	Beaumont	32	10/14/04
Carrollton	Tenet Health System Hospitals Dallas Inc DBA Trinity Medical Center	L03765	Carrollton	44	10/19/04
Channelview	Enpro Systems LTD	L04990	Channelview	14	10/19/04
College Station	Prodigene Inc	L05252	College Station	02	10/14/04
Corpus Christi	All Tech Inspection	L04974	Corpus Christi	09	10/26/04
Dallas	Mallinckrodt Inc	L03580	Dallas	48	10/14/04
Dallas	Medi Physics Inc DBA GE Healthcare	L05529	Dallas	14	10/20/04
Dallas	The University of Texas Southwestern Medical Center at Dallas	L00384	Dallas	86	10/20/04
Denton	Paramount Cardiovascular Associates PA	L05596	Denton	02	10/25/04
El Paso	El Paso Cardiology Associates PA	L05162	El Paso	03	10/19/04
El Paso	Tenet Hospitals Limited DBA Sierra Medical Center	L02365	El Paso	55	10/21/04
Fannin	Coleto Creek WLE LP	L02519	Fannin	16	10/26/04
Flower Mound	Imaging Specialists Group LTD DBA Imaging Specialists	L05407	Flower Mound	09	10/21/04
Fort Worth	Harris Methodist Fort Worth	L01837	Fort Worth	94	10/18/04
Fort Worth	Adventist Health System Sunbelt Healthcare Corporation DBA Huguley Health System	L02920	Fort Worth	25	10/25/04

CONTINUED AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Houston	Doctors Hospital 1997 LP DBA Doctors Hospital Parkway	L01964	Houston	42	10/18/04
Houston	Houston Heart Clinic	L05671	Houston	01	10/14/04
Houston	Houston Medical Imaging	L05184	Houston	05	10/22/04
Houston	Memorial Hermann Healthcare System DBA Hermann Hospital	L04655	Houston	22	10/21/04
Houston	Memorial Hermann Hospital System Inc DBA Memorial Hermann Hospital	L00650	Houston	68	10/13/04
Houston	Memorial Hermann Hospital System Inc DBA Memorial Hermann Hospital	L00650	Houston	69	10/18/04
Houston	Memorial Hermann Hospital System DBA Memorial Hospital Southwest	L00439	Houston	97	10/19/04
Houston	American Diagnostic Medicine Inc DBA First PET of Houston	L05394	Houston	02	10/26/04
Houston	CHCA West Houston LP DBA West Houston Medical Center	L02224	Houston	63	10/25/04
Houston	Memorial Hermann Hospital System DBA Memorial Hospital Southwest	L00439	Houston	98	10/26/04
Houston	Northwest Diagnostic Clinic PA	L05814	Houston	01	10/27/04
Irving	Baylor Medical Center at Irving DBA Irving Healthcare System	L02444	Irving	54	10/13/04
Jacksonville	Regional Health Care Center DBA Mother Frances Hospital-Jacksonville	L05362	Jacksonville	17	10/26/04
Kingsville	Christus Spohn Health System DBA Christus Spohn Hospital Kleberg	L02917	Kingsville	36	10/25/04
La Grange	Fayette Memorial Hospital	L03572	La Grange	17	10/18/04
La Porte	Dow Chemical Company USA	L00510	La Porte	64	10/21/04
Laredo	Laredo Texas Hospital Company LP DBA Laredo Medical Center	L01306	Laredo	48	10/27/04
Lewisville	Columbia Medical Center of Lewisville subsidiary LP DBA Medical Center of Lewisville	L02739	Lewisville	44	10/20/04
Marble Falls	Marble Falls Imaging Center LP DBA Marble Falls Imaging Center	L05301	Marble Falls	05	10/22/04
McAllen	McAllen Hospitals LP DBA McAllen Medical Center	L01713	McAllen	68	10/13/04
McAllen	McAllen PET Imaging Center LLC	L05460	McAllen	07	10/26/04
McAllen	McAllen Hospitals LP DBA McAllen Medical Center	L01713	McAllen	69	10/27/04
Mesquite	HMA Mesquite Hospitals Inc DBA Medical Center of Mesquite	L02428	Mesquite	40	10/27/04
North Richland Hills	Dallas Cardiology Associates DBA Heartplace North Richland Hills	L05548	North Richland Hills	06	10/22/04
Orange	Lanxess Corporation	L00976	Orange	51	10/25/04
Pampa	Titan Specialists LTD	L04920	Pampa	05	10/20/04
Pasadena	CHCA Bayshore LP DBA Bayshore Medical Center	L00153	Pasadena	75	10/19/04
Pasadena	MEMC Pasadena Inc	L05129	Pasadena	05	10/26/04

CONTINUED AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Plainview	Plainview Cardiology PA	L05446	Plainview	02	10/15/04
Round Rock	Columbia / St Davids Healthcare System LP DBA Medical Center of Round Rock	L03469	Round Rock	36	10/21/04
San Antonio	Cardiovascular Associates of San Antonio PA	L04996	San Antonio	08	10/27/04
San Antonio	CTRC Clinical Foundation	L01922	San Antonio	76	10/21/04
San Antonio	VHS San Antonio Partners LP DBA Baptist Health System	L00455	San Antonio	136	10/26/04
San Antonio	VHS San Antonio Partners LP DBA Baptist Health System	L00455	San Antonio	137	10/28/04
Sequin	Structural Metals Inc	L02188	Sequin	15	10/26/04
Sherman	Scela Inc DBA North Texas Nuclear Pharmacy	L05461	Sherman	03	10/18/04
Temple	Texas A&M University System Health Science Center	L05494	Temple	04	10/13/04
Texas City	Sid Acharya MD PA DBA Cardiovascular Specialists of Texas	L05714	Texas City	01	10/25/04
Throughout Tx	Kooney X-Ray Inc	L01074	Barker	97	10/19/04
Throughout Tx	Brazos Valley Inspection Services	L02859	Bryan	41	10/15/04
Throughout Tx	Alliance Geotechincal Group Inc	L05314	Dallas	06	10/20/04
Throughout Tx	Shell Oil Products US DBA Deer Park Refining Limited Partnership	L04554	Deer Park	19	10/25/04
Throughout Tx	Golder Associates Inc	L04645	Houston	05	10/18/04
Throughout Tx	Halliburton Energy Services Inc	L03284	Houston	29	10/22/04
Throughout Tx	H & G Inspection Company Inc ADBA Statewide Maintenance Company	L02181	Houston	185	10/15/04
Throughout Tx	Fugro Consultants LP	L00058	Houston	46	10/25/04
Throughout Tx	Material Inspection Technology	L05672	Houston	11	10/27/04
Throughout Tx	Stork Southwestern Laboratories Inc	L00299	Houston	119	10/22/04
Throughout Tx	Southern Services Inc DBA Southern Technical Services DBA Bix Testing Laboratories	L05270	Lake Jackson	36	10/14/04
Throughout Tx	Non Destructive Inspection Corporation	L02712	Lake Jackson	114	10/25/04
Throughout Tx	Gamma Surveys LLC	L05155	LaPorte	07	10/20/04
Throughout Tx	MTR	L05803	Livingston	02	10/22/04
Throughout Tx	High tech Testing Service Inc	L05021	Longview	49	10/20/04
Throughout Tx	Eagle X-Ray	L03246	Mont Belvieu	83	10/18/04
Throughout Tx	Turner Industrial Technical LLC	L05417	Nederland	10	10/14/04
Throughout Tx	Conam Inspection & Engineering Inc	L05010	Pasadena	77	10/21/04
Throughout Tx	Quantum Technical Services Inc	L03731	Pasadena	19	10/14/04
Throughout Tx	Texas Gamma Ray LLC	L05561	Pasadena	41	10/27/04
Throughout Tx	Raba-Kistner Consultants Inc ADBA Raba-Kistner-Brytest Consultants Inc	L01571	San Antonio	56	10/27/04
Throughout Tx	Weaver Services Inc DBA WSI Cased Hole Specialist	L01489	Snyder	25	10/28/04
Throughout Tx	Blazer Inspection Inc	L04619	Texas City	36	10/28/04
Throughout Tx	H & H X-Ray Services Inc	L02516	Tyler	48	10/19/04
Tyler	Physician Reliance Network Inc DBA Tyler Cancer Center	L04788	Tyler	05	10/19/04

CONTINUED AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Tyler	Trinity Mother Frances Health System	L01670	Tyler	111	10/26/04
Vernon	Wilbarger General Hospital	L03047	Vernon	14	10/27/04
Victoria	E I Dupont De Nemours & Company Packaging & Industrial Polymers (P&IP) Ethylene Copolymers	L05800	Victoria	01	10/27/04
Weslaco	Knapp Medical Center	L03290	Weslaco	35	10/14/04

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Austin	Columbia St. Davids Healthcare System LP DBA South Austin Hospital	L03273	Austin	54	10/15/04
Austin	Columbia St Davids Healthcare System LP DBA South Austin Hospital	L03273	Austin	55	10/19/04
Baytown	Exxomobil Refining & Supply Company	L01134	Baytown	57	10/22/04
Beaumont	R Leldon Sweet MD PA DBA Outpatient Cardiovascular Services	L05029	Beaumont	08	10/26/04
Channelview	Xxtreme Pipe Services LLC	L02576	Channelview	21	10/14/04
Dallas	Medical City Dallas Hospital DBA Medical City	L01976	Dallas	152	10/22/04
Denton	University of North Texas	L00101	Denton	78	10/14/04
Edinburg	Radiology Associates of McAllen DBA Radiology Associates-Edinburg	L04512	Edinburg	11	10/26/04
El Paso	Fay E Millett MD DBA EL Paso Eye Associates	L01529	El Paso	09	10/19/04
Euless	Cor Specialty Associates of North Texas	L05062	Euless	16	10/15/04
Georgetown	Southwestern University at Georgetown	L00372	Georgetown	20	10/22/04
Houston	Institute of Biosciences and Technology	L04681	Houston	19	10/15/04
Houston	Kelsey Seybold Clinic PA	L00391	Houston	56	10/22/04
Ingleside	E I Du Pont De Nemours & Company	L01753	Ingleside	35	10/22/04
Mesquite	National Surgicare JV1 LTD	L05654	Mesquite	01	10/15/04
Nocona	Nocona Hospital District DBA Nocona General Hospital	L04977	Nocona	08	10/15/04
Pasadena	Pasadena Paper Company	L00906	Pasadena	40	10/22/04
Port Lavaca	Union Carbide Corporation A Subsidiary of the DOW Chemical Company	L00051	Port Lavaca	79	10/22/04
Richardson	Optex Systems Inc	L04332	Richardson	08	10/15/04
Throughout Tx	City of Abilene Housing Authority	L05459	Abilene	03	10/15/04
Throughout Tx	Component Sales & Service Inc	L02243	Houston	21	10/14/04
Throughout Tx	ISG Resources Inc	L05281	Jewett	01	10/15/04
Throughout Tx	Schlumberger Technology Corporation	L00764	Sugar Land	88	10/22/04
Throughout Tx	P & S Perforators Inc	L02396	Victoria	24	10/14/04
Wichita Falls	North Texas Cardiology Center DBA North Texas Cardiology Center	L05443	Wichita Falls	04	10/15/04

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Bellaire	MRA Diagnostic Imaging Center LLC	L05574	Bellaire	02	10/15/04
La Porte	Lonza Inc	L02282	La Porte	12	10/22/04

In issuing new licenses, amending and renewing existing licenses, or approving exemptions to Title 25 Texas Administrative Code (TAC), Chapter 289, the Department of State Health Services (department), Radiation Control Program, has determined that the applicants are qualified by reason of training and experience to use the material in question for the purposes requested in accordance with 25 TAC, Chapter 289 in such a manner as to minimize danger to public health and safety or property and the environment; the applicants' proposed equipment, facilities and procedures are adequate to minimize danger to public health and safety or property and the environment; the issuance of the new, amended, or renewed license (s) or the issuance of the exemption (s) will not be inimical to the health and safety of the public or the environment; and the applicants satisfy any applicable requirements of 25 TAC, Chapter 289. In granting termination of licenses, the department has determined that the licensee has properly decommissioned its facilities according to the applicable requirements of 25 TAC, Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC, Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, P.E., Director, Radiation Control Program, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756-3189. For information call (512) 834-6688.

TRD-200406594
Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Notice of Agreed Order with Oilfield Prolog Services, Inc.

On October 19, 2004, the Radiation Program Officer, Department of State Health Services (department), approved the settlement agreement between the department and Oilfield Prolog Services, Inc. (licensee-L01828) of Denver City. The license was required to pay $1,000 in administrative penalties assessed for violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available, by appointment, for public inspection at the Texas Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200406592
Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Notice of Agreed Order with the Jackson County Hospital District

On November 1, 2004, the Radiation Program Officer, Department of State Health Services (department), approved the settlement agreement between the department and Jackson County Hospital District (registrant-M00539-000) of Edna. A total administrative penalty in the amount of $11,000 was assessed the registrant for violations of 25 Texas Administrative Code, Chapter 289. Of the total administrative penalty, $6,000 will be probated for a period of one year, and will be forgiven if the registrant complies with additional settlement agreement requirements.

A copy of all relevant material is available, by appointment, for public inspection at the Texas Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200406589
Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation on American Institute of Orthopaedic and Sport Medicine

Notice is hereby given that the Department of State Health Services (department) issued a notice of violation and proposal to assess an administrative penalty to American Institute of Orthopaedic and Sport Medicine (registrant-R06886-000) of Arlington. A total penalty of $14,000 is proposed to be assessed the registrant for alleged violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available, by appointment, for public inspection at the Texas Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200406593

Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation on Central Testing Company, Inc.

Notice is hereby given that the Department of State Health Services (department) issued a notice of violation and proposal to assess an administrative penalty to Central Testing Company, Inc. (unlicensed) of Sulphur, Louisiana. A total penalty of $4,000 is proposed to be assessed the company for alleged violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available, by appointment, for public inspection at the Texas Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200406590
Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation on Hill Country Health Centers, Inc., dba Dripping Springs Chiropractic Center

Notice is hereby given that the Department of State Health Services (department) issued a notice of violation and proposal to assess an administrative penalty to Hill Country Health Centers, Inc., dba Dripping Springs Chiropractic Center (registrant-R17871-000) of Dripping Springs. A total penalty of $5,000 is proposed to be assessed the registrant for alleged violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available, by appointment, for public inspection at the Texas Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200406591
Cathy Campbell
Director, Legal Services
Department of State Health Services
Filed: November 3, 2004

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Texas Health and Human Services Commission

Public Notice

The Health and Human Services Commission, State Medicaid Office, has received approval from the Centers for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 04-19, Amendment Number 683.

This amendment modifies the consumer directed services requirement for spending funds on attendant compensation from the funds available to the client for purchasing services. This change makes the spending requirement for consumer directed services for Primary Home Care the same as the spending requirement for Primary Home Care as approved in Attachment 4.19-B Page 6(e), section (6)(A). This amendment revises page 6(f) of Attachment 4.19-B. The effective date of the amendment will be September 01, 2004.

If additional information is needed, please contact Arnulfo Gomez by telephone at (512) 491-1166 or by E-mail at arnulfo.gomez@hhsc.state.tx.us.

TRD-200406489
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: November 1, 2004

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Texas Department of Housing and Community Affairs

Request for Proposal Uniform Physical Condition Standards

I. SUMMARY.

The Texas Department of Housing and Community Affairs (TDHCA) has issued a Request for Proposal (RFP) for Uniform Physical Condition Standards. TDHCA has identified the need for Uniform Physical Condition Standards inspections for Housing Tax Credit properties. The inspector must demonstrate qualifications and experience in one or more areas that are listed in the RFP.

Proposals must be received at TDHCA no later than, 4:00 p.m. on December 1, 2004. For a copy of the RFP contact Patricia Murphy at (512) 475-3140.

TRD-200406598
Edwina Carrington
Executive Director
Texas Department of Housing and Community Affairs
Filed: November 3, 2004

♦ ♦ ♦

Texas Department of Insurance

Company Licensing

Application for admission to the State of Texas by MILWAUKEE SAFEGUARD INSURANCE COMPANY, a foreign fire and/or casualty. The home office is in Brookfield, Wisconsin.

Application for admission to the State of Texas by UNITED CAPITAL TITLE INSURANCE COMPANY, a foreign title company. The home office is in Los Angeles, California.

Application to change the name of FEDERAL KEMPER LIFE ASSURANCE COMPANY to CHASE INSURANCE LIFE AND ANNUITY COMPANY, a foreign life, accident and/or health company. The home office is in Elgin, Illinois.

Application to change the name of ZURICH LIFE INSURANCE COMPANY OF AMERICA to CHASE INSURANCE LIFE COMPANY, a foreign life, accident and/or health company. The home office is in Elgin, Illinois.

Any objections must be filed with the Texas Department of Insurance, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas, 78701, within 20 days after this notice is published in the *Texas Register*.

TRD-200406595

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: November 3, 2004

♦ ♦ ♦

Legislative Budget Board

Tax Relief Amendment Implementation--Limit on Growth of Certain State Appropriations

Legal References

Article VIII, Sec. 22(a), Texas Constitution, approved by the voters in November 1978, states that: In no biennium shall the rate of growth of appropriations from state tax revenues not dedicated by this constitution exceed the estimated rate of growth of the state's economy. The legislature shall provide by general law procedures to implement this subsection.

This provision does not alter, amend, or repeal Article III, Section 49a, of the Texas Constitution, the well known "pay-as-you-go" provision.

To implement this provision of the Texas Constitution, the Sixty-sixth Legislature enacted Article 9, Chapter 302, Laws 1979 (Tex. Government Code Ann., Sec. 316) which placed with the Legislative Budget Board the responsibility for initial approval of a limitation on the growth of certain state appropriations. A part of the procedure for approving the limitation is set forth in Sections 316.003 and 316.004 as follows: Sec. 316.003. Before the Legislative Budget Board approves the items of information required by Section 316.002, the board shall publish in the *Texas Register* the proposed items of information and a description of the methodology and sources used in the calculations. Sec. 316.004. Not later than December 1 of each even-numbered year, the Legislative Budget Board shall hold a public hearing to solicit testimony regarding the proposed items of information and the methodology used in making the calculations required by Section 316.002.

The items of information mentioned above are identified as follows in Section 316.002:

(1) the estimated rate of growth of the state's economy from the current biennium to the next biennium;

(2) the level of appropriations for the current biennium from state tax revenues not dedicated by the constitution; and

(3) the amount of state tax revenues not dedicated by the constitution that could be appropriated for the next biennium within the limit established by the estimated rate of growth of the state's economy.

In this memorandum, each item of information is taken up in the order listed above.

Estimated Rate of Growth of the State's Economy

A definition of the "estimated rate of growth of the state's economy" is set forth in paragraph (b) of Section 316.002 in the following words:

(b) Except as provided by Subsection (c), the board shall determine the estimated rate of growth of the state's economy by dividing the estimated Texas total personal income for the next biennium by the estimated Texas total personal income for the current biennium. Using standard statistical methods, the board shall make the estimate by projecting through the biennium the estimated Texas total personal income reported by the United States Department of Commerce or its successor in function.

(c) If a more comprehensive definition of the rate of growth of the state's economy is developed and is approved by the committee established by Section 316.005, the board may use that definition in calculating the limit on appropriations.

The Commerce Department's Bureau of Economic Analysis defines state personal income as follows: the income received by persons from all sources, that is, from participation in production, from both government and business transfer payments, and from government interest. Personal income is the sum of wage and salary disbursements, supplements to wages and salaries, proprietors' income, rental income of persons, personal dividend income, personal interest income and transfer payments, less personal contributions for social insurance.

Table 1 displays the Commerce Department's personal income account for Texas for calendar year 2003. The largest component of Texas personal income is wage and salary disbursements, estimated at $360.5 billion during calendar 2003. Salary and wage disbursements are added with supplements to wages and salaries, primarily employer contributions to private pensions and welfare funds, and proprietors' income to arrive at total earnings by place of work. Texas total earnings by place of work reached an estimated $531.6 billion in calendar year 2003.

In deriving Texas total personal income, two adjustments are made to total earnings by place of work. Personal contributions for social insurance contributions, principally social security payroll taxes paid by employees and self-employed, are deducted. A place-of-residence adjustment is also made to reflect the earnings of workers who cross state borders to live or work. Dividends, interest and rent income are then added, along with transfer payments. The major types of transfer payments include social security, various retirement and unemployment insurance benefits, welfare, and disability and health insurance payments. Texas total personal income is estimated to be $668.5 billion for calendar year 2003.

The U.S. Department of Commerce reports personal income estimates by calendar quarter and year. Since the state's fiscal year begins on September 1 and ends August 31, an adjustment is required to present these data on a biennial basis. The Legislative Budget Board uses the data for the first three calendar quarters of a year plus the fourth quarter of the preceding year to represent the state's fiscal year. A biennium is the sum of two fiscal years. The historical record of the rate of growth in Texas personal income for the past fifteen completed biennia using the most recent data published by the U.S. Department of Commerce is shown in Table 2.

Forecasting Texas Personal Income

In reviewing standard statistical techniques for forecasting or projecting Texas personal income, the Legislative Budget Board has obtained the latest economic forecasts from the following sources listed alphabetically: (1) Texas Comptroller of Public Accounts, (2) Economy.com (formerly Regional Financial Associates), (3) Global Insight (formerly DRI-WEFA), (4) University of North Texas Center for Economic Development & Research, and (5) Perryman Group. These forecasts are based on econometric models developed and maintained by the forecasting services listed.

While each forecasting service brings its own approach to the development of economic projections, there are several characteristics common to the econometric models from which the Texas total personal income estimates are derived. First, each assumes that the U.S. economy is the driving force behind Texas economic activity. As a result, forecasts of U.S. economic variables are needed to drive each model. Secondly, each of the econometric models is structural in nature, representing certain assumptions about the structure of the Texas economy, consistent with economic theory. Structural models normally entail detailed

modeling of key sectors of the state's economy, followed by statistical testing to establish relationships with other sectors of the economy. Previous memoranda published on the constitutional limit include more detailed discussion of the forecasting methods used. See the following issues of the *Texas Register* : (5 TexReg 4272), (7 TexReg 3727), (9 TexReg 5219), (11 TexReg 4590), (13 TexReg 4599), (15 TexReg 6876), (17 TexReg 7702), (19 TexReg 9053), (21 TexReg 10919), (23 TexReg 11472), (25 TexReg 11735), and (27 TexReg 10977).

Table 3 details the Texas personal income growth rates of the various forecasting services for the 2006-07 biennium over the 2004-05 biennium. These forecasts range from 1.1226 or 12.26 percent to 1.1316 or 13.16 percent.

Table 4 briefly outlines the sources and dates for the Texas personal income growth rates presented in Table 3.

The personal income growth rates shown in Table 3 or any more recent forecasts will be presented to the Legislative Budget Board for its consideration in adopting this item of information. The Board is not limited to one or any combination of the growth rates shown in adopting a Texas personal income growth rate for the 2006-07 biennium.

Appropriations from State Tax Revenue Not Dedicated by the Constitution - 2004-05 Biennium

The amount of appropriations from state tax revenue not dedicated by the Constitution in the 2004-05 biennium, the base biennium, is the second item of information to be determined by the Legislative Budget Board. As of November 3, 2004 the staff estimates this amount to be $46,834,691,177. This item multiplied by the estimated rate of growth of Texas personal income from the 2004-05 biennium to the 2006-07 biennium produces the limitation on appropriations for the 2006-07 biennium under Article VIII, Section 22, of the Texas Constitution.

Calculating the 2006-07 Limitation

The limitation on appropriations of state tax revenue not dedicated by the State Constitution in the 2006-07 biennium may be illustrated by selecting a growth rate and applying it to the 2004-05 appropriations base. This is shown in Table 5, using the lowest and highest growth rates shown in Table 3. Depending on which personal income growth rate is adopted, current estimates suggest a limitation on 2006-07 biennial appropriations from non-dedicated state taxes ranging from $52.6 billion to $53.0 billion.

Method of Calculating the 2004-05 Appropriations from State Tax Revenue Not Dedicated by the Constitution

As stated above, LBB staff estimates the amount of appropriations from state tax revenue not dedicated by the Constitution in the 2004-05 biennium to be $46,834,691,177. This section details the sources of information used in this calculation.

Total appropriations for the 2004-05 biennium include those in the General Appropriations Act, House Bill No. 1 (H.B. 1), Seventy-eighth Legislature, plus any additional appropriations made in legislation passed by the Seventy- eighth Legislature for the 2004-05 biennium. Any subsequent appropriations made by the Seventy-ninth Legislature for the 2004-05 biennium would also be included in total appropriations.

Section I of Table 6 shows for general revenue related funds the total amount of appropriations, the amount financed from constitutionally dedicated tax revenue, from non-tax revenue and the remainder--the amount financed from tax revenue not dedicated by the Constitution--which is the amount subject to the limitation. General revenue related funds include the General Revenue Fund as well as the Available School Fund, State Textbook Fund and Foundation School Fund. The Game, Fish and Water Safety Account also receives tax revenue not dedicated by the Constitution, which is also included in the calculation of the limitation.

I. General Revenue Related Funds

A. Appropriations are classified in this table as the following: (1) "Estimated to be" line item appropriations and (2) all other line item appropriations.

1. "Estimated to Be" Line Item Appropriations: Each of these items under the subheading "estimated-to-be" may change under certain circumstances. For purposes of this calculation, most fiscal year 2004 amounts are based on actual 2004 expenditures. Amounts for fiscal year 2005 are taken from H.B. 1, Seventy-eighth Legislature.

2. As calculated in Table 7, the amount shown for "All Other Line Items" is the difference between total appropriations and the items listed separately as "estimated to be appropriations." General revenue related appropriations in Table 7 are from H.B. 1, Seventy- eighth Legislature. Adjustments were made to reflect the Governor's vetoes, appropriations from the Emergency Stabilization Fund and appropriations made during special sessions.

B. Source of Funding - General Revenue Related: Table 6, Part B shows that of the $58,601,936,475 of general revenue related fund appropriations, $46,786,843,677 is subject to the limitation because it is financed from state tax revenue not dedicated by the Constitution. By subtracting the appropriations financed from the known sources listed in items one through 8 from the total of $58,601,936,475 it can be established that appropriations totaling $52,316,453,920 remain to be financed. (See item 9 in Table 6, Part B.)

Dedicated state tax revenues deposited into general revenue related funds are estimated to total $2,426,681,927 during the 2004-05 biennium. Appropriations from general revenue related funds financed from non-tax revenue are estimated at $9,388,410,870 for the 2004-05 biennium. (See third column of Table 6, Part B.)

General revenue related fund appropriations to be financed from non-dedicated tax revenue are shown in column four of Table 6, Part B. This amount totals $46,786,843,677 for the 2004-05 biennium.

II. Other Taxes Outside of General Revenue-Related Funds

The state imposes a sales tax and a motor vehicles sales tax pursuant to S.B. 5 of the Seventy-seventh Legislative Session that is deposited into the Emissions Reduction Plan Account. The state imposes a sales and use tax on boats and boat motors, of which 95 percent is deposited into the General Revenue Fund and the remaining five percent is deposited into the Game, Fish and Water Safety Account. The state also imposes taxes on the sale of fireworks that is deposited into the Rural Volunteer Fire Department Account.

The revenue from these accounts is included as appropriations from tax revenue not dedicated by the Constitution. These amounts are based on actual 2004 revenues and estimated 2005 tax collections.

Grand Total

A grand total of $58,649,783,974 in 2004-05 biennial appropriations is included in this analysis. Of this amount, $2,426,681,927 is financed out of taxes dedicated by the State Constitution. Another $9,388,410,870 is financed out of non-tax revenue. The remaining $46,834,691,177 is financed out of tax revenue not dedicated by the State Constitution. This amount serves as a base for calculating the limitation on 2006-07 biennial appropriations from non-dedicated state taxes, as required by Art. VIII, Section 22, of the Texas Constitution.

TABLE 1
U.S. DEPARTMENT OF COMMERCE PERSONAL
INCOME ACCOUNT FOR TEXAS, CALENDAR YEAR 2003
In Millions of Current Dollars

Earnings by Place of Work		**Amount**	**Percent of Total**
Wage and Salary Disbursements		$360,520	67.8%
Supplements to Wages and Salaries		82,596	15.5
Proprietors' Income			
Farm	$2,775		
Nonfarm	85,750		
Subtotal		88,525	16.7
Total Earnings by Place of Work		$531,640	100.0%
Derivation of Total Personal Income			
Earnings by Place of Work (from above)		$531,640	
Less: Personal Contribution for Social Insurance	$26,953		
Plus: Adjustment for Residence	(1,466)		
Equals: Net Earnings by Place of Residence		$503,221	75.3%
Plus: Dividends, Interest and Rent		83,420	12.5
Plus: Personal Current Transfer Receipts		81,863	12.2
Total Personal Income		$668,504	100.0%

Note: Totals may not add due to rounding.

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Annual Personal Income By Major Source and Earnings by Industry*, October 2004.

TABLE 2
BIENNIUM-TO-BIENNIUM GROWTH RATES IN TEXAS PERSONAL INCOME
1974-75 TO 2002-03 BIENNIA

Base Biennium	Target Biennium	Growth Rate	Percent Increase
1972-73	1974-75	1.291	29.1%
1974-75	1976-77	1.282	28.2
1976-77	1978-79	1.308	30.8
1978-79	1980-81	1.349	34.9
1980-81	1982-83	1.252	25.2
1982-83	1984-85	1.180	18.0
1984-85	1986-87	1.078	7.8
1986-87	1988-89	1.100	10.0
1988-89	1990-91	1.150	15.0
1990-91	1992-93	1.133	13.3
1992-93	1994-95	1.123	12.3
1994-95	1996-97	1.149	14.9
1996-97	1998-99	1.174	17.4
1998-99	2000-01	1.164	16.4
2000-01	2002-03	1.051	5.1

TABLE 3
ESTIMATED GROWTH RATES FOR TEXAS PERSONAL INCOME
USING FIVE ECONOMETRIC MODELS
2004-05 BIENNIUM TO 2006-07 BIENNIUM

Source of Forecast	2006-07 Texas Personal Income Growth Rate
1. Texas Comptroller of Public Accounts	1.1301
2. Economy.com (formerly Regional Financial Associates)	1.1265
3. Global Insight (formerly DRI/WEFA)	1.1226
4. University of North Texas Center for Economic Development & Research	1.1237
5. Perryman Group	1.1316

Note: The growth rates shown above can be interpreted in percentage terms. For example, the growth rate of 1.1226 for the Global Insight forecast of Texas personal income indicates estimated personal income growth of 12.26 percent for the 2006-07 biennium.

TABLE 4
SUMMARY OF SOURCES AND METHODS FOR
TEXAS PERSONAL INCOME GROWTH RATES FOR THE
2006-07 BIENNIUM

Source of Forecast	Type of Forecast	Date of Forecast
1. Texas Comptroller of Public Accounts	Econometric	Spring 2004
2. Economy.com (formerly Regional Financial Associates)	Econometric	Fall 2004
3. Global Insight (formerly DRI/WEFA)	Econometric	Fall 2004
4. University of North Texas Center for Economic Development & Research	Econometric	October 2004
5. Perryman Group	Econometric	October 2004

Source: Compiled by the Legislative Budget Board, October 2004.

TABLE 5
TWO ILLUSTRATIONS OF A POSSIBLE
LIMIT ON 2006-07 BIENNIUM APPROPRIATIONS
OF STATE TAX REVENUE NOT DEDICATED BY
THE TEXAS CONSTITUTION
In Millions of Dollars

1. 2004-05 Base	$ 46,834.7	$ 46,834.7
2. Illustrative Growth Rates	X 1.1226	X 1.1316
3. 2006-07 Limitation on Growth in Appropriations	$ 52,574.5	$ 52,997.5

TABLE 6
2004-05 BIENNIAL APPROPRIATIONS
INCLUDED IN THE CALCULATION OF
THE LIMITATION BASE

				2004 Expenditures/ 2005Appropriations
I.	General Revenue Related Funds			
	A.	Appropriations		
		1. "Estimated to Be" Line Item Appropriations		
		(a) Voter Registration	$ 519,100	
		(b) Mixed Beverage Reimbursement	172,164,167	
		(c) County Taxes on University Lands	2,797,402	
		(d) Unclaimed Property	155,986,586	
		(e) Ranger Pensions	7,080	
		(f) Comptroller: Social Security / Benefit Replacement Pay (GR)	850,413,990	
		(g) Employees Retirement System	1,442,588,005	
		(h) Premium Co-Payments, Low Income Children	73,647,322	
		(i) Premium Credits (State Share)	46,674,226	
		(j) Vendor Drug Rebates–Medicaid	383,530,260	
		(k) Vendor Drug Rebates–CHIP	6,670,344	
		(l) Teacher Retirement System: Public Education Retirement	2,280,241,975	
		(m) Teacher Retirement System: Higher Education Retirement	427,334,807	
		(n) Teacher Retirement System: Retiree Health	556,855,924	
		(o) Optional Retirement Program	210,939,154	
		(p) Comptroller's Judicial Section	108,336,794	
		(q) Hotel-Motel Tax to Department of Economic Development	39,805,139	
		(r) Board of Public Accountancy: Examination	392,758	
		(s) Board of Public Architectural Examiners: Examinations	390,413	
		(t) Board of Professional Engineers: Examinations	1,026,005	
		(u) Board of Professional Land Surveying: National Exam	11,430	
		(v) Adjustment for Texas Education Agency Attendance Credit Revenue	35,419,334	
		Subtotal, "Estimated to Be"		$ 6,795,752,215
		2. All Other Line Items		$ 51,806,184,260
TOTAL (General Revenue Related Fund Appropriations)				$ 58,601,936,475

TABLE 6
2004-05 BIENNIAL APPROPRIATIONS
INCLUDED IN THE CALCULATION OF
THE LIMITATION BASE
(continued)

			Total Appropriations	Dedicated State Tax Revenues	Non Tax Revenues	Non-Dedicated State Tax Revenue
B.	Source of Funding - General Revenue Related					
	1	Parks	$ 64,000,000			$ 64,000,000
	2	Occupation Tax Revenue for Public Schools	907,950,000	907,950,000		
	3	Hotel-Motel Tax to the Department of Economic Development	39,805,139			39,805,139
	4	Motor Fuels (Unclaimed Motorboat Refunds)	32,002,500			32,002,500
	5	Motor Fuels Taxes	1,539,823,760	1,518,951,260		20,872,500
	6	Available School Fund Investment Income and Non-tax Revenue	1,771,045,395		1,771,045,395	
	7	State Textbook Fund Revenue	5,831,347		5,831,347	
	8	Foundation School Fund Revenue	1,925,024,414		1,925,024,414	
	9	Appropriations from Other Revenue	52,316,453,920		5,686,509,714	46,629,944,206
	SUBTOTAL (General Revenue Related)		$58,601,936,475	$2,426,681,927	$9,388,410,870	$46,786,843,677
II.	Other Taxes Outside of General Revenue-Related Funds		47,847,500			47,847,500
	GRAND TOTAL		$58,649,783,974	$2,426,681,927	$9,388,410,870	$46,834,691,177

TABLE 7
CALCULATION OF "ALL OTHER LINE ITEMS"
FOR THE 2004-05 BIENNIUM

	2004	2005	2004-2005 Biennium
General Revenue Related Appropriations Amount	$ 30,336,639,127	$ 28,635,255,295	$ 58,971,894,421
Less "Estimated To Be" Appropriations:			
Voter Registration (HB1, Article I-32)	3,000,000	500,000	3,500,000
Mixed Beverage Reimbursement (HB1, Article I-32)	83,238,999	83,989,000	167,227,999
County Taxes on University Lands (HB1, Article I-32)	1,250,000	1,250,000	2,500,000
Unclaimed Property (HB1, Article I-33)	60,000,000	60,000,000	120,000,000
Ranger Pensions (HB1, Article I-33)	4,640	4,640	9,280
Comptroller: Social Security / Benefit Replacement Pay (HB1, Article I-39)	483,302,503	487,286,424	970,588,927
Employees Retirement System (HB1, Article I-43)	751,256,618	759,445,599	1,510,702,217
Premium Co-Payments, Low Income Children (HB1, Article II-45)	43,950,000	43,950,000	87,900,000
Premium Credits (State Share) (HB1, Article II-45)	50,000	50,000	100,000
Vendor Drug Rebates–Medicaid (HB1, Article II-45)	164,814,586	181,487,342	346,301,928
Vendor Drug Rebates–CHIP (HB1, Article II-45)	1,500,000	1,500,000	3,000,000
Teacher Retirement System: Public Education Retirement (HB1, Article III-35)	1,130,327,977	1,186,844,375	2,317,172,352
Teacher Retirement System: Higher Education Retirement (HB1, Article III-35)	230,315,027	239,103,606	469,418,633
Teacher Retirement System: Retiree Health (HB1, Article III-36)	467,820,970	290,821,049	758,642,019
Optional Retirement Program (HB1, Article III-39)	115,840,902	117,418,754	233,259,656

TABLE 7
CALCULATION OF "ALL OTHER LINE ITEMS"
FOR THE 2004-05 BIENNIUM
(continued)

Comptroller's Judicial Section (HB1, Article IV-26)	66,018,090	67,751,182	133,769,272
Hotel-Motel Tax to Department of Economic Development (HB1, Article VII-3)	19,700,000	19,900,000	39,600,000
Board of Public Accountancy: Examination (HB1, Article VIII-1)	434,584	0	434,584
Board of Public Architectural Examiners: Examinations (HB1, Article VIII-7)	268,000	268,000	536,000
Board of Professional Engineers: Examinations (HB1, Article VIII-19)	518,772	518,772	1,037,544
Board of Professional Land Surveying: National Exam (HB1, Article VIII-41)	4,875	4,875	9,750
Subtotal, Line Items Shown Separately	$ 3,623,616,543	$ 3,542,093,618	$ 7,165,710,161
Total Other Line Items	$ 26,713,022,584	$ 25,093,161,677	$ 51,806,184,260

TRD-200406576
John O'Brien
Deputy Director
Legislative Budget Board
Filed: November 2, 2004

♦ ♦ ♦

Texas Lottery Commission

Instant Game Number 531 "$35,000 Crossword"

1.0 Name and Style of Game.

A. The name of Instant Game No. 531 is "$35,000 CROSSWORD". The play style is "key symbol match with a prize legend".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 531 shall be $3.00 per ticket.

1.2 Definitions in Instant Game No. 531.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - One of the symbols which appears under the Latex Overprint on the front of the ticket. Each Play Symbol is printed in Symbol font in black ink in positive. The possible play symbols are: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, and ?.

D. Play Symbol Caption - the small printed material appearing below each Play Symbol which explains the Play Symbol. One and only one of these Play Symbol Captions appears under each Play Symbol and each is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 531 - 1.2D

PLAY SYMBOL	CAPTION
A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	
U	
V	
W	
X	
Y	
Z	
	

E. Retailer Validation Code - Three small letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 531 - 1.2E

CODE	PRIZE
THR	$3.00
FIV	$5.00
TEN	$10.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a four (4) digit security number which will be boxed and placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned

beneath the bottom row of play data in the scratched-off play area. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $3.00, $5.00, $10.00, or $20.00.

H. Mid-Tier Prize - A prize of $100 or $500.

I. High-Tier Prize - A prize of $5,000 or $35,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (531), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 125 within each pack. The format will be: 531-0000001-001.

L. Pack - A pack of "$35,000 CROSSWORD" Instant Game tickets contain 125 tickets, which are packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket 001 will be shown on the front of the pack; the back of ticket 125 will be revealed on the back of the pack. Every other book will reverse i.e., the back of ticket 001 will be shown on the front of the pack and the front of ticket 125 will be shown on the back of the pack.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "$35,000 CROSSWORD" Instant Game No. 531 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "$35,000 CROSSWORD" Instant Game is determined once the latex on the ticket is scratched off to expose 139 (one hundred thirty-nine) possible play symbols. The player must scratch off all 18 (eighteen) boxed squares in the YOUR LETTERS to reveal 18 play symbol letters; then scratch the corresponding letters found in the CROSSWORD puzzle grid play area. If a player scratches at least three (3) complete "words" in the CROSSWORD puzzle grid play area, the player will win the corresponding prize indicated in the prize legend. For each of the 18 play symbol letters revealed in YOUR LETTERS play area, the player must reveal the identical key play symbol letter in the CROSSWORD puzzle grid play area. Letters combined to form a complete "word" must appear in an unbroken horizontal (left to right) sequence or vertical (top to bottom) sequence of letters within the CROSSWORD puzzle grid. Only letters within the CROSSWORD puzzle grid that are matched with the YOUR LETTERS can be used to form a complete "word". The three (3) small letters outside the squares in the YOUR LETTERS area are for validation purposes and cannot be used to play CROSSWORD. In the CROSSWORD puzzle grid, every lettered square within an unbroken horizontal or vertical sequence must be matched with the YOUR LETTERS to be considered a complete "word". Words within a word are not eligible for a prize. For example, all the YOUR LETTERS play symbols S, T, O, N, E, must be revealed for this to count as one complete "word". TON, ONE or any other portion of the sequence of STONE would not count as a complete "word". A complete "word" must contain at least three letters. Letters combined to form a complete "word" must appear in an unbroken horizontal or vertical sequence of letters in the CROSSWORD. To form a complete word, an unbroken sequence of letters cannot be interrupted by a block space. Any other words contained within a complete word are not added or counted for purposes of the prize legend. Every single letter in the vertical or horizontal unbroken sequence must: (a) be one of the 18 larger outlined play symbols letters revealed in the play area YOUR LETTERS, and (b) be included to form a complete "word". The possible complete words for this ticket are contained in the CROSSWORD play area. Each possible complete word must consist of three (3) or more letters and occupy an entire word space. Players must match all of the play symbol letters to the identical key play symbols in a possible complete word in order to complete the word. If the letters revealed form three (3) or more complete words each of which occupy a complete word space on the CROSSWORD play area, the player will win the corresponding prize shown in the prize legend for forming that number of complete words. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. One hundred thirty-nine (139) possible Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have 139 (one hundred thirty-nine) possible Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 139 (one hundred thirty-nine) possible Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 139 (one hundred thirty-nine) possible Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets within a book will not have identical patterns.

B. Adjacent tickets in a pack will not have identical patterns.

C. Each ticket consists of a Your Letters area and one Crossword Puzzle Grid.

D. The Crossword Puzzle Grid will be formatted with at least 1000 configurations (i.e. puzzle layouts not including words).

E. All Crossword Puzzle Grid configurations will be formatted within a grid that contains 11 spaces (height) by 11 spaces (width).

F. Each word will appear only once per ticket on the Crossword Puzzle Grid.

G. Each letter will only appear once per ticket in the YOUR LETTERS play area.

H. Each Crossword Puzzle Grid will contain the following: a) 4 sets of 3 - letter words b) 5 sets of 4 - letter words c) 3 sets of 5 - letter words d) 3 sets of 6 - letter words e) 1 set of 7 - letter words f) 2 sets of 8 - letter words g) 1 set of 9 - letter words. h) 19 words per puzzle per ticket.

I. There will be a minimum of three (3) vowels in the YOUR LETTERS play area.

J. The length of words found in the Crossword Puzzle Grid will range from 3-9 letters.

K. Only words from the approved word list will appear in the Crossword Puzzle Grid.

L. None of the prohibited words (see attached list) will appear horizontally (in either direction), vertically, (in either direction) or diagonally (in either direction) in the Crossword Puzzle Grid play area.

M. You will never find a word horizontally (in either direction), vertically (in either direction) or diagonally (in either direction) in the YOUR LETTERS play area that matches a word in the Crossword Puzzle Grid.

N. Each Crossword Puzzle Grid will have a maximum number of different grid formations with respect to other constraints. That is, for identically formatted Crossword puzzles (i.e. the same grid), all "approved words" will appear in every logical (i.e. 3 letter word = 3 letter space) position, with regards to limitations caused by the actual letters contained in each word (i.e. will not place the word ZOO in a position that causes an intersecting word to require the second letter to be "Z", when in fact, there are no approved words with a "Z" in the second letter position).

O. No one (1) letter, with the exception of vowels, will appear more than nine (9) times in the Crossword Puzzle grid.

P. No ticket will match eleven (11) words or more.

Q. Each ticket may only win one (1) prize.

R. Three (3) to ten (10) completed words will be revealed as per the prize structure.

S. All non-winning tickets will contain: a) One (1) completed word approximately 20% of the time b) Two (2) completed words approximately 80% of the time.

T. NON-WINNING TICKETS: Sixteen (16) to eighteen (18) YOUR LETTERS will open at least one (1) letter in the Crossword Puzzle Grid.

U. NON-WINNING TICKETS: At least 15% of tickets will open at least one (1) letter in the Crossword Puzzle Grid with all 18 letters.

V. NON-WINNING TICKETS 100% of the tickets will have at least five (5) words as a near-win. A near win is defined as a word with all letters less one (1) revealed in the Crossword Puzzle Grid. (For example, using the word EYE and EAGLE. If missing the letter "E" these words would be considered a near-win).

2.3 Procedure for Claiming Prizes.

A. To claim a "$35,000 CROSSWORD" Instant Game prize of $3.00, $5.00, $10.00, $20.00, $100, or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and 2.3.C of these Game Procedures.

B. To claim a "$35,000 CROSSWORD" Instant Game prize of $5,000 or $35,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$35,000 CROSSWORD" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "$35,000 CROSSWORD" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "$35,000 CROSSWORD" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated therefor, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated therefor, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated therefore. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 6,960,000 tickets in the Instant Game No. 531. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 531 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$3	1,099,680	6.33
$5	876,960	7.94
$10	167,040	41.67
$20	69,600	100.00
$100	14,616	476.19
$500	2,552	2,727.27
$5,000	31	224,516.13
$35,000	10	696,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 3.12. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 531 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 531, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

The following is a list of words approved by the Texas Lottery for use in this game.

ACE	BOW	FAR	INN	NOD	RAN
ACT	BOY	FEE	IVY	NOR	RAP
ADD	BUD	FEW	JAB	NOT	RAT
ADO	BUG	FEZ	JAR	NOW	RAW
AFT	BUS	FIR	JAW	NUT	RAY
AGE	BUY	FIT	JAY		RED
AGO	CAB	FIX	JIG	OAK	RIB
AHA	CAN	FOE	JOB	OAR	RIG
AID	CAP	FOG	JOG	OAT	RIM
AIM	CAR	FOR	JOY	ODD	RIP
AIR	CAT	FOX	JUG	OFF	ROT
ALL	COB	FRY	KEY	OIL	ROW
ALP	COW	FUN	KID	OLD	RUB
AMP	COY	FUR	KIN	ONE	RUG
AND	CRY	GAG	KIT	OPT	RUN
ANT	CUB	GAP	LAB	ORE	RUT
ANY	CUE	GEM	LAD	OUR	RYE
APE	CUP	GET	LAG	OUT	SAW
APT	CUT	GUT	LAP	OWE	SAY
ARC	DAB	GUY	LAW	OWL	SEA
ARM	DAY	HAM	LEE	OWN	SEE
ART	DEN	HAT	LEG	PAN	SET
ASH	DEW	HAY	LET	PAR	SEW
ASK	DIG	HEM	LOW	PAW	SHY
AWE	DIM	HEN	MAD	PAY	SIP
AYE	DIP	HER	MAN	PEA	SIR
BAD	DOG	HIM	MAP	PEG	SIT
BAH	DOT	HIP	MAT	PEN	SIX
BAN	DRY	HIS	MAY	PEP	SKI
BAR	DUB	HIT	MET	PET	SLY
BAT	DUO	HOE	MID	PIE	SON
BAY	DYE	HOG	MIX	PIG	SOW
BED	EAR	HOP	MOB	PIN	SPA
BEE	EAT	HOT	MOO	PIT	SPY
BEG	EBB	HOW	MOP	PLY	SUB
BET	EGG	HUB	MUD	POD	SUM
BID	EGO	HUE	MUG	POP	SUN
BIG	ELK	HUG	NAB	PRO	TAB
BIN	END	HUM	NAP	PRY	TAG
BIT	ERA	HUT	NET	PUT	TAN
BOA	EYE	ICE	NEW	RAG	TAP
BOG	FAN	INK	NIL	RAM	TAR

TEA	ACHE	BARK	BRAN	CLUE	DAZE
TEE	ACID	BARN	BRIM	COAL	DEAL
TEN	ACRE	BASE	BROW	COAT	DEAN
TIE	AFAR	BASH	BUCK	COAX	DECK
TIP	AHOY	BASS	BULB	CODE	DEED
TOE	AIDE	BATH	BULK	COIL	DEEM
TON	AJAR	BEAD	BULL	COIN	DEEP
TOO	AKIN	BEAK	BUMP	COLD	DEER
TOP	ALAS	BEAM	BUNK	COLT	DENT
TOT		BEAN	BUNT	COMB	DESK
TOW	ALLY	BEAR	BUOY	CONE	DIAL
TOY	ALOE	BEAU	BURY	COOK	DICE
	ALSO	BEEF	BUSH	COOL	DILL
TRY	ALTO	BEEP	BUSY	COPE	DIME
TUB	AMID	BEET	CAGE	COPY	DIRE
TUG	ANEW	BELL	CAKE	CORD	DIRT
TWO	ANTE	BELT	CALF	CORE	DISH
URN	ANTI	BEND	CALL	CORK	DISK
USE		BENT	CALM	CORN	DIVE
VAN	AQUA	BEST	CAMP	COST	DOCK
VAT	ARCH	BIAS	CANE	COVE	DOLL
VET	AREA	BIKE	CAPE	COZY	DOME
VIA	ARID	BILL	CARD	CREW	DONE
	ATOM	BIND	CARE	CRIB	DOOR
WAG	AUNT	BIRD	CARS	CROP	DOVE
WAX	AURA	BLOT	CART	CROW	DOWN
WAY	AUTO	BLUE	CASE	CUBE	DRAW
WEB	AVID	BLUR		CUFF	DROP
WET	AWAY	BOAT	CAST	CURB	DRUM
WHO	AXIS	BODY	CAVE	CURE	DUAL
WHY	AXLE	BOIL	CELL	CURL	DUCK
WIG	BABY	BOLD	CHAT	CUTE	DUCT
WIT	BACK	BOLT	CHEF	CYAN	DUEL
YAK	BAIL	BOND	CHIN	DALE	DUET
YEN	BAIT	BOOK	CHIP	DAMP	DULL
YES	BAKE		CITE	DARE	DUNE
YET	BALD	BOOT	CITY	DARK	DUSK
YOU	BALK	BOSS	CLAM	DART	DUST
ZAP	BALL	BOTH	CLAW	DASH	DUTY
ZIP	BAND	BOUT	CLAY	DATA	EACH
ZOO	BANK	BOWL	CLIP	DATE	EARL
ABLE	BARE	BRAG	CLUB	DAWN	EARN

EAST	FOLD	GRIP	HOLD	JUST	LIMB
EASY	FOND	GROW	HOLE	KEEN	LIME
ECHO	FOOD	GULF	HOME	KEEP	LINE
EDGE	FOOT	GULL	HOOD	KEYS	LINK
EDIT	FORK	GULP	HOOK	KICK	LINT
ELSE	FORM	GUST	HOOP	KIND	LION
EPIC	FORT	HAIL	HOPE	KING	LIST
ETCH	FOUR	HAIR	HOSE	KITE	LIVE
EVEN	FREE	HALF	HOST	KNEE	LOAD
EXAM	FROG	HALL	HOUR	KNIT	LOAF
EXIT	FROM	HALT	HOWL	KNOT	LOAN
FACE	FUEL	HAND	HUGE	KNOW	LOCK
FACT	FULL	HARD	HULA	LACE	LOFT
FADE	FUND	HARE	HULL	LACK	LONG
FAIL	FUSE	HARK	HUNT	LADY	LOOK
FAIR	FUSS	HARP	HUSH	LAIR	LOOP
FALL	GAIN	HATS	HYPE	LAKE	LOUD
FAME	GALA	HAUL	ICON	LAMB	LOVE
FARE	GAME	HAVE	IDEA	LAMP	LUCK
FARM	GATE	HAWK	IDLE	LAND	LULL
FAST	GAZE	HAYS	INCH	LANE	LURE
FAWN	GEAR	HAZE	INTO	LARD	LURK
FEAR	GIFT	HAZY	IOTA	LARK	LUTE
FEED	GIRL	HEAL	IRIS	LASH	LYNX
FEEL	GIVE	HEAR	IRON	LAST	MADE
FEET	GLAD	HEAT	ITCH	LATE	MAIL
FILE	GLEE	HEEL	ITEM	LAVA	MAIN
FILL	GLOW	HEIR	JACK	LAWN	MAKE
FILM	GLUE	HELD	JADE	LAZY	MALL
FINE	GLUT	HELP	JAZZ	LEAD	MALT
FIRE	GNAT	HERB	JEEP	LEAF	MANY
FISH	GOAL	HERD	JEST	LEAK	MARK
FLAG	GOAT	HERE	JIVE	LEAN	MARS
FLAP	GOLF	HERO	JOIN	LEAP	MASK
FLAT	GONE	HIDE	JOKE	LEFT	MAST
FLAW	GOOD	HIGH	JOLT	LEND	MATH
FLEA	GOWN	HIKE	JUDO	LESS	MAZE
FLEE	GRAB	HILL	JULY	LEVY	MEAL
FLEW	GRAY	HINT	JUMP	LIFE	MEET
FLIP	GREY	HIRE	JUNE	LIFT	MELT
FLOW	GRID	HIVE	JUNK	LIKE	MEMO
FOAM	GRIN	HOAX	JURY	LILY	MEND

MENU	NONE	PEER	RAMP	SALE	SLIM
MESH	NOOK	PICK	RARE	SALT	SLIP
MESS	NOON	PIER	RATE	SAME	SLOW
MICE	NORM	PILE	READ	SAND	SMOG
MILD	NOSE	PINE	REAL	SAVE	SNAP
MILE	NOTE	PINK	REAR	SCAN	SNOW
MILK	NOUN	PINT	REED	SCAR	SNUG
MILL	NUMB	PIPE	REEF	SEAL	SOAK
MIND	OATH	PITA	REEL	SEAM	SOAP
MINE	OBEY	PITY	RELY	SEAT	SOAR
MINK	OBOE	PLAN	RENT	SEED	SOCK
MINT	OKAY	PLAY	REST	SEEK	SODA
MISS	ONCE	PLEA	RICE	SEEM	SOFA
MIST	ONLY	PLOT	RICH	SELF	SOFT
MOAT	ONTO	PLOW	RIDE	SELL	SOIL
MOCK	ONUS	PLUM	RING	SEMI	SOLD
MODE	ONYX	PLUS	RINK	SEND	SOLE
MOLD	OOZE	POEM	RIPE	SENT	SOLO
MOOD	OPEN	POLL	RISE		SOME
MOON	OPUS	POND	RISK	SHED	SONG
MORE	OUCH	PONY	ROAD	SHIN	SOON
MOSS	OVAL	POOL	ROAM	SHIP	SORE
MOST	OVEN	POSE	ROAR	SHOE	SORT
MOTH	OVER	POSH	ROBE	SHOP	SOUL
MOVE	OXEN	POST	ROCK	SHOW	SOUP
MUCH	PACE	POUR	ROLE	SHUT	SOUR
MULE	PACK	PULL	ROLL	SICK	
MUST	PACT	PURE	ROOF	SIDE	SPAN
MYTH	PAGE	PURR	ROOM	SIFT	SPIN
NAIL	PAID	PUSH	ROOT	SIGN	SPOT
NAME	PALE	PUTT	ROPE	SILK	STAR
NARY	PALM	QUIP	ROSE	SILO	STAY
NEAR	PARK	QUIT	RUBY	SING	STEM
NEAT	PART	QUIZ	RUDE	SINK	STEP
NEED	PASS	RACE	RUIN	SIZE	STEW
NEON	PAST	RACK	RULE	SKEW	STIR
NEST	PATH	RAFT	RUNG	SKIM	STOP
NEXT	PAVE	RAGE	RUSH	SKIN	SUCH
NICE	PAWN	RAID	RUST	SKIP	SUIT
NICK	PEAK	RAIL	SACK	SKIS	SURE
NINE	PEAL	RAIN	SAGE	SLAP	SURF
NODE	PEAR	RAKE	SAKE	SLED	SWAN

SWAT	TOLL	VOTE	WORM	AGILE	APPLE
SWIM	TONE	WADE	WORN	AGONY	APPLY
TACK	TOOL	WAGE	WRAP	AGREE	APRON
TACT	TOSS	WAIT	WREN	AHEAD	ARENA
TAIL	TOUR	WAKE	YARD	AISLE	ARGUE
TAKE	TOWN	WALK	YARN	ALARM	ARISE
TALE	TRAP	WALL	YAWN	ALBUM	ARMOR
TALK	TRAY	WAND	YEAR	ALERT	AROMA
TALL	TREE	WANT	YELL	ALIAS	ARRAY
TAME	TRIM	WARD	YOGA	ALIBI	ARROW
TANK	TRIO	WARM	YOLK	ALIEN	ASCOT
TAPE	TRIP	WARN	YORE	ALIGN	ASHES
TASK	TROT	WARY	YOUR	ALIKE	ASIDE
TAXI	TRUE	WASH	ZEAL	ALIVE	ASPEN
TEAK	TUBE	WATT	ZERO	ALLEY	ASSET
TEAM	TUCK	WAVE	ZEST	ALLOT	ATLAS
TEAR	TUNA	WEAK	ZINC	ALLOW	ATOLL
TEEN	TUNE	WEAR	ZONE	ALLOY	ATTIC
TELL	TURF	WEEK	ZOOM	ALOHA	AUDIO
TEND	TURN	WEEP	ABATE	ALONE	AUDIT
TENT	TUSK	WELD	ABIDE	ALONG	AVAIL
TERM	TWIG	WELL	ABODE	ALOOF	AVERT
TEST	TWIN	WEST	ABOUT	ALPHA	AVOID
TEXT	TYPE	WHAT	ABOVE	ALTER	AWAIT
THAT	UNDO	WHEN		AMASS	AWAKE
THAW	UNIT	WHIM	ABYSS	AMAZE	AWARD
THEN	URGE	WIDE	ACORN	AMBER	AWARE
THEY	USED	WIFE	ACTOR	AMIGO	AWASH
THIN	VAIL	WILD	ACUTE	AMINO	AWFUL
THUS	VARY	WIND	ADAGE	AMISS	AWOKE
TIDE	VASE		ADAPT	AMONG	AXIOM
TIDY	VAST	WING	ADEPT	AMPLE	AZURE
TIER	VEAL	WIPE	ADIEU	AMUSE	BACON
TILE	VENT	WIRE	ADIOS	ANGER	BADGE
TILT	VERB	WISE	ADMIT	ANGLE	BAGEL
TIME	VERY	WISH	ADOPT	ANGST	BAKER
TINT	VEST	WITH	ADORE	ANKLE	BANJO
TINY	VETO	WOLF	ADULT	ANNEX	BARGE
TIRE	VIEW	WOOD	AFFIX	ANNOY	BARON
TOAD	VINE	WOOL	AFTER	ANTIC	BASIC
TOIL	VISA	WORD	AGAIN	ANVIL	BASIL
TOLD	VOLT	WORK	AGENT	APART	BASIN

BASIS
BATCH
BATON
BAYOU
BEACH
BEARD
BEECH
BEGIN
BEIGE
BEING
BELOW
BENCH
BERET
BERRY
BIRCH
BIRDS
BISON
BLACK
BLAME
BLAND
BLANK
BLARE
BLAST
BLAZE
BLEND
BLIND
BLINK
BLITZ
BLOCK
BLOOM
BLUFF
BLUNT
BLUSH
BOARD
BOAST
BONUS
BOOST
BOOTH
BOUND
BRACE
BRAID
BRAIN
BRAKE
BRAND
BRASS
BRAVE
BRAVO
BRAWN
BREAD
BREAK
BREED
BRIAR
BRICK
BRIEF
BRING
BROOK
BROOM
BROWN
BRUSH
BUDDY
BUDGE
BUGLE
BUILD
BUILT
BUNCH
BURST
CABIN
CABLE
CACHE
CADET
CAMEL
CAMEO
CANAL
CANDY
CANOE
CARGO
CARRY
CARVE
CATCH
CAUSE
CEASE
CEDAR
CELLO
CHAIN
CHAIR
CHALK
CHAOS
CHARM
CHART
CHASE
CHEAP
CHECK
CHEER
CHESS
CHIEF
CHILD
CHILI
CHILL
CHIME
CHIRP
CHORD
CHORE
CHUTE
CIDER
CIVIC
CIVIL
CLAIM
CLASH
CLASS
CLEAN
CLEAR
CLERK
CLICK
CLIFF
CLIMB
CLOAK
CLOCK
CLOSE
CLOTH
CLOUD
CLOWN
CLUES
COACH
COAST
COBRA
COMET
COMIC
CONGA
CORAL
COUCH
COUNT
COURT
COVER
CRAFT
CRANE
CRATE
CRAVE
CRAWL
CREEK
CREST
CRISP
CROWD
CROWN
CRUSH
CRUST
CURVE
CYCLE
DAILY
DAIRY
DAISY
DANCE
DEBIT
DECAL
DECOY
DELAY
DELTA
DENIM
DEPOT
DEPTH
DEUCE
DIARY
DIGIT
DINER
DISCO
DITCH
DODGE
DOUBT
DOUGH
DOZEN
DRAFT
DRAIN
DRAMA
DREAM
DRESS
DRIFT
DRIVE
DWELL
EAGLE
EARLY
EARTH
EIGHT
ELBOW
EMCEE
EMPTY
ENACT
ENJOY
ENTER
ENTRY
ENVOY
EQUAL
ERASE
ERODE
ERROR
ESSAY
EVADE
EVENT
EVERY
EXACT
EXIST
EXTRA
FABLE
FACET
FAINT
FAULT
FAUNA
FEAST
FEIGN
FEMUR
FENCE
FETCH
FEVER
FIELD
FINAL
FLAGS
FLAIR
FLAKE
FLAME
FLARE
FLASH
FLEET
FLOAT
FLOCK
FLOOR
FLORA
FLOSS
FLOUR
FLUID
FLUTE
FOCUS

FORCE
FOUND
FRAIL
FRAME
FRANK
FRESH
FRONT
FROST
FROWN
FRUIT
FUNNY
GAMES
GIANT
GIVEN
GLARE
GLASS
GLAZE
GLITZ
GLOBE
GLOOM
GLORY
GLOSS

GLOVE
GOING
GOOSE
GORGE
GRACE
GRADE
GRAIN
GRAND
GRANT
GRAPE
GRAPH
GRASP
GRASS
GRAVY
GREAT
GREEN
GREET
GRILL
GRINS
GROOM
GROUP
GUARD
GUESS
GUEST
GUIDE
HABIT
HANDS
HANDY
HAPPY
HARDY
HASTE
HATCH
HEARD
HEART
HEAVY
HEDGE
HELLO
HINGE
HIPPO
HITCH
HOBBY
HONEY
HONOR
HORSE
HOTEL
HOUND
HOUSE
HUMAN
HUMID
HUMOR
HUNCH
HURRY
HUTCH
HYDRO
HYPER
IDEAL
IDEAS
IGLOO
IMAGE
IMPLY
INDEX
INFER
INNER
INPUT
IRATE
IRONY
ISSUE
ITEMS
IVORY
JAUNT
JEANS
JELLY
JEWEL
JOIST
JOKER
JOLLY
JOUST
JUDGE
JUICE
JUMBO
JUROR
KARAT
KAYAK
KNACK
KNEAD
KNOCK
KOALA
LABEL
LACES
LADLE
LAKES
LAMBS
LAPEL
LAPSE
LARGE
LASER
LATCH
LATER
LAUGH
LAYER
LEAFY
LEARN
LEASE
LEASH
LEAST
LEAVE
LEDGE
LEGAL
LEMON
LEVEL
LEVER
LIGHT
LILAC
LIMIT
LINEN
LINGO
LIVID
LOBBY
LOCAL
LODGE
LOGIC
LOOSE
LOYAL
LUCKY
LUNAR
LUNCH
LYRIC
MAUVE
MAYBE
MAYOR
MEDAL
MEDIA
MELON
MERCY
MERGE
MERIT
MERRY
MESSY
METAL
METER
MIDST
MIGHT
MILKY
MIMIC
MINCE
MINED
MINES
MINOR
MIRTH
MITER
MIXED
MODEM
MOIST
MONEY
MONTH
MOODY
MOOSE
MOTOR
MOTTO
MOUSE
MOUTH
MOVER
MOVIE
MUDDY
MUNCH
MURAL
MUSIC
NACHO
NAIVE
NASAL
NATAL
NERVE
NEVER
NEWER
NICHE
NIECE
NIGHT
NINES
NINTH
NOBLE
NOBLY
NOISE
NOISY
NOMAD
NORTH
NOVEL
NUDGE
NURSE
NYLON
OASIS
OCCUR
OCEAN
OFFER
OFTEN
OLIVE
ONION
OPERA
OPTIC
ORBIT
ORDER
OTHER
OTTER
OUGHT
OUNCE
OUTDO
OZONE
PAILS
PAINT
PALMS
PANDA
PANEL
PAPER
PARCH
PARTY
PASTA
PASTE
PATCH
PATIO
PAUSE
PEACE
PEACH
PEALS
PEARL
PECAN
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PENNY
PETAL
PETTY
PHASE
PHONE
PHOTO
PIANO
PIECE
PILOT
PINCH
PINTO
PITCH
PIVOT
PIXEL
PIZZA
PLACE
PLAID
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PLUMB
PLUME
PLUSH
PLUTO

POINT
POLAR
POLKA
POPPY
PORCH
POUCH
POUND
POWER
PRESS
PRICE
PRIDE
PRIME
PRINT
PRIOR
PRISM
PRIZE
PROOF
PROSE
PROUD
PUPIL
PURSE
PUTTY
QUAIL
QUAKE
QUART
QUEEN
QUERY
QUEST
QUEUE
QUICK
QUIET
QUILL
QUILT
QUIRK
QUITE
QUITS
QUOTA
QUOTE
RADAR
RADIO
RAISE
RALLY
RANCH
RANGE
RAPID
RATIO
RAVEN
RAZOR
REACH
REACT
READY
RECAP
REFER
REGAL
REIGN
RELAX
RELAY
RELIC
RENEW
REPLY
RESET
RETRY
REUSE
RHINO
RHYME
RIDGE
RIGHT
RINSE
RISEN
RIVAL
RIVER
ROAST
ROBIN
ROBOT
RODEO
ROTOR
ROUGH
ROUND
ROUTE
ROYAL
RULES
RURAL
SALAD
SALON
SALVE
SATIN
SAUCE
SAUNA
SCALD
SCALE
SCARF
SCENE
SCENT
SCOFF
SCOLD
SCOOP
SCOOT
SCORE
SCOUT
SCRAP
SCRUB
SCUBA
SEIZE
SENSE
SERVE
SEVEN
SHADE
SHAKE
SHALE
SHALL
SHAME
SHAPE
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SHARK
SHARP
SHAVE
SHAWL
SHEEP
SHEER
SHEET
SHELF
SHELL
SHIFT
SHINE
SHIRT
SHOAL
SHOCK
SHOES
SHORE
SHORT
SHRED
SHRUB
SIEGE
SIGHT
SINCE
SINUS
SIREN
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SKILL
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SLEEP
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SNAIL
SNAKE
SNEAK
SNIFF
SNORE
SNOWY

SOGGY
SOLAR
SOLID
SOLVE
SONAR
SONIC
SORRY
SOUND
SOUTH
SPACE
SPARE
SPARK
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SPEAR
SPEED
SPELL
SPICE
SPIKE
SPILL
SPLIT
SPOIL
SPOOL
SPOON
SPORT
SPOUT
SPRAY
SQUAD
SQUID
STACK
STAFF
STAGE
STAIN
STAIR
STAKE
STAMP
STAND
STARE
START
STATE
STEAK
STEAM
STEEL
STEEP
STEER
STICK
STILL
STING
STOCK
STOMP
STONE
STORE
STORK
STORM
STORY
STOVE
STRAP
STRAW
STRAY
STRUT
STUCK
STUDY
STUFF
STUNT
STYLE
SUAVE
SUEDE
SUGAR
SUITE
SUNNY
SUPER
SURGE
SWAMP
SWARM
SWEAT
SWEEP
SWEET
SWIFT
SWING
SWIRL
SWOON
SYRUP
TABLE
TANGO
TASTE
TEACH
TEETH
TEMPO

TEMPT	TRASH	VAULT	WORRY	AFFECT	ASSESS
TENOR	TREAT	VENOM	WORTH	AFFIRM	ASSETS
TENSE	TREND	VENUE	WOVEN	AFFORD	ASSIGN
THANK	TRIAL	VENUS	WRECK	AFLOAT	ASSIST
THEIR	TRIBE	VERGE	WRIST	AFRAID	ASSUME
THEME	TRICK	VERSE	WRITE	AGENCY	ASSURE
THERE	TROOP	VIDEO	WRONG	AGENDA	ASTUTE
THESE	TROUT	VILLA	YACHT	AGHAST	ATTACH
THICK	TRUCE	VINYL	YEARN	ALCOVE	ATTAIN
THING	TRUCK	VISIT	YIELD	ALLEGE	ATTEND
THINK	TRUNK	VISOR	YOUNG	ALLIED	ATTEST
THIRD	TRUST	VITAL	YOUTH	ALLUDE	AUTUMN
THORN	TRUTH	VIVID	ZEBRA	ALLURE	AVALON
THOSE	TULIP	VOCAL	ABACUS	ALMOND	AVENUE
THREE	TWEAK	VOGUE	ABDUCT	ALMOST	AWHILE
THROW	TWEED	VOICE		ALPINE	AZALEA
THUMB	TWINE	VOTER	ABROAD	AMBUSH	BABBLE
THUMP	TWIRL	WAGON	ABRUPT	AMULET	BABOON
TIDAL	TWIST	WAIST	ABSENT	ANTHEM	BADGER
TIGER	UNCLE	WALTZ	ABSORB	ANTLER	BAFFLE
TIGHT	UNDER	WASTE	ACCENT	APATHY	BAKERY
TIMID	UNFIT	WATCH	ACCEPT	APIARY	BALLET
TITLE	UNIFY	WATER	ACCESS	APPALL	BALLOT
TOAST	UNION	WAVER	ACCORD	APPEAL	BALSAM
TODAY	UNITY	WEAVE	ACCRUE	APPEAR	BAMBOO
TOKEN	UNTIE	WEDGE	ACCUSE	APPEND	BANANA
TOOTH	UNTIL	WEIGH	ACETIC	ARCADE	BANDIT
TOPIC	UPPER	WHALE	ACORNS	ARCHER	BANKER
TORCH	UPSET	WHARF	ACROSS	ARCTIC	BANTER
TOTAL	URBAN	WHEAT	ACTING	ARGENT	BARBER
TOTEM	USAGE	WHEEL	ACTION	ARMADA	BARLEY
TOUCH	USHER	WHERE	ACTIVE	AROUND	BARREL
TOUGH	USUAL	WHICH	ACTUAL	ARREST	BARTER
TOWEL	USURP	WHILE	ADJUST	ARRIVE	BASKET
TOWER	UTTER	WHIRL	ADMIRE	ARTERY	BATTER
TOXIC	VAGUE	WHITE	ADRIFT	ARTIST	BATTLE
TRACE	VALET	WHOLE		ASCEND	BAUBLE
TRACK	VALID	WHOSE	ADVERB	ASHORE	BAZAAR
TRADE	VALOR	WIDEN	ADVICE	ASLEEP	BEACON
TRAIL	VALUE	WIDTH	ADVISE	ASPECT	BEAGLE
TRAIN	VALVE	WINDY	AERIAL	ASPIRE	BEAKER
TRAIT	VAPOR	WORLD	AFFAIR	ASSERT	BEARER

BEAUTY	BUFFET	CHOICE	COUPON	DETACH	ENTITY
BECAME	BURDEN	CHOOSE	COURSE	DETAIL	EQUITY
BECOME	BUREAU	CHORAL	COYOTE	DETOUR	ERASER
BEFORE	BURLAP	CHORES	CRAFTY	DEVICE	ERRAND
BEHALF	BURROW	CHORUS	CRATER	DEVOTE	ESCAPE
BEHAVE	BUSHEL	CHROME	CRAVAT	DIESEL	ESTATE
BEHIND	BUTTER	CINEMA	CRAYON	DIGEST	ESTEEM
BETTER	BUTTON	CIRCLE	CREASE	DILUTE	EXCEED
BEWARE	CACTUS	CIRCUS	CREATE	DINNER	EXCESS
BEYOND	CAMERA	CITRUS	CREDIT	DIRECT	EXCUSE
BICEPS	CAMPUS	CLAUSE	CRITIC	DISHES	EXHALE
BILLOW	CANADA	CLEVER	CROCUS	DIVERT	EXPAND
BINARY	CANARY	CLIENT	CRUISE	DIVIDE	EXPECT
BINDER	CANCEL	CLINCH	CRUNCH	DOCTOR	EXPERT
BIONIC	CANDID	CLOSET	CURFEW	DOLLAR	FABRIC
BOILER	CANDLE	CLOUDS	CUSTOM	DOMAIN	FACADE
BORDER	CANINE	CLOUDY	DAMAGE	DOMINO	FACIAL
BORING	CANOPY	CLOVER	DANCER	DONATE	FACTOR
BORROW	CANVAS	COBWEB	DANGER	DONKEY	FALCON
BOTANY	CANYON	COCOON	DARING	DOSAGE	FAMILY
BOTHER	CARAFE	COFFEE	DAZZLE	DRAGON	FAMOUS
BOTTLE	CARBON	COGNAC	DEBATE	DREAMS	FARMER
BOTTOM	CAREER	COLLAR	DECADE	DUPLEX	FASTEN
BOUNCE	CARPET	COLONY	DECENT	DURING	FASTER
BOVINE	CARROT	COLUMN	DECIDE	EASILY	FATHER
BOWLER	CARTON	COMEDY	DECODE	EDITOR	FAUCET
BRANCH	CASHEW	COMMIT	DEDUCE	EFFECT	FEEDER
BREACH	CASTLE	COMMON	DEFEAT	EFFORT	FELINE
BREATH	CASUAL	COMPEL	DEFINE	EITHER	FIDDLE
BREEZE	CATTLE	COMPLY	DEGREE	EMERGE	FIGURE
BRIDGE	CAVERN	CONVEX	DELUGE	EMPIRE	FILLER
BRIGHT	CELERY	CONVEY	DEMAND	ENAMEL	FILTER
BROACH	CELLAR	CONVOY	DENIAL	ENCODE	FINGER
BROKEN	CEMENT	COOKIE	DENTAL	ENCORE	FINISH
BROKER	CENSUS	COPIER	DEPART	ENDURE	FLAMES
BRONZE	CENTER	COPPER	DEPEND	ENERGY	FLAWED
BROWSE	CEREAL	CORNER	DEPICT	ENGINE	FLEECE
BRUNCH	CHALET	CORRAL	DERAIL	ENIGMA	FLIGHT
BUBBLE	CHANCE	COSMIC	DERIVE	ENOUGH	FLORAL
BUCKET	CHANGE	COTTON	DESERT	ENSIGN	FLOWER
BUCKLE	CHARGE	COUGAR	DESIGN	ENTAIL	FLYING
BUDGET	CHEESE	COUPLE	DESIRE	ENTIRE	FOLLOW

FOREST
FORGET
FORMAL
FORMAT
FORMER
FOSSIL
FREEZE
FRIEND
FROLIC
FROZEN
FRUGAL
FUNNEL
FUSION
FUTURE
GADGET
GALAXY
GARDEN
GATHER
GAZEBO
GENIUS
GENTLE
GLIDER
GLOBAL
GLOOMY
GLOSSY
GOBLET
GOGGLE
GOLDEN
GOLFER
GOSSIP
GOVERN
GRAPES
GROUND
GROWTH
GUITAR
GYPSUM
HAMLET
HAMMER
HAMPER
HANDLE
HANGAR
HAPPEN
HARBOR
HEALTH
HEATER
HECKLE
HECTIC
HEIGHT
HELIUM
HELMET
HERMIT
HIATUS
HIKING
HOBBLE
HOCKEY
HOLLOW
HONEST
HORNET
HUDDLE
HUMANE
HUMBLE
HUNGER
HUNGRY
HURDLE
HUSTLE
HYPHEN
ICICLE
IMMUNE
IMPACT
IMPEDE
IMPORT
IMPOSE
INCHES
INCOME
INDEED
INDOOR
INFANT
INFORM
INNING
INSECT
INSIDE
INSIST
INTACT
INTEND
INTERN
INVEST
INVITE
IODINE
ISLAND
ITALIC
ITSELF
JACKET
JAGUAR
JARGON
JAUNTY
JERSEY
JESTER
JIGGLE
JIGSAW
JINGLE
JOCKEY
JOKING
JOVIAL
JOYFUL
JOYOUS
JUGGLE
JUMBLE
JUNGLE
JUNIOR
KARATE
KENNEL
KERNEL
KETTLE
KINDLY
KITTEN
KNIGHT
LABELS
LACTIC
LADDER
LADIES
LAGOON
LARGER
LARYNX
LATELY
LATEST
LAUNCH
LAWFUL
LAWYER
LAYOUT
LEADER
LEAGUE
LEAVES
LEDGER
LEEWAY
LEGACY
LEGEND
LENDER
LENGTH
LESSON
LETTER
LIGHTS
LIKELY
LILIES
LINEAR
LINGER
LIQUID
LISTEN
LITTLE
LIVING
LIZARD
LOCATE
LOCKER
LOTION
LOUNGE
LOVELY
LUMBER
LUXURY
MAGNET
MAMMAL
MANAGE
MANNER
MANUAL
MARBLE
MARGIN
MARINE
MARKER
MARKET
MARLIN
MAROON
MARVEL
MASCOT
MASTER
MATRIX
MATTER
MATURE
MEADOW
MEDIUM
MELLOW
MELODY
MEMBER
MEMORY
MERLIN
METEOR
METHOD
METRIC
METTLE
MIDDLE
MIDWAY
MIGHTY
MINGLE
MINNOW
MINTED
MINUET
MINUTE
MIRAGE
MIRROR
MISFIT
MISHAP
MISSES
MISTED
MITTEN
MOBILE
MODERN
MODEST
MODIFY
MODULE
MOMENT
MONKEY
MORROW
MORTAR
MOTION
MOTIVE
MURMUR
MUSCLE
MUSEUM
MUSKOX
MUSLIN
MUSSEL
MUTINY
MUTUAL
MYRIAD
MYRTLE
MYSELF
MYSTIC
NAPKIN
NARROW
NATION
NEEDLE
NEGATE
NEPHEW
NETTLE
NEURAL
NEURON
NEWTON
NIBBLE
NICELY
NICKEL
NIMBLE
NIMBLY
NIMBUS
NOBODY
NORMAL
NOTARY
NOTICE
NOTIFY
NOTING
NOTION
NOVICE
NOZZLE
NUANCE
NUGGET

NUMBER
NUZZLE
OBJECT
OBTAIN
OCTAVE
OFFICE
OFFSET
OLIVER
OMELET
ONWARD
OPAQUE
OPTION
ORANGE
ORCHID
ORIGIN
ORIOLE

OUTFIT
OUTING
OUTLAW
OUTPUT
OUTRUN
OUTSET
OXYGEN
OYSTER
PACIFY
PACKED
PADDLE
PAJAMA
PALACE
PALLET
PAMPER
PANTRY
PARADE
PARCEL
PARDON
PARENT
PARLOR
PARROT
PASTEL
PASTRY
PATENT

PATROL
PAUPER
PAYOUT
PEAKED
PEANUT
PEBBLE
PEDDLE
PENCIL
PEOPLE
PEPPER
PERMIT
PERSON
PERUSE
PHRASE
PHYSIC
PICKED
PICKLE
PICNIC
PIECED
PIGEON
PILLAR
PILLOW
PILOTS
PIRATE
PISTON
PLANET
PLAQUE
PLASMA
PLEASE
PLEDGE
PLURAL
POCKET
PODIUM
POETRY
POLICE
POLICY
POLISH
POLITE
POLLEN
PONIES
POODLE
POPLAR

POROUS
PORTER
POSSUM
POTATO
POWDER
PREFER
PREFIX
PRETTY
PROFIT
PROMPT
PROPER
PUBLIC
PUDDLE
PULLEY
PUPPET
PURELY
PURIFY
PURPLE
PURSUE
PUZZLE
PYTHON
QUAINT
QUARRY
QUARTZ
QUENCH
QUICHE
QUIVER
RABBIT
RACKET
RADISH
RADIUM
RADIUS
RAFFLE
RAISIN
RAMBLE
RANDOM
RANGER
RAPIDS
RAPPEL
RASCAL
RATHER
RATING

RATTLE
RAVINE
REALLY
REASON
REBATE
RECALL
RECENT
RECESS
RECIPE
RECORD
REDEEM
REDUCE
REFILL
REFINE
REFLEX
REFORM
REFUEL
REFUGE
REFUND
REFUSE
REGAIN
REGARD
REGION
REGRET
REJECT
RELATE
RELIEF
RELISH
REMAIN
REMARK
REMEDY
REMIND
REMOTE
REMOVE
RENOWN
RENTAL
REPAIR
REPEAT
REPLAY
REPORT
RERUNS
RESCUE

RESIDE
RESIST
RESORT
RESTED
RESULT
RESUME
RETAIL
RETIRE
RETURN
REVEAL
REVIEW
REWARD
REWIND
RHYTHM
RIBBON
RIDDLE
RIPPLE
RITUAL
ROBUST
ROCKET
RODENT
ROSTER
ROTATE
RUDDER
RUFFLE
RUNNER
RUNOFF

RUNWAY
RUSSET
RUSTLE
SACHET
SADDLE
SAFARI
SAFELY
SAILOR
SALAMI
SALARY
SALINA
SALINE
SALTED
SALUTE

SAMPLE
SANDAL
SATIRE
SATURN
SAVORY
SCARCE
SCHEME
SCHOOL
SCORCH
SCRAPE
SCREAM
SCREEN
SCRIBE
SCRIPT
SCROLL
SCYTHE
SEARCH
SEASON
SEATED
SECOND
SECRET
SECURE
SEESAW
SELDOM
SELECT
SENATE
SENIOR
SENSOR
SEQUEL
SERENE
SERIES
SESAME
SETTLE
SHADOW
SHAGGY
SHELVE
SHIELD
SHIVER
SHOULD
SHOVEL
SHOWER
SHRIMP

SHRINK
SIERRA
SIGNAL
SILICA
SILVER
SIMPLE
SINGLE
SISTER
SIZZLE
SKETCH
SKIING
SLALOM
SLEEVE
SLEIGH
SLEUTH
SLIGHT
SLOGAN
SLOWLY
SNAZZY
SNEEZE
SOCCER
SOCIAL
SODIUM
SOFTEN
SOFTER
SOFTLY
SOLEMN
SOMBER
SONNET
SOOTHE
SORROW
SOURCE
SPARSE
SPEECH
SPIDER
SPIRAL
SPIRIT
SPLASH
SPLINT
SPOKEN
SPONGE
SPORTS
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STAPLE
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STATUE
STATUS
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STEREO
STITCH
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STRAIT
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STRIKE
STRING
STRIVE
STROBE
STROLL
STRONG
STRUCK
STUCCO
STUDIO
STURDY
SUBDUE
SUBLET
SUBMIT
SUBTLE
SUBURB
SUBWAY
SUDDEN
SUMMER
SUMMIT
SUNDAE
SUNSET
SUPERB
SUPPER
SUPPLY
SURREY
SURVEY
SWITCH
SYMBOL
SYSTEM
TACKLE
TACTIC
TAILOR
TALENT
TAMPER
TARGET
TARTAN
TATTOO
TENANT
TENDER
TENDON
TENNIS
TENURE
THANKS
THEORY
THESIS
THIRST
THREAD
THRIFT
THRILL
THROAT
THRONE
TICKET
TICKLE
TIMBER
TISSUE
TOFFEE
TOMATO
TONGUE
TONSIL
TOPEKA
TOPPLE
TOUCAN
TOWARD
TRANCE
TRAVEL
TREATY
TREMOR
TRENCH
TRIVIA
TROPHY
TUMBLE
TUNNEL
TURKEY
TURNIP
TURTLE
TUXEDO
TWELVE
TWENTY
TYCOON
TYPIST
UMPIRE
UNABLE
UNEASY
UNFAIR
UNFOLD
UNGLUE
UNIQUE
UNLESS
UNLIKE
UNLOAD
UNLOCK
UNPACK
UNPLUG
UNTIDY
UNWIND
UNWRAP
UPDATE
UPHILL
UPLIFT
UPRISE
UPROAR
UPSIDE
UPWARD
URGENT
USEFUL
UTMOST
UTOPIA
VACANT
VACATE
VACUUM
VALLEY
VANISH
VANITY
VELVET
VENDOR
VERIFY
VERTEX
VESSEL
VIABLE
VICTOR
VIOLET
VIOLIN
VIRTUE
VISION
VISUAL
VOLLEY
VOLUME
VOYAGE
WAFFLE
WAITER
WALLET
WALNUT
WALRUS
WANDER
WARDEN
WARMTH
WASHER
WEALTH
WEASEL
WICKER
WILLOW
WINDOW
WINTER
WISDOM
WITHIN
WOBBLE
WONDER
WORTHY
WRENCH
WRITER
YELLOW
YONDER
ZENITH
ZIGZAG
ZIPPER
ZODIAC
ABANDON
ABDOMEN
ABILITY
ABOLISH
ABSENCE
ACADEMY
ACCLAIM
ACCOUNT
ACHIEVE
ACQUIRE
ACREAGE
ACROBAT
ACTRESS
ADDRESS
ADJOURN
ADMIRAL
ADVANCE
ADVERSE
AEROBIC
AEROSOL
AFFLICT
AGAINST
AGELESS
AGILITY
AGITATE

AILMENT
AIMLESS
AIRFARE
AIRLINE
AIRPORT
ALCHEMY
ALFALFA
ALGEBRA
ALLERGY
ALMANAC
ALMONDS
ALREADY
ALUMNUS
AMAZING
AMIABLE
AMMONIA
AMNESIA
AMPLIFY
AMUSING
ANAGRAM
ANALOGY
ANALYST
ANALYZE
ANARCHY
ANATOMY
ANCIENT
ANDROID
ANGUISH
ANIMATE
ANNUITY
ANOMALY
ANOTHER
ANSWERS
ANTENNA
ANTIQUE
ANTONYM
ANXIETY
ANXIOUS
ANYBODY
APOLOGY
APPAREL
APPEASE
APPLAUD
APPLIES
APPOINT
APRICOT
AQUATIC
ARCHAIC
ARRANGE
ARRIVAL
ARTICLE
ARTISAN
ASHAMED
ASPHALT
ASSURED
ASTOUND
ATHLETE
ATTEMPT
ATTRACT
AUCTION
AUDIBLE
AUDITOR
AVERAGE
AVIATOR
AVOCADO
AWESOME
AWKWARD
AWNINGS
BACKLOG
BAGGAGE
BALANCE
BALCONY
BALLOON
BANDAGE
BANQUET
BARBELL
BARGAIN
BAROQUE
BARRIER
BATTERY
BEANBAG
BEARING
BECAUSE
BEDPOST
BEDROCK
BEEHIVE
BELATED
BELLBOY
BENEATH
BENEFIT
BEQUEST
BESIDES
BESIEGE
BETWEEN
BICYCLE
BILLION
BIOLOGY
BISCUIT
BLANKET
BLATANT
BLOSSOM
BLUNDER
BOBSLED
BOLSTER
BONANZA
BONFIRE
BOOSTER
BOREDOM
BOULDER
BOUQUET
BOWLING
BRACKET
BREATHE
BREVITY
BRISTLE
BROTHER
BUFFALO
BUILDER
BULLPEN
CABARET
CABBAGE
CABINET
CABOOSE
CADENCE
CALCIUM
CALORIE
CALVARY
CALYPSO
CANTEEN
CANYONS
CAPITAL
CAPSULE
CAPTAIN
CAPTION
CAPTIVE
CARAMEL
CAREFUL
CARIBOU
CARRIER
CARTOON
CASCADE
CATALOG
CAUTION
CEILING
CENTRAL
CENTURY
CERTAIN
CERTIFY
CHAMBER
CHANNEL
CHAPTER
CHARADE
CHARIOT
CHARTER
CHASSIS
CHATTER
CHEETAH
CHICKEN
CHIMNEY
CHRONIC
CIRCUIT
CITIZEN
CLASSIC
CLEANER
CLEANSE
CLIMATE
CLUSTER
CLUTTER
COASTAL
COCONUT
COLLECT
COLLEGE
COLLIDE
COMBINE
COMFORT
COMMAND
COMMEND
COMMENT
COMMUNE
COMPACT
COMPANY
COMPARE
COMPASS
COMPETE
COMPLEX
COMPUTE
CONCEAL
CONCEDE
CONCEPT
CONCERN
CONCERT
CONCISE
CONDUCT
CONDUIT
CONFIRM
CONFORM
CONFUSE
CONNECT
CONSENT
CONSIST
CONSOLE
CONSULT
CONSUME
CONTACT
CONTAIN
CONTENT
CONTEST
CONTEXT
CONTOUR
CONVENE
COOKIES
CORDIAL
CORONET
COUNTER
CURIOUS
CURTAIN
CUSHION
CYCLIST
CYCLONE
DAMSELS
DANCING
DECEIVE
DECIBEL
DECIMAL
DECLARE
DECLINE
DEFAULT
DEFENSE
DEFLECT
DEFROST
DEGREES
DELIGHT
DELIVER
DENSITY
DENTIST
DEPLETE
DEPOSIT
DEPRIVE
DERRICK
DESCEND
DESCENT
DESERVE
DESKTOP
DESPITE
DESSERT
DESTINY
DEVELOP
DEWDROP
DIAGRAM
DIALECT

DIAMOND
DICTATE
DIFFUSE
DIGITAL
DIGNIFY
DIGNITY
DILEMMA
DIPLOMA
DISCARD
DISCERN
DISCORD
DISCUSS
DISMISS
DISPLAY
DISPUTE
DISTANT
DISTILL
DISTORT
DISTURB
DIVERGE
DIVERSE
DIVIDED
DOLPHIN
DOORWAY
DORMANT
DRESSER
DRIZZLE
DYNAMIC
DYNASTY
EARDRUM
ECLIPSE
ECONOMY
EDITION
EDUCATE
ELEGANT
ELEMENT
ELEVATE
ELLIPSE
ELUSIVE
EMERALD
EMOTION
ENCLOSE
ENQUIRY
ENTROPY
EQUINOX
ERRATIC
ESSENCE
EVENING
EXAMINE
EXAMPLE
EXHAUST
EXPENSE
EXPLAIN
EXPRESS
EXTREME
FACTORS
FACTORY
FACULTY
FANFARE
FARTHER
FASHION
FATIGUE
FEATHER
FEATURE
FEDERAL
FEELING
FERTILE
FICTION
FINANCE
FINESSE
FISSION
FIXTURE
FLANNEL
FLATTEN
FLORIST
FOOLISH
FOREIGN
FOREVER
FORGIVE
FORMULA
FORTUNE
FORWARD
FOUNDER
FRAGILE
FRANTIC
FREEDOM
FREEWAY
FREIGHT
FRIGATE
FUNERAL
FURIOUS
GALLERY
GARNISH
GENERAL
GENERIC
GENUINE
GEOLOGY
GESTURE
GIRAFFE
GLACIAL
GLACIER
GLASSES
GLIMMER
GLIMPSE
GOLFING
GONDOLA
GOODBYE
GORILLA
GRADUAL
GRAMMAR
GRANOLA
GRAPHIC
GRAVITY
GRIDDLE
GRIZZLY
GROCERY
GUITARS
GYMNAST
HABITAT
HAIRCUT
HAIRPIN
HALOGEN
HAMMOCK
HAMSTER
HARMONY
HARNESS
HARVEST
HEALTHY
HEATHER
HEIRESS
HELPFUL
HELPING
HERRING
HERSELF
HEXAGON
HICKORY
HISTORY
HOBBIES
HOLIDAY
HONESTY
HOPEFUL
HORIZON
HOSTESS
HOUSTON
HOWEVER
HUSBAND
HYDRANT
HYGIENE
ICEBERG
IMAGINE
IMITATE
IMMENSE
IMPRESS
IMPRINT
IMPROVE
IMPULSE
INCLUDE
INDOORS
INERTIA
INFLATE
INHABIT
INHERIT
INQUIRE
INSPECT
INSPIRE
INSTALL
INSTANT
INSTEAD
INSTILL
IRONING
ISOLATE
ITALICS
ITEMIZE
JEWELER
JEWELRY
JOGGING
JUGGLER
JUNIPER
JUSTIFY
KETTLES
KEYHOLE
KINGDOM
KNEECAP
LACKING
LANDING
LANTERN
LASTING
LAUNDRY
LECTURE
LEISURE
LENGTHY
LENIENT
LEOPARD
LETTUCE
LEXICON
LIBERTY
LIBRARY
LICENSE
LIONESS
LIQUIDS
LITERAL
LOBSTER
LOGGING
LOOMING
LOTTERY
LOVABLE
LOYALTY
LOZENGE
LUGGAGE
LULLABY
MACHINE
MAGENTA
MAGICAL
MAGNIFY
MAILBOX
MAJESTY
MANAGER
MANDATE
MANNERS
MANSION
MARBLES
MARQUEE
MASONRY
MASSIVE
MAXIMUM
MEANING
MEASURE
MEDIATE
MEDICAL
MEETING
MENTION
MERCURY
MERMAID
MESSAGE
METEORS
MIGRATE
MILEAGE
MINERAL
MINIMAL
MINIMUM
MINUTES
MIRACLE
MISSILE
MISSING
MISSION
MISTAKE
MITTENS
MIXTURE
MOISTEN
MOLLUSK

MONITOR	OPTICAL	PERFORM	PRIMARY	RAPPORT	RESIDUE
MONSOON	ORCHARD	PERFUME	PRINTER	RAVIOLI	RESOLVE
MOORING	OREGANO	PERHAPS	PRIVATE	READOUT	RESPECT
MORAINE	ORGANIC	PERPLEX	PROBLEM	REALIGN	RESPOND
MORNING	OSTRICH	PERSIST	PROCEED	REALISM	RESTFUL
MUFFLER	OUTDOOR	PHANTOM	PROCESS	REALITY	RESTORE
MUNDANE	OUTLOOK	PIANIST	PROCURE	REALIZE	RETREAT
MUSICAL	OUTPOST	PICCOLO	PRODUCE	REALTOR	REUNION
MUSKRAT	OUTRAGE	PICTURE	PRODUCT	REASONS	REVENUE
MUSTANG	OUTSIDE	PIGMENT	PROFILE	REBOUND	REVERSE
MUSTARD	OVERALL	PILLOWS	PROGRAM	REBUILD	REVOLVE
MYSTERY	OVERJOY	PINBALL	PROJECT	RECEIPT	REWRITE
NARRATE	OXIDIZE	PIONEER	PROMISE	RECEIVE	RHUBARB
NATURAL	PACIFIC	PIRATES	PRONOUN	RECITAL	ROASTED
NECKTIE	PACKAGE	PITCHER	PROTECT	RECLAIM	ROMANCE
NEITHER	PADDOCK	PLANNED	PROTEIN	RECLINE	ROOFTOP
NEMESIS	PADLOCK	PLASTER	PROVERB	RECOVER	ROOSTER
NEPTUNE	PAGEANT	PLASTIC	PROVIDE	RECRUIT	ROSEBUD
NERVOUS	PAJAMAS	PLATEAU	PROWESS	RECTIFY	ROUTINE
NETWORK	PANCAKE	PLATOON	PRUDENT	RECYCLE	ROWBOAT
NEUTRAL	PANTHER	PLIABLE	PUDDING	REFEREE	ROYALTY
NOMINAL	PARADED	PLUMAGE	PUMPKIN	REFINED	RUNNING
NOMINEE	PARADOX	POLYGON	PUPPIES	REFLECT	SALVAGE
NONSTOP	PARASOL	POMPOUS	PURPOSE	REFRAIN	SANDALS
NOSTRIL	PARKING	POPCORN	PURRING	REFRESH	SANDBAG
NOTABLE	PARSLEY	POPULAR	PURSUIT	REFUSAL	SAPLING
NOTHING	PARSONS	PORTAGE	PUZZLED	REGIMEN	SARCASM
NOURISH	PARTIAL	PORTRAY	PYRAMID	REGULAR	SARDINE
NOVELTY	PARTNER	POSTAGE	QUALIFY	REJOICE	SAUSAGE
NUMERAL	PASSAGE	POSTURE	QUALITY	RELAPSE	SAWDUST
NURSERY	PASSIVE	POWERED	QUARTER	RELEASE	SAWFISH
OATMEAL	PASTURE	PRAIRIE	QUARTET	RELIEVE	SAWMILL
OBSCURE	PATIENT	PRECEDE	QUICKLY	REMARKS	SCALLOP
OBSERVE	PATRIOT	PREDICT	QUIETLY	REMNANT	SCAMPER
OBVIOUS	PATTERN	PREFACE	RACCOON	REMODEL	SCANNER
OCTAGON	PAUSING	PRELUDE	RADIATE	RENEWAL	SCARLET
OCTOBER	PAYLOAD	PREMIUM	RADICAL	REPLACE	SCENTED
OCTOPUS	PEACOCK	PRETEND	RAILWAY	REPLICA	SCIENCE
ODYSSEY	PELICAN	PRETZEL	RAINBOW	REPTILE	SCOOTER
OFFENSE	PENALTY	PREVAIL	RAMBLER	REQUEST	SCRATCH
OPERATE	PERCENT	PREVENT	RANCHER	REQUIRE	SCREECH
OPINION	PERFECT	PREVIEW	RANKING	RESERVE	SCRUPLE

SCUTTLE
SEAFOOD
SEAGULL
SEAPORT
SEASIDE
SEAWEED
SECTION
SEGMENT
SEISMIC
SELFISH
SELLOUT
SELTZER
SERIOUS
SERVANT
SERVICE
SESSION
SETBACK
SETTING
SETTLER
SEVENTY
SEVERAL
SHAMPOO
SHATTER
SHELTER
SHERIFF
SHIMMER
SHUDDER
SHUFFLE
SHUTTER
SIBLING
SIGNIFY
SILENCE
SILICON
SINCERE
SITTING
SIXTEEN
SKIRTED
SKYDIVE
SKYLARK
SLEIGHT
SLUMBER
SMARTLY
SNIPPET
SNORKEL
SNUGGLE
SOARING
SOCIETY
SOLDIER
SOMEDAY
SOPRANO
SPANIEL
SPARKLE
SPARROW
SPECIAL
SPINACH
SPINDLE
SPONSOR
SQUEEZE
STADIUM
STAMINA
STANDBY
STAPLER
STARTLE
STATION
STELLAR
STOMACH
STORAGE
STRANGE
STRETCH
STUDENT
STYLISH
SUBSIDE
SUCCEED
SUCCESS
SUGGEST
SUMMARY
SUNBURN
SUNDIAL
SUNDOWN
SUNRISE
SUPPORT
SUPPOSE
SUPREME
SURFACE
SURPLUS
SUSPEND
SUSTAIN
SWALLOW
SWEATER
SWIFTLY
SYMPTOM
SYNONYM
TARNISH
TEACHER
TEDIOUS
TENSION
TERRACE
TERRAIN
TERRIER
TEXTILE
THEATER
THERMAL
THIRSTY
THOUGHT
THROUGH
THUNDER
TOASTER
TONIGHT
TOOLBOX
TORNADO
TOURISM
TOURIST
TRACTOR
TRAFFIC
TRAGEDY
TRAILER
TRANSIT
TRAPEZE
TREETOP
TREMBLE
TRIBUTE
TRICEPS
TRILOGY
TRIUMPH
TRIVIAL
TROLLEY
TROUBLE
TRUMPET
TUESDAY
TUITION
TYPHOON
TYPICAL
UNAWARE
UNCOVER
UNDERGO
UNICORN
UNIFORM
UNKNOWN
UNUSUAL
UPFRONT
UPGRADE
UPSTAGE
UTENSIL
UTILITY
VACANCY
VACCINE
VALIANT
VAMPIRE
VANILLA
VARIETY
VARIOUS
VARNISH
VEHICLE
VENTURE
VERANDA
VERBOSE
VERDICT
VERSION
VERTIGO
VIBRANT
VICTORY
VILLAGE
VINEGAR
VINTAGE
VIRTUAL
VISIBLE
VISITOR
VITAMIN
VOLCANO
VOLTAGE
VOUCHER
VOYAGER
VULTURE
WALLABY
WARNING
WASHING
WAYBILL
WAYWARD
WEALTHY
WEATHER
WEDDING
WEEKEND
WELCOME
WESTERN
WHETHER
WHISKER
WHISPER
WHISTLE
WICHITA
WILDCAT
WINNING
WISHFUL
WITHOUT
WITNESS
WORKDAY
WRANGLE
WRAPPER
ZILLION
ZOOLOGY
ABDICATE
ABRASION
ABSOLUTE
ABUNDANT
ACADEMIC
ACCIDENT
ACCOLADE
ACCOUNTS
ACCURACY
ACCURATE
ACOUSTIC
ACQUAINT
ADDENDUM
ADDITION
ADEQUATE
ADHESIVE
ADJACENT
ADMONISH
ADVOCATE
AEROBICS
AFFINITY
AFFLUENT
AIRBORNE
AIRCRAFT
AIRPLANE
AIRSPEED
AIRTIGHT
ALLOCATE
ALPHABET
ALTITUDE
ALUMINUM
AMBITION
AMORTIZE
ANACONDA
ANALYSIS
ANCESTOR
ANECDOTE
ANNOUNCE
ANTELOPE
ANYTHING
APPENDIX
APPETITE
APPRAISE
APPROACH
APPROVAL
APTITUDE
AQUARIUM
ARACHNID
ARGUMENT
ARMCHAIR
AROMATIC
ARPEGGIO

ARRANGED
ARROGANT
ARTIFACT
ARTISTIC

ASSEMBLE
ASSEMBLY
ASTERISK
ASTEROID
ASTONISH
ATHLETIC
ATLANTIC
ATTITUDE
ATTORNEY
AUDIENCE
AUTOMATE
AVIATION
BACHELOR
BACKDROP
BACKFIRE
BACKPACK
BACKSPIN
BACKWARD
BACKYARD
BACTERIA
BAGPIPES
BALLPARK
BALLROOM
BANISTER
BARBECUE
BARRACKS
BASEBALL
BASEMENT
BATHROOM
BEGINNER
BEHAVIOR
BEVERAGE
BIRTHDAY
BLACKOUT
BLIZZARD
BLUEBIRD

BOATYARD
BONAFIDE
BOOKCASE
BOOKMARK
BOOKSHOP
BOOKWORM
BOULDERS
BOUNDARY
BOUTIQUE
BRACELET
BROCHURE
BUILDING
BULLETIN
BULLSEYE
BUNGALOW
CALCULUS
CALENDAR
CALLIOPE
CALORIES
CAMPAIGN
CAMPFIRE
CANISTER
CAPACITY
CARDINAL
CAREFREE
CARELESS
CARNIVAL
CARRIAGE
CASSETTE
CATAPULT
CATEGORY
CAUSEWAY
CAUTIOUS
CEREMONY
CHAMPION
CHARCOAL
CHARISMA
CHECKERS
CHEERFUL
CHESTNUT
CHIPMUNK
CINNAMON

CITATION
CLARINET
CLEARING
CODEWORD
COHERENT
COINCIDE
COLESLAW
COLLAPSE
COLONIAL
COLOSSAL
COMMERCE
COMPLAIN
COMPLETE
COMPOUND
COMPRESS
COMPUTER
CONCERTO
CONCLUDE
CONCRETE
CONFETTI
CONFLICT
CONFOUND
CONQUEST
CONSERVE
CONSIDER
CONSTANT
CONSUMER
CONTINUE
CONTRACT
CONTRAST
CONVERGE
CONVERSE
CONVINCE
COOKBOOK
CORRIDOR
CRITICAL
CROSSBAR
CUCUMBER
CUFFLINK
CUPBOARD
CUSTOMER
CYLINDER

DAFFODIL
DARKROOM
DAUGHTER
DAYDREAM
DAYLIGHT
DECEMBER
DECIPHER
DECISION
DEDICATE
DEFIANCE
DEFINITE
DELEGATE
DELICATE
DELIVERY
DESCRIBE
DESERVED
DESIGNER
DIAGNOSE
DIAGONAL
DIALOGUE
DIAMETER
DILIGENT
DIMINISH
DIPLOMAT
DIRECTOR
DISAGREE
DISASTER
DISCOUNT
DISCOVER
DISGUISE
DISKETTE
DISPATCH
DISPENSE
DISSOLVE
DISTANCE
DISTINCT
DISTRACT
DISTRICT
DIVIDEND
DIVISION
DOCUMENT
DOMESTIC

DOMINANT
DOMINION
DOUBTFUL
DOUGHNUT
DOWNHILL
DOWNTOWN
DRAWBACK
DRESSING
DRIVEWAY
DWELLING
ECONOMIC
EGGPLANT
ELDORADO
ELECTION
ELECTRIC
ELEPHANT
ELEVATOR
EMPHASIS
EMPLOYEE
EMPLOYER
ENGINEER
ENQUIRER
ENTIRETY
ENTRANCE
ENVELOPE
EPILOGUE
EQUALITY
EQUATION
ESTIMATE
EVALUATE
EVENTFUL
EVERYDAY
EXERCISE
EXPEDITE
EXTERIOR
EXTERNAL
EYEGLASS
FABULOUS
FAMILIAR
FAREWELL
FEEDBACK
FESTIVAL

FILAMENT
FIREWOOD
FLAGPOLE
FLAMINGO
FLOTILLA
FLOURISH
FOOTBALL
FORCEFUL
FORECAST
FOUNTAIN
FRACTION
FRAGMENT
FRECKLES
FREQUENT
FRESHMAN
FRICTION
FRIENDLY
FRONTIER
FUNCTION
GALACTIC
GENEROUS
GEODESIC
GERANIUM
GLORIOUS
GLOSSARY
GOLDFISH
GRACEFUL
GRADUATE
GRAPHICS
GRATUITY
GREENERY
GUARDIAN
GUIDANCE
HANDBAGS
HANDSOME
HARDWARE
HARDWOOD
HAYSTACK
HEADACHE
HEREDITY
HERITAGE
HILLSIDE

HISTORIC
HOLIDAYS
HOLOGRAM
HOMEWORK
HONEYBEE
HOSPITAL
HUMIDITY
HUMILITY
HYACINTH
HYDROGEN
HYSTERIA
ILLUSION
IMPOSING
INCIDENT
INCREASE
INDIRECT
INDUSTRY
INFINITE
INFINITY
INFORMAL
INFUSION
INNOCENT
INNOVATE
INSECURE
INSIGNIA
INSTANCE
INSTINCT
INSTRUCT
INSULATE
INTENDED
INTERCOM
INTEREST
INTERIOR
INTERNAL
INTERVAL
INTREPID
INTRIGUE
INVESTOR
IRRIGATE
IRRITATE
JEALOUSY
JETLINER
JUDGMENT
JUVENILE
KANGAROO
KEROSENE
KINDNESS
KNAPSACK
LACROSSE
LAMINATE
LANDLORD
LANDMARK
LANGUAGE
LANTERNS
LATITUDE
LAUGHTER
LAWRENCE
LEAPFROG
LEFTOVER
LEMONADE
LENGTHEN
LEVERAGE
LICORICE
LIFEBOAT
LIFETIME
LIGAMENT
LIKEWISE
LINOLEUM
LIPSTICK
LITERACY
LITERARY
LOCATION
LOGISTIC
LOOPHOLE
LOWLANDS
LUMINOUS
LUNCHEON
MACARONI
MACKEREL
MAGAZINE
MAGICIAN
MAINLAND
MAINTAIN
MAJESTIC
MAJORITY
MANDOLIN
MANEUVER
MANICURE
MANIFEST
MANIFOLD
MARATHON
MARGINAL
MARIGOLD
MARINADE
MARINATE
MARITIME
MARRIAGE
MATERIAL
MATTRESS
MAVERICK
MEANTIME
MECHANIC
MEDICINE
MEDIOCRE
MERCHANT
MERCIFUL
MERIDIAN
MERINGUE
METALLIC
METAPHOR
MIDNIGHT
MIDPOINT
MINIMIZE
MINSTREL
MISCHIEF
MISPLACE
MISSPELL
MOCCASIN
MODERATE
MODESTLY
MOISTURE
MOLASSES
MOLECULE
MOLEHILL
MONARCHY
MONOPOLY
MONOTONE
MONUMENT
MORTGAGE
MOSQUITO
MOTHBALL
MOTORCAR
MOTORIZE
MOUNTAIN
MOVEMENT
MULBERRY
MULTIPLE
MULTIPLY
MUSHROOM
MUSTACHE
NAMESAKE
NAUTILUS
NAVIGATE
NECKLACE
NEEDLESS
NEIGHBOR
NEWCOMER
NEWSCAST
NICKNAME
NINETEEN
NINETIES
NITROGEN
NOBILITY
NOBLEMAN
NOMINATE
NONSENSE
NORMALLY
NORTHERN
NOTARIZE
NOVEMBER
NUISANCE
OBEDIENT
OBLIVION
OBSOLETE
OBSTACLE
OCCASION
ODOMETER
OFFICIAL
OFFSHORE
OMISSION
OPERATOR
OPPONENT
OPTIMISM
ORDINARY
ORNAMENT
OUTBOUND
OUTBREAK
OUTDOORS
OUTFIELD
OVERCAST
OVERCOAT
OVERHAUL
OVERTIME
OVERTURE
OVERVIEW
PAMPHLET
PANORAMA
PARABOLA
PARADIGM
PARADISE
PARAFFIN
PARAKEET
PARALLAX
PARALLEL
PARKLAND
PARTICLE
PASSPORT
PASSWORD
PATIENCE
PAVEMENT
PAVILION
PEACOCKS
PEDESTAL
PEDICURE
PEGBOARD
PENDULUM
PENGUINS
PERCEIVE
PERIODIC
PERMEATE
PEROXIDE
PERSONAL
PERSUADE
PETULANT
PHARMACY
PHEASANT
PHONETIC
PHYSICAL
PINAFORE
PINNACLE
PINPOINT
PIONEERS
PIPELINE
PLATFORM
PLATINUM
PLEASANT
POPULACE
PORPOISE
PORRIDGE
PORTABLE
PORTRAIT
POSITION
POSSIBLE
POSTCARD
POSTPONE
PRACTICE
PRECINCT
PRECIOUS
PRESENCE
PRESSURE
PRESTIGE
PREVIOUS
PRIMROSE
PRIORITY
PRISTINE
PRODUCER
PROGRESS
PROPERLY
PROPERTY
PROSPECT
PROTOCOL
PROVINCE

PULLOVER
PUNCTUAL
PURCHASE
QUADRANT
QUANTIFY
QUANTITY
QUESTION
QUICKEST
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RADIATOR
RAILROAD
RAINCOAT
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REACTION
REAPPEAR
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RECREATE
REDEFINE
REFERRAL
REGAINED
REGARDED
REGIONAL
REGISTER
REINDEER
RELATION
RELATIVE
RELAXING
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RELOCATE
REMEMBER
REMINDER
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REPORTER
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RESEARCH
RESIDENT
RESOLVED
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RESOURCE
RESPONSE
RESTLESS
RESTRAIN
RESTRICT
RESTROOM
REVIEWER
REVISION
RHAPSODY
RHETORIC
ROMANTIC
ROTATION
SAILBOAT
SAILFISH
SANCTITY
SANDWICH
SANITARY
SAPPHIRE
SATURATE
SAWTOOTH
SCABBARD
SCAFFOLD
SCENARIO
SCHEDULE
SCHOONER
SCISSORS
SCORPION
SCRABBLE
SCRAMBLE
SCRIBBLE
SCRUTINY
SCULPTOR
SEABOARD
SEACOAST
SEAHORSE
SEASHORE
SEASONAL
SECRETLY
SECURITY
SEDATION
SEDIMENT
SEMESTER
SENSIBLE
SENTENCE
SEPARATE
SEQUENCE
SERENADE
SHAMROCK
SHEPHERD
SHERBERT
SHILLING
SHIPMATE
SHIPMENT
SHIPYARD
SHOELACE
SHOPPING
SHOULDER
SHOWBOAT
SHOWERED
SHOWROOM
SHUTDOWN
SIDELINE
SIDESTEP
SIDEWALK
SIDEWAYS
SIMPLIFY
SIMULATE
SINGULAR
SLIGHTLY
SLIPPERY
SNOWBALL
SNOWSHOE
SOCIABLE
SOFTBALL
SOFTWARE
SOLIDIFY
SOLITARY
SOLITUDE
SOLSTICE
SOLUTION
SOMBRERO
SOMEBODY
SOMETIME
SONGBOOK
SORCERER
SOUTHERN
SOUVENIR
SPACIOUS
SPECIFIC
SPECTRUM
SPLENDID
SPLENDOR
SPOONFUL
SPORADIC
SPRINKLE
SQUADRON
SQUIRREL
STALLION
STAMPEDE
STANDARD
STANDOFF
STRAIGHT
STRAINER
STRATEGY
STRENGTH
STRUGGLE
STUBBORN
STUDIOUS
STUNNING
SUBMERGE
SUBTRACT
SUBURBAN
SUCCINCT
SUITABLE
SUITCASE
SUNLIGHT
SUNSHINE
SUPERIOR
SURPRISE
SURROUND
SUSPENSE
SWIMSUIT
SYMMETRY
SYMPATHY
SYMPHONY
SYNDROME
TACTICAL
TANGIBLE
TAPESTRY
TEASPOON
TEENAGER
TELECAST
TELEGRAM
TENDENCY
TERMINAL
TERRIBLE
TERRIFIC
TEXTBOOK
THEMATIC
THIRTEEN
THURSDAY
TOBOGGAN
TOGETHER
TOLERANT
TOLERATE
TOMORROW
TORTILLA
TRANQUIL
TRANSFER
TRANSMIT
TRAVERSE
TREASURE
TRESPASS
TRIANGLE
TRICYCLE
TRILLION
TROMBONE
TROPICAL
TURNOVER
TWEEZERS
ULTIMATE
UMBRELLA
UNBROKEN
UNCOMMON
UNDERCUT
UNDERDOG
UNDERSEA
UNDERWAY
UNICYCLE
UNIVERSE
UNLIKELY
UNSETTLE
UNSTABLE
UPCOMING
VACATION
VAGABOND
VALIDATE
VALUABLE
VANGUARD
VARIABLE
VARIANCE
VELOCITY
VERTEBRA
VERTICAL
VICINITY
VIGNETTE
VINEYARD
VIRTUOSO
VITALITY
WAITRESS
WARDROBE
WARRANTY
WHATEVER
WHEREVER
WINDFALL
WINDMILL
WIRELESS
WITHDRAW
WORKLOAD
WORKSHOP
WRANGLER
YOURSELF
YOUTHFUL
ZUCCHINI
ABSURDITY

ACCORDION
ACROBATIC
ADMIRABLE
ADMISSION
ADVANTAGE
ADVENTURE
ADVERSARY
ADVERTISE
AEROSPACE
AESTHETIC
AFFIDAVIT
AFFILIATE
AFTERMATH
AFTERNOON
ALABASTER
ALBATROSS
ALGORITHM
ALLIGATOR
AMBIGUOUS
AMBITIOUS
AMPERSAND
AMPHIBIAN
AMPLIFIER
AMPLITUDE
ANCESTRAL
ANCHOVIES
ANONYMOUS
ANTHOLOGY
ANTIQUITY
APARTMENT
APOLOGIZE
APPETIZER
APPLIANCE
AQUEDUCTS
ARBITRARY
ARGONAUTS
ARMSTRONG
ARROGANCE
ARROWHEAD
ARTICHOKE
ASPARAGUS
ASSISTANT
ASTROLOGY
ASTRONAUT
ASTRONOMY
ATTENTION
AUTHORITY
AUTOGRAPH
AUTOMATIC
AVAILABLE
BACKWARDS
BADMINTON
BALLERINA
BANDSTAND
BAROMETER
BINOCULAR
BIOGRAPHY
BIOSPHERE
BLEACHERS
BLINDFOLD
BLUEBERRY
BLUEGRASS
BLUEPRINT
BOOKSTORE
BOOMERANG
BOULEVARD
BREAKFAST
BRIEFCASE
BRILLIANT
BROADCAST
BULLDOZER
CAFETERIA
CALCULATE
CALIBRATE
CAPACITOR
CAPTIVATE
CARDBOARD
CARPENTER
CARTWHEEL
CASSEROLE
CENTIPEDE
CERTITUDE
CHALLENGE
CHAMPAGNE
CHARACTER
CHECKLIST
CHEMISTRY
CHILDHOOD
CHOCOLATE
CLASSROOM
CLEARANCE
CLOCKWISE
COMMITTEE
COMMUNITY
COMPANION
COMPETENT
COMPONENT
CONCIERGE
CONDITION
CONFIDENT
CONFUSING
CONNECTED
CONSCIOUS
CONSONANT
CONSTRUCT
CONTAINER
CONTENDER
CONTINENT
COROLLARY
CRANBERRY
CRITICISM
CROCODILE
DANDELION
DANGEROUS
DEDICATED
DEFICIENT
DELICIOUS
DEMOCRACY
DEPARTURE
DESPERATE
DETECTIVE
DETERGENT
DETERMINE
DIAGNOSIS
DIFFERENT
DIFFICULT
DIGNIFIED
DIMENSION
DIRECTION
DISAPPEAR
DISCOVERY
DISPENSER
DOCTORATE
DORMITORY
DUPLICATE
EARTHWORM
ECCENTRIC
EDITORIAL
EDUCATION
EMERGENCY
EMOTIONAL
ENCHANTED
ENCOUNTER
ENDURANCE
ENTERTAIN
EQUIPMENT
ESTABLISH
ESTIMATES
ETIQUETTE
EVAPORATE
EVERGREEN
EVERYBODY
EXCELLENT
EXCLUSIVE
EXECUTIVE
EXHAUSTED
EXISTENCE
EXPANSION
EXPENSIVE
EXPERTISE
EXTENSION
FANTASTIC
FINGERTIP
FLOWERPOT
FLUCTUATE
FORBIDDEN
FORESIGHT
FORGETFUL
FORTUNATE
FOUNTAINS
FRAMEWORK
FRANCHISE
FREQUENCY
FURNITURE
GATHERING
GENERATOR
GENTLEMAN
GEOMETRIC
GOLDENROD
GRATITUDE
GREATBEND
GREYHOUND
GROCERIES
GUIDELINE
GYMNASIUM
GYMNASTIC
HAILSTORM
HAMBURGER
HANDSHAKE
HAPPENING
HAPPINESS
HARMONICA
HEADLIGHT
HEADPHONE
HEARTBEAT
HIBERNATE
HIERARCHY
HIGHLANDS
HIGHLIGHT
HISTORIAN
HONEYCOMB
HONEYMOON
HOROSCOPE
HORSEBACK
HORSESHOE
HOURGLASS
HOUSEHOLD
HOUSEWORK
HURRICANE
HYDRAULIC
HYPNOTIZE
IDENTICAL
IMAGINARY
IMMEDIATE
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IMPLEMENT
IMPORTANT
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INAUGURAL
INCENTIVE
INCLUSION
INCORRECT
INFLUENCE
INGENIOUS
INGENUITY
INSERTION
INSURANCE
INTEGRITY
INTELLECT
INTERCEPT
INTERFERE
INTERLUDE
INTERPRET
INTERRUPT
INTERVIEW
INTRICATE
INTRODUCE
INVENTION
INVENTIVE
INVISIBLE
IRREGULAR
JELLYFISH
KNOWLEDGE
LABYRINTH
LANDOWNER
LANDSCAPE
LAZYBONES
LEGENDARY
LEISURELY

LIBRARIAN
LIFESTYLE
LIGHTNING
LIMELIGHT
LIMESTONE
LIMOUSINE
LIVESTOCK
LOCKSMITH
LONGEVITY
LUMINANCE
LUXURIOUS
MACHINERY
MAGNITUDE
MANHATTAN
MARGARINE
MARKETING
MARMALADE
MARVELOUS
MCPHERSON
MEANWHILE
MEDALLION
MENAGERIE
MESSENGER
METEORITE
MEZZANINE
MICROFILM
MICROWAVE
MIDSUMMER
MILLIPEDE
MILLSTONE
MINCEMEAT
MINIATURE
MISTLETOE
MODERNIZE
MONOLOGUE
MOONLIGHT
MULTIPLEX
MUNICIPAL
MYTHOLOGY
NECESSARY
NECESSITY
NEGOTIATE
NEWSPAPER
NIGHTFALL
NOCTURNAL
NONLINEAR
NORTHEAST
NORTHWEST
NOSTALGIA
NUMERATOR
NUTRITION
OBEDIENCE
OBLIGATED
OBSESSION
OCCUPANCY
OLFACTORY
OPTOMETRY
ORCHESTRA
OVERBOARD
OVERWHELM
PALLADIUM
PANTOMIME
PAPERWORK
PARACHUTE
PARAGRAPH
PARAMETER
PARCHMENT
PARTITION
PARTRIDGE
PASSENGER
PATCHWORK
PEACETIME
PENINSULA
PEPPERONI
PERENNIAL
PERISCOPE
PERMANENT
PERPETUAL
PERSEVERE
PETROLEUM
PHENOMENA
PHYSICIAN
PINEAPPLE
PISTACHIO
PLENTIFUL
PLUTONIUM
PNEUMATIC
POLLUTION
POLYESTER
PORCELAIN
PORCUPINE
POTASSIUM
POTENTIAL
POTPOURRI
PRECEDENT
PREEMPTED
PRESENTLY
PRESIDENT
PRETENDER
PREVALENT
PRIMARILY
PRIMITIVE
PRINCETON
PRINCIPAL
PRIVILEGE
PROCESSED
PROFESSOR
PROJECTOR
PROMENADE
PROMOTION
PROOFREAD
PROVISION
PROXIMITY
PUBLISHER
PUPPETEER
QUADRUPLE
QUALIFIED
QUALITIES
QUARTERLY
QUICKSAND
QUOTATION
RACETRACK
RASPBERRY
REARRANGE
REASONING
RECEPTION
RECIPIENT
RECOGNIZE
RECOMMEND
RECONCILE
RECORDING
RECTANGLE
RECYCLING
REDUNDANT
REFERENCE
REFLECTOR
REGARDING
REGULATOR
REHEARSAL
REINFORCE
REITERATE
REJECTION
RELEVANCE
RELUCTANT
REMOVABLE
RENEWABLE
REPRESENT
REQUISITE
RESEMBLES
RESERVOIR
RESIDENCE
RESILIENT
RESISTANT
RESONANCE
RESPECTED
RESTRAINT
RIVERVIEW
ROADBLOCK
SADDLEBAG
SAFEGUARD
SAGEBRUSH
SANDPAPER
SATELLITE
SATISFIES
SATURATED
SAXOPHONE
SCAPEGOAT
SCARECROW
SCORECARD
SCRIBBLER
SCRIMMAGE
SCULPTURE
SECESSION
SECLUSION
SECRETARY
SECTIONAL
SEEDLINGS
SEEMINGLY
SELECTION
SEMANTICS
SEMICOLON
SENSATION
SENSITIVE
SENTIMENT
SERIOUSLY
SHEEPSKIN
SHELLFISH
SHIPBOARD
SHIPSHAPE
SHIPWRECK
SIDEBURNS
SIGNATURE
SIMILARLY
SIMULATED
SINCERELY
SITUATION
SKETCHPAD
SLAPSTICK
SNOWFLAKE
SOCIALIZE
SOCIOLOGY
SOLICITOR
SOLILOQUY
SOLITAIRE
SOMETHING
SOURDOUGH
SOVEREIGN
SPACESHIP
SPAGHETTI
SPEARMINT
SPECTATOR
SPOKESMAN
SPOTLIGHT
SPRINKLER
STABILITY
STAINLESS
STALEMATE
STARLIGHT
STATEMENT
STEAMBOAT
STOCKINGS
STOPWATCH
STOREROOM
STRATEGIC
STREETCAR
STRUCTURE
STYROFOAM
SUBMARINE
SUBSCRIBE
SUBSTANCE
SUNFLOWER
SUPERVISE
SURRENDER
SYMBOLISM
TANGERINE
TECHNICAL
TECHNIQUE
TELEGRAPH
TELEPHONE
TELESCOPE
TEMPORARY
TENTATIVE
TERRITORY
TESTIMONY
THEREFORE
THESAURUS
THRESHOLD
TIMETABLE
TOOTHPICK
TOUCHDOWN
TRADEMARK
TRADITION

TRANSFORM
TRANSLATE
TRANSPORT
TURQUOISE
UNANIMOUS
UNCERTAIN
UNDECIDED
UNDERLINE
UNDERPASS
UNIVERSAL
UNWILLING
UTILITIES
VALENTINE
VARIATION
VEGETABLE
VENERABLE
VENTILATE
VERSATILE
VESTIBULE
VICTORIAN
VIDEOTAPE
VOLUNTARY
VOLUNTEER
WALLPAPER
WAREHOUSE
WEDNESDAY
WHIRLPOOL
WHOLESALE
WHOLESOME
WONDERFUL
WORKHORSE
WORLDWIDE
WRESTLING
YARDSTICK
YESTERDAY
YOUNGSTER

TRD-200406578
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: November 2, 2004

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Public Utility Commission of Texas

Notice of Intent to File LRIC Study Pursuant to P.U.C. Substantive Rule §26.215

Notice is given to the public of the filing on October 26, 2004, with the Public Utility Commission of Texas (commission), a notice of intent to file a long fun incremental cost (LRIC) study pursuant to P.U.C. Substantive Rule §26.215. The applicant will file the LRIC study on or around November 5, 2004

Docket Title and Number: Application of Verizon Southwest for Transparent LAN Service (TLS) Access Link Aggregation (ALA) Pursuant to P.U.C. Substantive Rule §26.215, Docket Number 30362.

Any party that demonstrates a justiciable interest may file with the administrative law judge, written comments or recommendations concerning the LRIC study referencing Docket Number 30362. Written comments or recommendations should be filed no later than forty-five (45) days after the date of a sufficient study and should be filed at the Public Utility Commission of Texas, by mail at P.O. Box 13326, Austin, Texas, 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free 1-800-735-2989. All comments should reference Docket Number 30362.

TRD-200406486

Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: October 29, 2004

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Notice of Petition for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas of a petition on October 27, 2004, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of Verizon Wireless' (Verizon Wireless) request for numbering resources in the Laredo and Longview rate centers.

Docket Title and Number: Petition of Verizon Wireless for Review of Pooling Administrator's Denial of Application for Numbering Resources. Docket Number 30367.

The Application: Verizon Wireless submitted an application to the Pooling Administrator (PA) for numbering resources in the Laredo and Longview rate center. The PA denied the request based on the grounds that Verizon did not meet the month-to-exhaust and number utilization criteria established by the Federal Communications Commission.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than November 19, 2004. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 30367.

TRD-200406482
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: October 29, 2004

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Texas Department of Transportation

Notice of Availability--Final Environmental Impact Statement

Pursuant to Title 43 Texas Administrative Code §2.43(e)(5)(F), the Texas Department of Transportation (department) is advising the public of the availability of the approved final environmental impact statement (FEIS) for the proposed construction of State Highway (SH) 121, from Interstate Highway (IH) 30 to Farm-to-Market Road (FM) 1187 in Tarrant County. The proposed project is being developed jointly with the North Texas Tollway Authority (NTTA) and the Federal Highway Administration (FHWA).

The proposed project is approximately 15 miles in length and is planned to be a controlled-access divided highway. NTTA is planning to construct an approximately 8 mile portion of the project between IH 30 and Dirks Rd./ Altamesa Boulevard as a tolled facility. The department is planning to construct the interchanges at IH 30 and IH 20 and the remaining approximately 7 mile portion of the project from Dirks Road/ Altamesa Boulevard to FM 1187. This approximately 7 mile portion of the project is planned to ultimately become a tolled facility. The project is planned for 6 lanes from IH 30 to IH 20 and 4 lanes from IH 20 to FM 1187. The minimum right-of-way width requirement is 220 feet. The purpose of the proposed project is to improve regional mobility, increase people and goods carrying capacity, and alleviate further overburdening of the local transportation system. The social, economic, and environmental impacts of the proposed project have been analyzed in the FEIS.

A total of five build alternatives, in addition to the no-build alternative, were evaluated in the FEIS for this proposed project. The five build alternatives are referred to as alternatives A, B, C, D, and C/A. Because of existing land use and land use plan development patterns within the proposed project area, the proposed build alternatives are essentially confined to the same horizontal alignment with the vertical profile varying among the alternatives. Because the build alternatives share the same basic horizontal alignment, implementing any of them would result in similar environmental consequences. The major differences among the build alternatives is that if Alternative B or D were implemented, potential impacts to cultural resources could occur and implementation of Alternative A would result in more single family housing displacements than the other alternatives. Because environmental consequences of implementing any of the build alternatives are similar, the information gained during the comment phase of the draft environmental impact statement public hearing was a valuable component in determining the recommended alternative. The recommended alternative which meets the purpose and need of the proposed project while incorporating public input has been determined to be the C/A alternative.

Copies of the FEIS are available for review at the following locations: Texas Department of Transportation, Fort Worth District Office, located at 2501 S.W. Loop at McCart Street, Fort Worth, Texas 76133 (mailing address P.O. Box 6868 Fort Worth, Texas 76115-0868). Copies of the FEIS may be reviewed at the City of Fort Worth, located at 1000 Throckmorton Street, Fort Worth, Texas 76102; the NCTCOG Headquarters, located at Center Point Two, 2nd floor, 616 Six Flags Drive, Arlington, Texas 76011; the NTTA Headquarters, located at 5900 West Plano Parkway, Plano, Texas, 75093, and the City of Fort Worth Central Library, located at 300 W. 3rd Street, Fort Worth, Texas, 76102. The FEIS may also be obtained on the department's homepage via the internet at www.dot.state.tx.us. Select 'Transportation Studies' on the homepage to obtain the FEIS.

Copies of the FEIS may be obtained for the cost of actual reproduction. Comments should be sent to Texas Department of Transportation, SH 121 FEIS, Fort Worth District Office, P.O. Box 6868, Fort Worth, Texas 76115-0868. Comments must be received or postmarked before December 31, 2004.

TRD-200406572
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Filed: November 2, 2004

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University of Houston

Notice of Amended Request for Proposal

In compliance with Chapter 2254, Texas Government Code, the University of Houston furnishes this notice of amended request for proposal originally published in the November 5, 2004 issue of the *Texas Register*. The University of Houston seeks proposals from a firm to provide debt collection services for collecting unpaid student accounts. The University invites firms with demonstrated expertise, experience, and success in collecting unpaid student accounts to submit comprehensive responses to this request for proposal. Interested parties are invited to express their interest and describe their capabilities on or before December 5, 2004.

The term of the contract is to be for a four (4) year period beginning on or about April 1, 2005 and ending April 30, 2009, subject to one (1) year renewal option. Further technical information can be obtained from Gene Gillis at 713.743.5886. All proposals must be specific and must be responsive to the criteria set forth in this request.

SCOPE OF WORK: The firm that is selected for award will assume responsibility for all of the following, without limitation: (a) collecting Accounts referred by the University; (b) complying with all federal and state law and regulations and Board of Regents and University policies and procedures applicable to collection of Accounts and to confidentiality of student information; (c) monitoring all acts and/or omissions related to Services, in order to ensure compliance with all terms and conditions set forth in this RFP and in any contract that results from the University's selection of a the firm; (d) maintaining an accurate, complete, and current data base of information regarding Accounts referred by the University; (e) upgrading and patching the firm's and/or the University's information University capabilities, such that the University is able to electronically transmit and receive information to and from the firm's; (f) generating reports and financial statements, in formats acceptable to the University, about Accounts assigned by the University for collection; and (g) maintaining a surety or fidelity bond throughout the duration of any contract for Services that is executed between the firm and the University.

INFORMATION ABOUT THE UNIVERSITY OF HOUSTON: The University is the largest Texas state institution of higher education located in an urban, metropolitan environment. As a premier research and teaching institution, our campus serves nearly 36,000 students. The University has 14 colleges and offers a host of undergraduate, graduate, and professional degree programs in a variety of disciplines; courses are conducted throughout most of the calendar year. The University ranks in the top 1 percent in the nation for its student enrollment size and is 12th in the nation for its international student enrollment. Approximately 89% of the students come from within the state of Texas. Moreover, of our student body, approximately 65% come from Harris County, which is the county in which the University of Houston is located.

GENERAL INSTRUCTIONS: Submit one (1) original and two (2) copies of your proposal in a sealed envelope to: Office of the Bursar, University of Houston, 9 Ezekiel Cullen Building, Houston, Texas 77204-2008 before 3:00 P.M. December 5, 2004. The original shall be prepared on a word processor and formatted in at least 10-point-font that is clearly readable. The copies shall be of good, readable quality.

COMPLIANCE WITH RFP REQUIREMENTS: By submission of a Proposal, a Proposer agrees to be bound by the requirements set forth in this RFP. The University, at its sole discretion, may disqualify a Proposal from consideration, if the University determines a Proposal is non-responsive and/or non-compliant, in whole or in part, with the requirements set forth in this RFP.

SIGNATURE, CERTIFICATION OF PROPOSER: The Proposal must be signed and dated by a representative of the Proposer who is authorized to bind the Proposer to the terms and conditions contained in this RFP and to compliance with the information submitted in the proposal. Each Proposer submitting a Proposal certifies to both (i) the completeness, veracity, and accuracy of the information provided in the Proposal and (ii) the authority of the individual whose signature appears on the Proposal to bind the Proposer to the terms and conditions set for in this RFP. Proposals submitted without the required signature shall be disqualified.

OWNERSHIP OF PROPOSALS: All Proposals become the physical property of the University upon receipt.

USE, DISCLOSURE OF INFORMATION: Proposers acknowledge that the University is an agency of the State of Texas and is, therefore, required to comply with the Texas Public Information Act. If a Proposal includes proprietary data, trade secrets, or information the Proposer wishes to except from public disclosure, then the Proposer must specifically label such data, secrets, or information as follows: "PRIVILEGED AND CONFIDENTIAL -- PROPRIETARY INFORMATION." To the extent permitted by law, information labeled by the Proposer as proprietary will be used by the University only for purposes related to or arising out of the (i) evaluation of Proposals, (ii) selection of a Proposer pursuant to the RFP process, and (iii) negotiation and execution of a Contract, if any, with the Proposer selected.

RESCISSION OF PROPOSAL: A Proposal can be withdrawn from consideration at any time prior to expiration of the Deadline for Proposals pursuant to a written request sent to the Treasurer.

REQUEST FOR CLARIFICATION: The University reserves the right to request clarification of any information contained in a Proposal.

QUESTIONS BY PROPOSERS: The deadline for questions submitted by Proposers is 4:00 PM CST on November 15, 2004. The University will accept no questions after this date. Questions must be submitted in writing; the question, written University response, and addenda, if any, related to the RFP will be distributed no later than November 17, 2004 to all Proposers who have sent the Proposer's email contact information to the University's Bursar by 4:00 PM CST on November 15, 2004. If the University determines a question has been sufficiently answered in the RFP, the inquiring Proposer will be referred to the relevant section of the RFP. Questions must be emailed to the Gene Gillis, at glgillis@central.uh.edu.

ADDENDA TO THE RFP: Each Proposer will be provided with copies of University-approved addenda, including amendments, if any, to the RFP. If and as necessary, as determined by the University, Proposers will, in turn, be allowed time to revise or supply additional information in response to such addenda.

PRE-PROPOSAL CONFERENCE: There will not be a pre-proposal conference.

COMMUNICATIONS WITH UNIVERSITY PERSONNEL: Except as provided in this RFP and as is otherwise necessary for the conduct of ongoing University business operations, Proposers are expressly and absolutely prohibited from engaging in communications with University personnel who are involved in any manner in the review and/or evaluation of the Proposals; selection of a Proposer; and/or negotiations or formalization of a Contract. If any Proposer engages in conduct or communications that the University determines are contrary to the prohibitions set forth in this section, the University may, at its sole discretion, disqualify the Proposer and withdraw the Proposer's Proposal from consideration.

EVALUATION OF PROPOSALS: The Proposals will be reviewed in accordance with the criteria set forth in this RFP. Proposals that are (i) incomplete, (ii) not properly certified and signed, (iii) not in the required format, or (iv) otherwise non-compliant, in whole or in part, with any of the requirements set forth in this RFP may be disqualified by the University.

INFORMATION REQUESTED: Each firm must respond fully and accurately to all requests for information and/or documentation sought by this RFP. Each firm must provide information about all of the following in support of its Proposal: (A) Business: Financial Information: (i) Provide current DBA name and registration of the firm; (ii) Provide any other names under which the firm has operated/performed collection services (include the reason(s) for the name changes); (iii) Describe your form of legal entity (sole proprietorship / corporation/

limited partnership/ partnership); (iv) Provide name(s) of owner(s); partners; limited partners, or shareholders (if an S corporation); (v) Provide, as applicable, name of parent corporation / entity; (vi) Provide location(s) of corporate office(s)/regional office(s)/local office(s); (vii) Provide name(s), title(s), phone number(s), and fax number(s) of main contact(s) to be assigned as account representative(s) to University and their experience in the industry and tenure with your company; (viii) Insurance carriers(s), types, and amounts of coverage currently maintained by Proposer; (ix) Include your most current financial statements; (B)Services, Reports, and Billing: (i)Describe the services the Proposer is able to provide; (ii) Provide examples of reports provided to customer; (iii) Provide examples of letters sent to debtors; (iv) Describe other collection services the firm is able to provide to the University; (v) Describe your policies and procedures for handling complaints about personnel/collection activities as well as ensuring confidentiality and privacy of information pertinent to accounts referred for collection; (vi) Describe your information Universitys, including capabilities, both present and future, for storage, processing, transmittal, receipt, and retrieval of University collections data, and interaction/communication/reporting capability; (C) Fees: Please provide a fee schedule for the services that will be provided in accordance with the terms of this request for proposal; (D) Experience: (i) Provide and overview of your firm, including whether you would be considered a local, regional, or national firm and the demographics of your client base; (ii) Describe the resources available to your firm to aid in the recovery of the bad debts; (iii) Indicate the number of years The firm has performed collection services; (iv) Describe your experience with collection services and, more specifically, for colleges or universities; (v) Provide a list of college or universities for whom you perform tuition and fee debt collection services; (vi) Provide the number and dollar amount of accounts currently under contract segregated by type of account; (vii) Provide the percentage of accounts collected by the firm and time frames during which such collections were accomplished; (viii) Provide a description of the qualifications and experience of those engaged in debt collection activities; (ix) Indicate the number of accounts typically assigned to any one collector; (x) Describe the ongoing training required of personnel engaged in collection activities; (xi) Describe the procedures background/security checks performed on personnel engaged in debt collection activities; (xii) Indicate whether you intend to subcontract any aspect of the collection services and if so the service and vendor identified; (E) References: Provide three (3) references (must be from universities of higher education of similar size in terms of student enrollment) for whom the firm currently provides tuition and fee collection services, with names, titles, and phone numbers of contacts; (F) Legal Information: Is your firm, or any professionals employed by your firm, currently a defendant in any criminal proceedings or under criminal investigation, or being subject to any proceedings involving alleged securities violations; or any administrative action, including state and or federal regulatory agency proceedings, which resulted in censure or the suspension or revocation of any licenses? If yes, please describe.

DISCUSSIONS WITH PROPOSERS: The University may conduct discussions and/or negotiations with any Proposer that appears to be eligible for award ("Eligible Proposer") pursuant to the selection criteria set forth in this RFP. In conducting discussions and/or negotiations, the University will not disclose information derived from Proposals submitted by competing Proposers, except as and if law requires disclosure.

MODIFICATION OF PROPOSALS: All Eligible Proposers will be afforded the opportunity to submit best and final Proposals if (a) negotiations with any other Proposer result in a material alteration to the RFP and (b) such material alteration has a cost consequence that could alter the Proposer's quotations regarding rates for Services.

SELECTION OF PROPOSER: The Proposer selected for award will be the Proposer whose Proposal, as presented in response to this RFP and as determined by the University in accordance with the evaluation criteria set forth in this RFP, to be the most advantageous to the University. Proposers acknowledge that the University is not bound to accept the lowest-priced Proposal.

EVALUATION OF PROPOSALS: Submission of a Proposal indicates the Proposer's acceptance of the evaluation process set forth in this RFP and the Proposer's acknowledgement that subjective judgments must be made by the University in regard to the evaluation process.

CRITERIA FOR EVALUATION: Evaluation of Proposals and award to the Selected Proposer will be based on the following factors, as weighted and listed as follows: (i) Demonstrated ability of the Proposer to fulfill current and predicted System needs (40%); (ii) Stability and success of the Proposer's business profile (40%); and (iii) Rates for Services quoted (20%). The University may also consider other information it deems relevant to the selection of a Contractor.

CONSIDERATION OF ADDITIONAL INFORMATION: The University reserves the right to ask for and consider any additional information deemed beneficial to the University in evaluation of the Proposals.

TERMINATION: This Request for Proposal in no manner obligates the University of Houston University to the eventual purchase of any services described, implied or which may be proposed until confirmed by a written consultant contract. Progress towards this end is solely at the discretion of the University of Houston University and may be terminated without penalty or obligation at any time prior to the signing of a contract. The University of Houston University reserves the right to cancel this RFP at any time, for any reason and to reject any or all proposals.

TRD-200406570

Brian S. Nelson

Executive Director for Contract Administration/Associate General Counsel for Contract Compliance

University of Houston

Filed: November 2, 2004

Notice of Amended Request for Proposal

In compliance with Chapter 2254, Texas Government Code, the University of Houston furnishes this notice of amended request for proposal originally published in the November 5, 2004 issue of the *Texas Register*. The University of Houston seeks proposals from a firm to provide debt collection services for National Direct Student Loan/Federal Perkins Loan/Health Professions Student Loan Debt Accounts referred to the a firm for collection by the University of Houston. The University invites firms with demonstrated expertise, experience, and success in collecting unpaid accounts to submit comprehensive responses to this request for proposal. Interested parties are invited to express their interest and describe their capabilities on or before December 5, 2004.

The term of the contract is to be for a four (4) year period beginning on or about April 1, 2005 and ending April 30, 2009, subject to one (1) year renewal option. Further technical information can be obtained from Gene Gillis at 713.743.5886. All proposals must be specific and must be responsive to the criteria set forth in this request.

SCOPE OF WORK: The firm that is selected for award will assume responsibility for all of the following, without limitation: (a) collecting Accounts referred by the University; (b) complying with all federal and state law and regulations and Board of Regents and University policies and procedures applicable to collection of Accounts and to confidentiality of student information; (c) monitoring all acts and/or omissions

related to Services, in order to ensure compliance with all terms and conditions set forth in this RFP and in any contract that results from the University's selection of a the firm; (d) maintaining an accurate, complete, and current data base of information regarding Accounts referred by the University; (e) upgrading and patching the firm's and/or the University's information University capabilities, such that the University is able to electronically transmit and receive information to and from the firm's; (f) generating reports and financial statements, in formats acceptable to the University, about Accounts assigned by the University for collection; and (g) maintaining a surety or fidelity bond throughout the duration of any contract for Services that is executed between the firm and the University.

INFORMATION ABOUT THE UNIVERSITY OF HOUSTON: The University is the largest Texas state institution of higher education located in an urban, metropolitan environment. As a premier research and teaching institution, our campus serves nearly 36,000 students. The University has 14 colleges and offers a host of undergraduate, graduate, and professional degree programs in a variety of disciplines; courses are conducted throughout most of the calendar year. The University ranks in the top 1 percent in the nation for its student enrollment size and is 12th in the nation for its international student enrollment. Approximately 89% of the students come from within the state of Texas. Moreover, of our student body, approximately 65% come from Harris County, which is the county in which the University of Houston is located.

GENERAL INSTRUCTIONS: Submit one (1) original and two (2) copies of your proposal in a sealed envelope to: Office of the Bursar, University of Houston, 9 Ezekiel Cullen Building, Houston, Texas 77204-2008 before 3:00 P.M. December 5, 2004. The original shall be prepared on a word processor and formatted in at least 10-point-font that is clearly readable. The copies shall be of good, readable quality.

COMPLIANCE WITH RFP REQUIREMENTS: By submission of a Proposal, a Proposer agrees to be bound by the requirements set forth in this RFP. The University, at its sole discretion, may disqualify a Proposal from consideration, if the University determines a Proposal is non-responsive and/or non-compliant, in whole or in part, with the requirements set forth in this RFP.

SIGNATURE, CERTIFICATION OF PROPOSER: The Proposal must be signed and dated by a representative of the Proposer who is authorized to bind the Proposer to the terms and conditions contained in this RFP and to compliance with the information submitted in the proposal. Each Proposer submitting a Proposal certifies to both (i) the completeness, veracity, and accuracy of the information provided in the Proposal and (ii) the authority of the individual whose signature appears on the Proposal to bind the Proposer to the terms and conditions set for in this RFP. Proposals submitted without the required signature shall be disqualified.

OWNERSHIP OF PROPOSALS: All Proposals become the physical property of the University upon receipt.

USE, DISCLOSURE OF INFORMATION: Proposers acknowledge that the University is an agency of the State of Texas and is, therefore, required to comply with the Texas Public Information Act. If a Proposal includes proprietary data, trade secrets, or information the Proposer wishes to except from public disclosure, then the Proposer must specifically label such data, secrets, or information as follows: "PRIVILEGED AND CONFIDENTIAL -- PROPRIETARY INFORMATION." To the extent permitted by law, information labeled by the Proposer as proprietary will be used by the University only for purposes related to or arising out of the (i) evaluation of Proposals, (ii) selection of a Proposer pursuant to the RFP process, and (iii) negotiation and execution of a Contract, if any, with the Proposer selected.

RESCISSION OF PROPOSAL: A Proposal can be withdrawn from consideration at any time prior to expiration of the Deadline for Proposals pursuant to a written request sent to the Treasurer.

REQUEST FOR CLARIFICATION: The University reserves the right to request clarification of any information contained in a Proposal.

QUESTIONS BY PROPOSERS: The deadline for questions submitted by Proposers is 4:00 PM CST on November 15, 2004. The University will accept no questions after this date. Questions must be submitted in writing; the question, written University response, and addenda, if any, related to the RFP will be distributed no later than November 15, 2004 to all Proposers who have sent the Proposer's email contact information to the University's Bursar by 4:00 PM CST on November 17, 2004. If the University determines a question has been sufficiently answered in the RFP, the inquiring Proposer will be referred to the relevant section of the RFP. Questions must be emailed to the Gene Gillis, at glgillis@central.uh.edu.

ADDENDA TO THE RFP: Each Proposer will be provided with copies of University-approved addenda, including amendments, if any, to the RFP. If and as necessary, as determined by the University, Proposers will, in turn, be allowed time to revise or supply additional information in response to such addenda.

PRE-PROPOSAL CONFERENCE: There will not be a pre-proposal conference.

COMMUNICATIONS WITH UNIVERSITY PERSONNEL: Except as provided in this RFP and as is otherwise necessary for the conduct of ongoing University business operations, Proposers are expressly and absolutely prohibited from engaging in communications with University personnel who are involved in any manner in the review and/or evaluation of the Proposals; selection of a Proposer; and/or negotiations or formalization of a Contract. If any Proposer engages in conduct or communications that the University determines are contrary to the prohibitions set forth in this section, the University may, at its sole discretion, disqualify the Proposer and withdraw the Proposer's Proposal from consideration.

EVALUATION OF PROPOSALS: The Proposals will be reviewed in accordance with the criteria set forth in this RFP. Proposals that are (i) incomplete, (ii) not properly certified and signed, (iii) not in the required format, or (iv) otherwise non-compliant, in whole or in part, with any of the requirements set forth in this RFP may be disqualified by the University.

INFORMATION REQUESTED: Each firm must respond fully and accurately to all requests for information and/or documentation sought by this RFP. Each firm must provide information about all of the following in support of its Proposal: (A) Business: Financial Information: (i) Provide current DBA name and registration of the firm; (ii) Provide any other names under which the firm has operated/performed collection services (include the reason(s) for the name changes); (iii) Describe your form of legal entity (sole proprietorship / corporation/ limited partnership/ partnership); (iv) Provide name(s) of owner(s); partners; limited partners, or shareholders (if an S corporation); (v) Provide, as applicable, name of parent corporation / entity; (vi) Provide location(s) of corporate office(s)/regional office(s)/local office(s); (vii) Provide name(s), title(s), phone number(s), and fax number(s) of main contact(s) to be assigned as account representative(s) to University and their experience in the industry and tenure with your company; (viii) Insurance carriers(s), types, and amounts of coverage currently maintained by Proposer; (ix) Include your most current financial statements; (B)Services, Reports, and Billing: (i)Describe the services the Proposer is able to provide; (ii) Provide examples of reports provided

to customer; (iii) Provide examples of letters sent to debtors; (iv) Describe other collection services the firm is able to provide to the University; (v) Describe your policies and procedures for handling complaints about personnel/collection activities as well as ensuring confidentiality and privacy of information pertinent to accounts referred for collection; (vi) Describe your information Universitys, including capabilities, both present and future, for storage, processing, transmittal, receipt, and retrieval of University collections data, and interaction/communication/reporting capability; (C) Fees: Please provide a fee schedule for the services that will be provided in accordance with the terms of this request for proposal; (D) Experience: (i) Provide and overview of your firm, including whether you would be considered a local, regional, or national firm and the demographics of your client base; (ii) Describe the resources available to your firm to aid in the recovery of the bad debts; (iii) Indicate the number of years The firm has performed collection services; (iv) Describe your experience with collection services and, more specifically, for colleges or universities; (v) Provide a list of college or universities for whom you perform tuition and fee debt collection services; (vi) Provide the number and dollar amount of accounts currently under contract segregated by type of account; (vii) Provide the percentage of accounts collected by the firm and time frames during which such collections were accomplished; (viii) Provide a description of the qualifications and experience of those engaged in debt collection activities; (ix) Indicate the number of accounts typically assigned to any one collector; (x) Describe the ongoing training required of personnel engaged in collection activities; (xi) Describe the procedures background/security checks performed on personnel engaged in debt collection activities; (xii) Indicate whether you intend to subcontract any aspect of the collection services and if so the service and vendor identified; (E) References: Provide three (3) references (must be from universities of higher education of similar size in terms of student enrollment) for whom the firm currently provides tuition and fee collection services, with names, titles, and phone numbers of contacts; (F) Legal Information: Is your firm, or any professionals employed by your firm, currently a defendant in any criminal proceedings or under criminal investigation, or being subject to any proceedings involving alleged securities violations; or any administrative action, including state and or federal regulatory agency proceedings, which resulted in censure or the suspension or revocation of any licenses? If yes, please describe.

DISCUSSIONS WITH PROPOSERS: The University may conduct discussions and/or negotiations with any Proposer that appears to be eligible for award ("Eligible Proposer") pursuant to the selection criteria set forth in this RFP. In conducting discussions and/or negotiations, the University will not disclose information derived from Proposals submitted by competing Proposers, except as and if law requires disclosure.

MODIFICATION OF PROPOSALS: All Eligible Proposers will be afforded the opportunity to submit best and final Proposals if (a) negotiations with any other Proposer result in a material alteration to the RFP and (b) such material alteration has a cost consequence that could alter the Proposer's quotations regarding rates for Services.

SELECTION OF PROPOSER: The Proposer selected for award will be the Proposer whose Proposal, as presented in response to this RFP and as determined by the University in accordance with the evaluation criteria set forth in this RFP, to be the most advantageous to the University. Proposers acknowledge that the University is not bound to accept the lowest-priced Proposal.

EVALUATION OF PROPOSALS: Submission of a Proposal indicates the Proposer's acceptance of the evaluation process set forth in this RFP and the Proposer's acknowledgement that subjective judgments must be made by the University in regard to the evaluation process.

CRITERIA FOR EVALUATION: Evaluation of Proposals and award to the Selected Proposer will be based on the following factors, as weighted and listed as follows: (i) The firm's demonstrated competence and experience with performing collection services for institutions of higher education; and, demonstrated capabilities at accomplishing a high-volume, high success rate in collecting on past due accounts (20%); (ii) The estimated cost to the University of the firm's services (20%); (iii) Capabilities, both present and future, of the firm's information system (s) for storage, processing, transmittal, receipt, and retrieval of University collections data, compatibility of the firm's information system (s) with the University's student information system (s), both systems presently utilized and systems that will be implemented by the University during the term of the contract executed by the University and the firm (20%); (iv) The policies and procedures the firm has formulated, implemented, monitored, and enforced for collection of accounts, including those applicable to maintaining the confidentiality of University and student information, the firm's knowledge and understanding of and compliance with federal and state law and regulation applicable to collection activities and to the confidentiality of student information (15%); (v) Proposed methods for resolution of disputes regarding accounts or collections (10%); (vi) The menu of collection services the firm proposes to provide to the University along with the format and substance of reports and financial statements (10%); (vii) Responses from Contractor's references in regard to satisfaction and evaluation of the firm's services, and qualifications and experience of the individuals who perform collections on behalf of the firm (5%). The University may also consider other information it deems relevant to the selection of a Contractor.

CONSIDERATION OF ADDITIONAL INFORMATION: The University reserves the right to ask for and consider any additional information deemed beneficial to the University in evaluation of the Proposals.

TERMINATION: This Request for Proposal in no manner obligates the University of Houston University to the eventual purchase of any services described, implied or which may be proposed until confirmed by a written consultant contract. Progress towards this end is solely at the discretion of the University of Houston University and may be terminated without penalty or obligation at any time prior to the signing of a contract. The University of Houston University reserves the right to cancel this RFP at any time, for any reason and to reject any or all proposal

TRD-200406575

Brian S. Nelson

Executive Director for Contract Administration/Associate General Counsel for Contract Compliance

University of Houston

Filed: November 2, 2004

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University of Houston System

Consultant Contract Award Notice

In compliance with the provisions of Chapter 2254, Subchapter B, Texas Government Code, The University of Houston System furnishes this notice of consultant contract award. The consultant will provide services in implementation of the PeopleSoft Student Administrative System. Requests for proposals were filed in the July 2, 2004, issue of the *Texas Register* (29 TexReg 6457).

The contract was awarded to Accenture LLP, 41 South High Street, Suite 2000, Columbus, Ohio 43215-6187, for a total amount of $250,191.

The beginning date of the contract is October 28, 2004 and the ending date is December 22, 2005.

For further information, please call (713) 743-9116.

TRD-200406480

Brian S. Nelson

Executive Director for Contract Administration/Associate General Counsel for Contract Compliance

University of Houston System

Filed: October 29, 2004

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Texas Water Development Board

Applications Received

Pursuant to the Texas Water Code, Section 6.195, the Texas Water Development Board provides notice of the following applications received by the Board:

Red River Redevelopment Authority, 107 Chapel Lane, New Boston, Texas, 75570, received April 4, 2004, application for financial assistance in the amount of $8,000,000 from the Texas Water Development Funds.

North Channel Water Authority, P. O. Box 24338, Houston, Texas, 77229, received September 30, 2004, application for financial assistance in the amount of $13,000,000 from the Texas Water Development Funds.

Canyon Lake Water Supply Corporation, P.O. Box 1742, Canyon Lake, Texas, 78133, received October 4, 2004, application for financial assistance in the amount of $7,500,000 from the Texas Water Development Funds.

TRD-200406597

Suzanne Schwartz

General Counsel

Texas Water Development Board

Filed: November 3, 2004

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Texas Workers' Compensation Commission

Invitation to Apply to the Medical Advisory Committee (MAC)

The Texas Workers' Compensation Commission seeks to have a diverse representation on the MAC and invites qualified individuals from all regions of Texas to apply for openings on the MAC in accordance with the eligibility requirements of the *Procedures and Standards for the Medical Advisory Committee*. The Medical Review Division is currently accepting applications for the following Medical Advisory Committee representative vacancies:

Primary

* Public Health Care Facility

Alternate

* Public Health Care Facility

* Dentist

* Pharmacist

* Podiatrist

* Employer

* Employee

* General Public Representative 1

* General Public Representative 2

Commissioners for the Texas Workers' Compensation Commission appoint the Medical Advisory Committee members who are composed of 18 primary and 18 alternate members representing health care providers, employees, employers, insurance carriers, and the general public. Primary members are required to attend all Medical Advisory Committee meetings, subcommittee meetings, and work group meetings to which they are appointed. The alternate member may attend all meetings, however during a primary member's absence, the alternate member must attend meetings to which the primary member is appointed. Requirements and responsibilities of members are established in the Procedures and Standards for the Medical Advisory Committee as adopted by the Commission.

The Medical Advisory Committee meetings must be held at least quarterly each fiscal year during regular Commission working hours. Members are not reimbursed for travel, per diem, or other expenses associated with Committee activities and meetings. Voluntary service on the Medical Advisory Committee is greatly appreciated by the TWCC Commissioners and the TWCC Staff.

The purpose and task of the Medical Advisory Committee, which includes advising the Commission's Medical Review Division on the development and administration of medical policies, rules and guidelines, are outlined in the Texas Workers' Compensation Act, §413.005.

Applications and other relevant Medical Advisory Committee information may be viewed and downloaded from the Commission's website at *http://www/twcc.state.tx.us.* Click on 'Commission Meetings', then 'Medical Advisory Committee'. Applications may also be obtained by calling Jane McChesney, MAC Coordinator, at 512-804-4855 or Ruth Richardson, Manager of Monitoring, Analysis and Education, Medical Review Division at 512-804-4850 .

The qualifications as well as the terms of appointment for all positions are listed in the Procedures and Standards for the Medical Advisory Committee. These Procedures and Standards are as follows:

LEGAL AUTHORITY The Medical Advisory Committee for the Texas Workers' Compensation Commission, Medical Review Division is established under the Texas Workers' Compensation Act, (the Act) §413.005.

PURPOSE AND ROLE The purpose of the Medical Advisory Committee (MAC) is to bring together representatives of health care specialties and representatives of labor, business, insurance and the general public to advise the Medical Review Division in developing and administering the medical policies, fee guidelines, and the utilization guidelines established under §413.011 of the Act.

COMPOSITION Membership. The composition of the committee is governed by the Act, as it may be amended. Members of the committee are appointed by the Commissioners and must be knowledgeable and qualified regarding work-related injuries and diseases.

Members of the committee shall represent specific health care provider groups and other groups or interests as required by the Act, as it may be amended. As of September 1, 2001, these members include a public health care facility, a private health care facility, a doctor of medicine, a doctor of osteopathic medicine, a chiropractor, a dentist, a physical therapist, a podiatrist, an occupational therapist, a medical equipment supplier, a registered nurse, and an acupuncturist. Appointees must have at least six (6) years of professional experience in the medical profession they are representing and engage in an active practice in their field.

The Commissioners shall also appoint the other members of the committee as required by the Act, as it may be amended. An insurance carrier representative may be employed by: an insurance company; a certified self-insurer for workers' compensation insurance; or a governmental entity that self-insures, either individually or collectively. An insurance carrier member may be a medical director for the carrier but may not be a utilization review agent or a third party administrator for the carrier.

A health care provider member, or a business the member is associated with, may not derive more than 40% of its revenues from workers compensation patients. This fact must be certified in their application to the MAC.

The representative of employers, representative of employees, and representatives of the general public shall not hold a license in the health care field and may not derive their income directly from the provision of health care services.

The Commissioners may appoint one alternate representative for each primary member appointed to the MAC, each of whom shall meet the qualifications of an appointed member.

Terms of Appointment: Members serve at the pleasure of the Commissioners, and individuals are required to submit the appropriate application form and documents for the position. The term of appointment for any primary or alternate member will be two years, except for unusual circumstances (such as a resignation, abandonment or removal from the position prior to the termination date) or unless otherwise directed by the Commissioners. A member may serve a maximum of two terms as a primary, alternate or a combination of primary and alternate member. Terms of appointment will terminate August 31 of the second year following appointment to the position, except for those positions that were initially created with a three-year term. For those members who are appointed to serve a part of a term that lasts six (6) months or less, this partial appointment will not count as a full term.

Abandonment will be deemed to occur if any primary member is absent from more than two (2) consecutive meetings without an excuse accepted by the Medical Review Division Director. Abandonment will be deemed to occur if any alternate member is absent from more than two (2) consecutive meetings which the alternate is required to attend because of the primary member's absence without an excuse accepted by the Medical Review Division Director.

The Commission will stagger the August 31st end dates of the terms of appointment between odd and even numbered years to provide sufficient continuity on the MAC.

In the case of a vacancy, the Commissioners will appoint an individual who meets the qualifications for the position to fill the vacancy. The Commissioners may re-appoint the same individual to fill either a primary or alternate position as long as the term limit is not exceeded. Due to the absence of other qualified, acceptable candidates, the Commissioners may grant an exception to its membership criteria, which are not required by statute.

RESPONSIBILITY OF MAC MEMBERS Primary Members. Make recommendations on medical issues as required by the Medical Review Division.

Attend the MAC meetings, subcommittee meetings, and work group meetings to which they are appointed.

Ensure attendance by the alternate member at meetings when the primary member cannot attend.

Provide other assistance requested by the Medical Review Division in the development of guidelines and medical policies.

Alternate Members. Attend the MAC meetings, subcommittee meetings, and work group meetings to which the primary member is appointed during the primary member's absence.

Maintain knowledge of MAC proceedings.

Make recommendations on medical issues as requested by the Medical Review Division when the primary member is absent at a MAC meeting.

Provide other assistance requested by the Medical Review Division in the development of guidelines and medical policies when the primary member is absent from a MAC meeting.

Committee Officers. The TWCC Commissioners designate the chairman of the MAC. The MAC will elect a vice chairman. A member shall be nominated and elected as vice chairman when he/she receives a majority of the votes from the membership in attendance at a meeting at which nine (9) or more primary or alternate members are present.

Responsibilities of the Chairman: Preside at MAC meetings and ensure the orderly and efficient consideration of matters requested by the Medical Review Division; prior to meetings, confer with the Medical Review Division Director, and when appropriate, the TWCC Executive Director to receive information and coordinate:

a. Preparation of a suitable agenda.

b. Planning MAC activities.

c. Establishing meeting dates and calling meetings.

d. Establishing subcommittees.

e. Recommending MAC members to serve on subcommittees.

If requested by the Commission, appear before the Commissioners to report on MAC meetings.

COMMITTEE SUPPORT STAFF The Director of Medical Review will provide coordination and reasonable support for all MAC activities. In addition, the Director will serve as a liaison between the MAC and the Medical Review Division staff of TWCC, and other Commission staff if necessary.

The Medical Review Director will coordinate and provide direction for the following activities of the MAC and its subcommittees and work groups:

Preparing agenda and support materials for each meeting.

Preparing and distributing information and materials for MAC use.

Maintaining MAC records.

Preparing minutes of meetings.

Arranging meetings and meeting sites.

Maintaining tracking reports of actions taken and issues addressed by the MAC.

Maintaining attendance records.

SUBCOMMITTEES The chairman shall appoint the members of a subcommittee from the membership of the MAC. If other expertise is needed to support subcommittees, the Commissioners or the Director of Medical Review may appoint appropriate individuals.

WORK GROUPS When deemed necessary by the Director of Medical Review or the Commissioners, work groups will be formed by the Director. At least one member of the work group must also be a member of the MAC.

WORK PRODUCT No member of the MAC, a subcommittee, or a work group may claim or is entitled to an intellectual property right in work performed by the MAC, a subcommittee, or a work group.

MEETINGS Frequency of Meetings. Regular meetings of the MAC shall be held at least quarterly each fiscal year during regular Commission working hours.

CONDUCT AS A MAC MEMBER Special trust has been placed in members of the Medical Advisory Committee. Members act and serve on behalf of the disciplines and segments of the community they represent and provide valuable advice to the Medical Review Division and the Commission. Members, including alternate members, shall observe the following conduct code and will be required to sign a statement attesting to that intent.

Comportment Requirements for MAC Members:

Learn their duties and perform them in a responsible manner;

Conduct themselves at all times in a manner that promotes cooperation and effective discussion of issues among MAC members;

Accurately represent their affiliations and notify the MAC chairman and Medical Review Director of changes in their affiliation status;

Not use their memberships on the MAC: a. in advertising to promote themselves or their business. b. to gain financial advantage either for themselves or for those they represent; however, members may list MAC membership in their resumes;

Provide accurate information to the Medical Review Division and the Commission;

Consider the goals and standards of the workers' compensation system as a whole in advising the Commission;

Explain, in concise and understandable terms, their positions and/or recommendations together with any supporting facts and the sources of those facts;

Strive to attend all meetings and provide as much advance notice to the Texas Workers' Compensation Commission staff, attn: Medical Review Director, as soon as possible if they will not be able to attend a meeting; and

Conduct themselves in accordance with the MAC Procedures and Standards, the standards of conduct required by their profession, and the guidance provided by the Commissioners, Medical Review Division or other TWCC staff.

TRD-200406535
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Filed: November 1, 2004

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Texas Workforce Commission

Resolution of the Texas Workforce Commission Establishing the Unemployment Obligation Assessment for Calendar Year 2005

1. In accordance with the formula provided in 40 T.A.C. §815.132 as set out in part in subsection (e):

"(e) The rate of the portion of the assessment that is to be used to pay a bond obligation is a percentage of the product of the unemployment obligation assessment ratio and the sum of the employer's prior year general tax rate, the replenishment tax rate and the deficit tax rate. The percentage to be determined by Commission resolution, shall not exceed 200%." The "percentage" for 2005 is 96%.

TRD-200406577
John Moore
General Counsel
Texas Workforce Commission
Filed: November 2, 2004

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How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 29 (2004) is cited as follows: 29 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "29 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 29 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For subscription information, see the back cover or call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC)*** is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15:

1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 16, April 9, July 9, and October 8, 2004). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).

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