# TEXAS REGISTER

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Part I - Volume 20, Number 88

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**Texas Register**

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## How to Use the Texas Register

**Information Available:** The 11 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**Withdrawn Rules** - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.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 a 30-day public comment period.

**Tables and Graphics** - graphic material from the proposed, emergency and adopted sections.

**Open Meetings** - notices of open meetings.

**In Addition** - miscellaneous information required to be published by statute or provided as a public service.

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 20 (1995) is cited as follows: 20 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 "20 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 20 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.

### Texas Administrative Code

The ***Texas Administrative Code*** (***TAC***) is the official 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***. West Publishing Company, the official publisher of the ***TAC***, publishes on an annual basis.

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 ***Official TAC*** also is available on WESTLAW, West's computerized legal research service, in the TX-ADC database.

To purchase printed volumes of the ***TAC*** or to inquire about WESTLAW access to the ***TAC*** call West: **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:

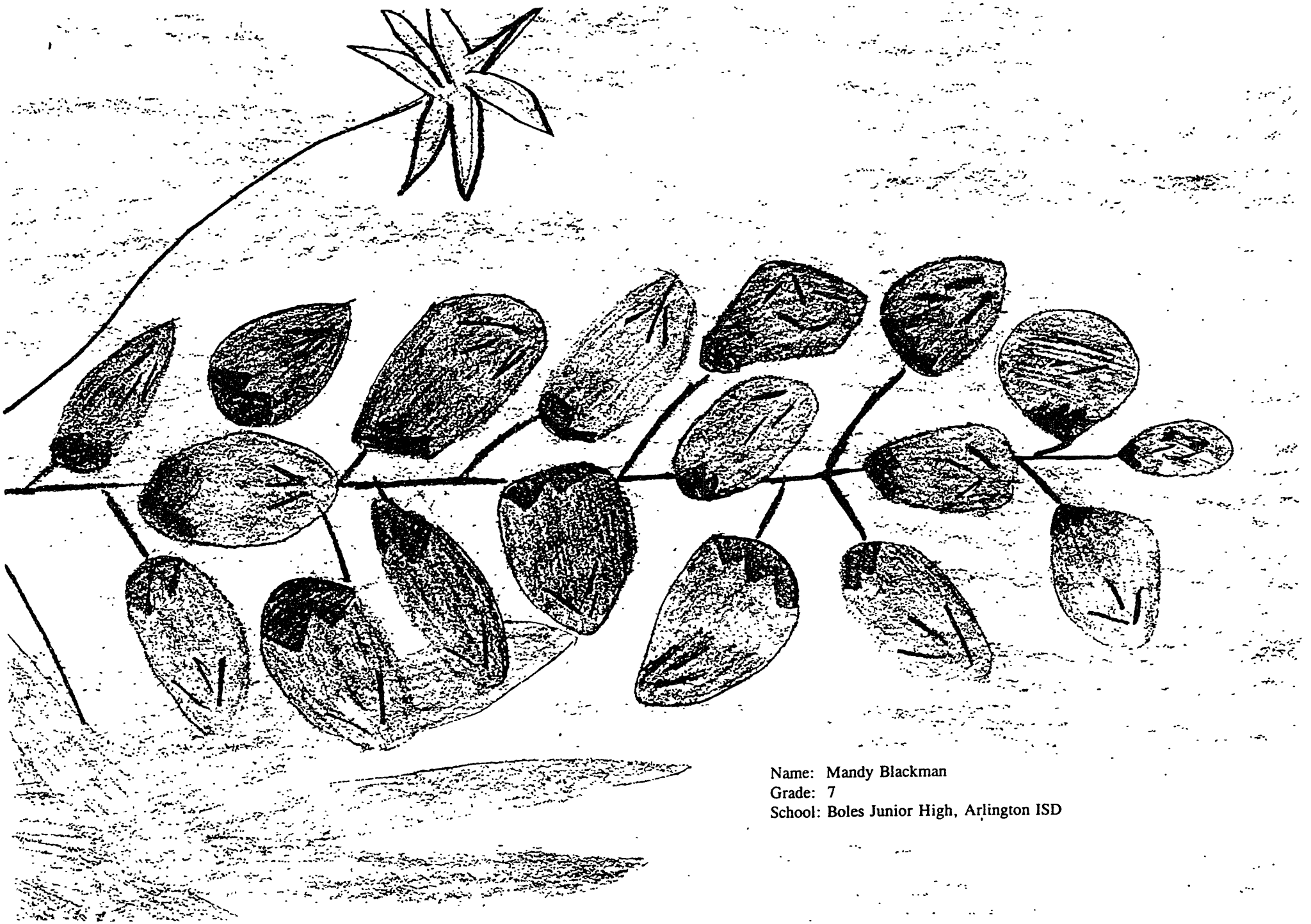
1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the 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 21, April 15, July 12, and October 11, 1994). In its second issue each month the ***Texas Register*** contains a cumulative ***Table of TAC Titles Affected*** for the preceding month. 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).

**Update by FAX:** An up-to-date ***Table of TAC Titles Affected*** is available by FAX upon request. Please specify the state agency and the TAC number(s) you wish to update. This service is free to ***Texas Register*** subscribers. Please have your subscription number ready when you make your request. For non-subscribers there will be a fee of $2.00 per page (VISA, MasterCard). (512) 463-5561.



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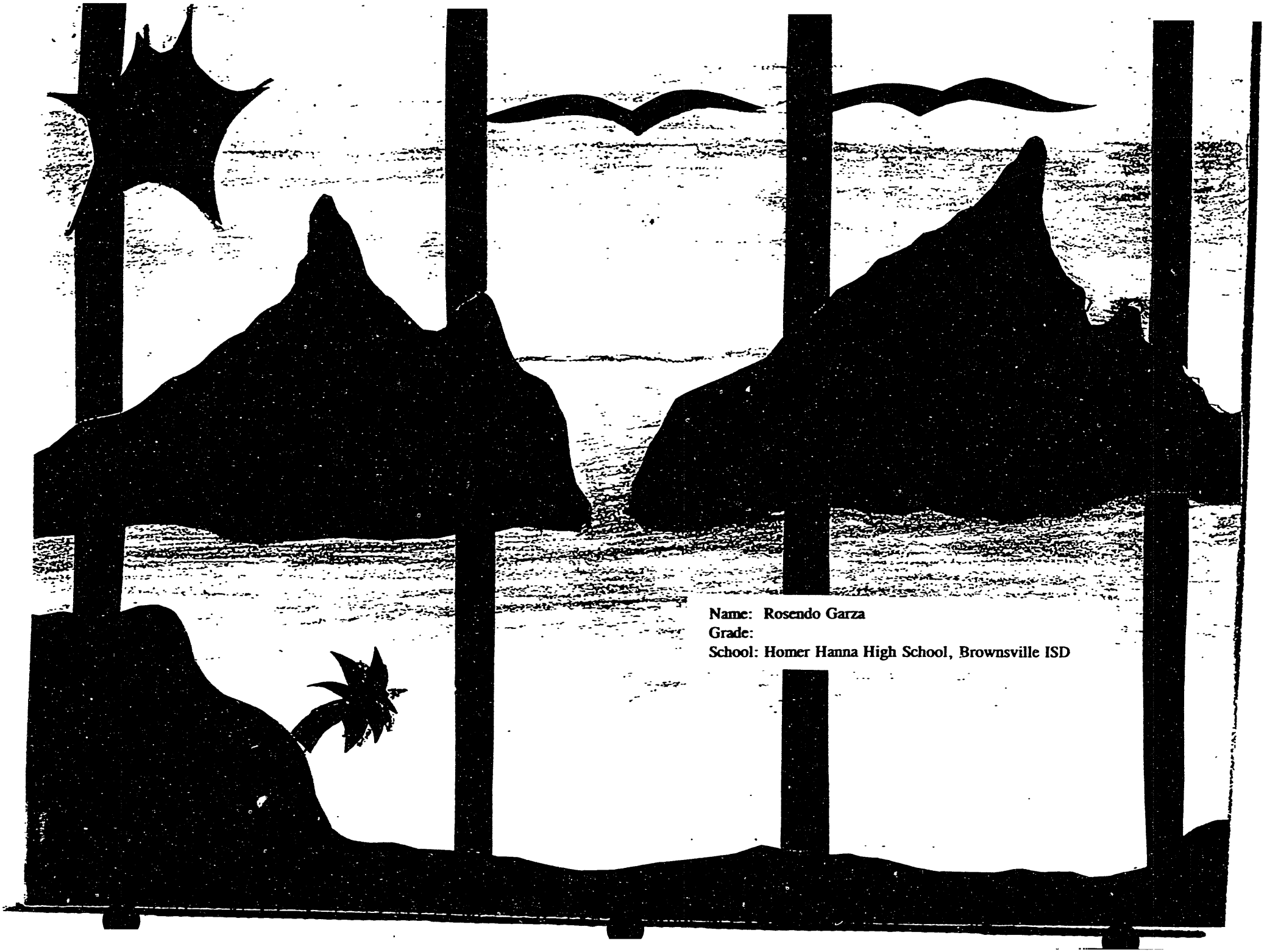
School: Boles Junior High, Arlington ISD



Name: Rosendo Garza
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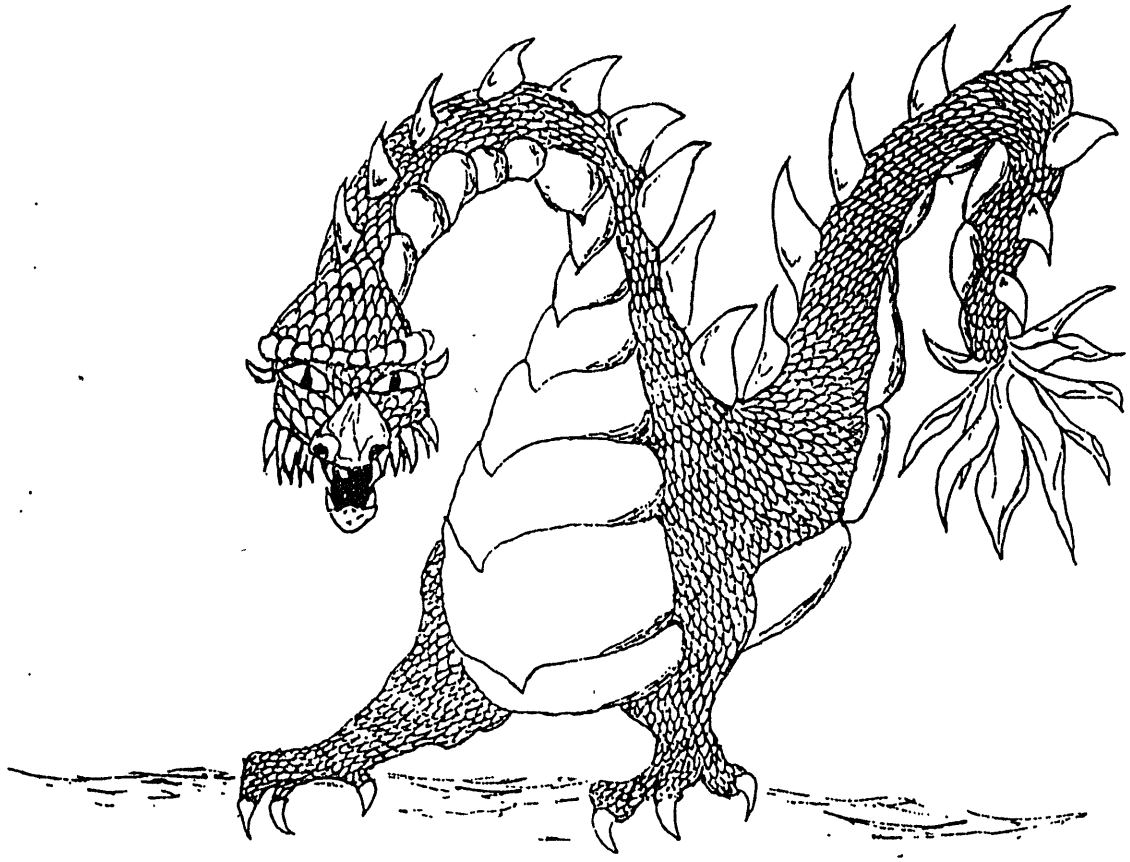
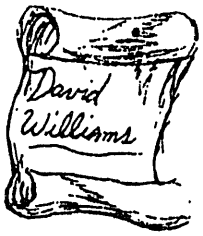
School: Homer Hanna High School, Brownsville ISD



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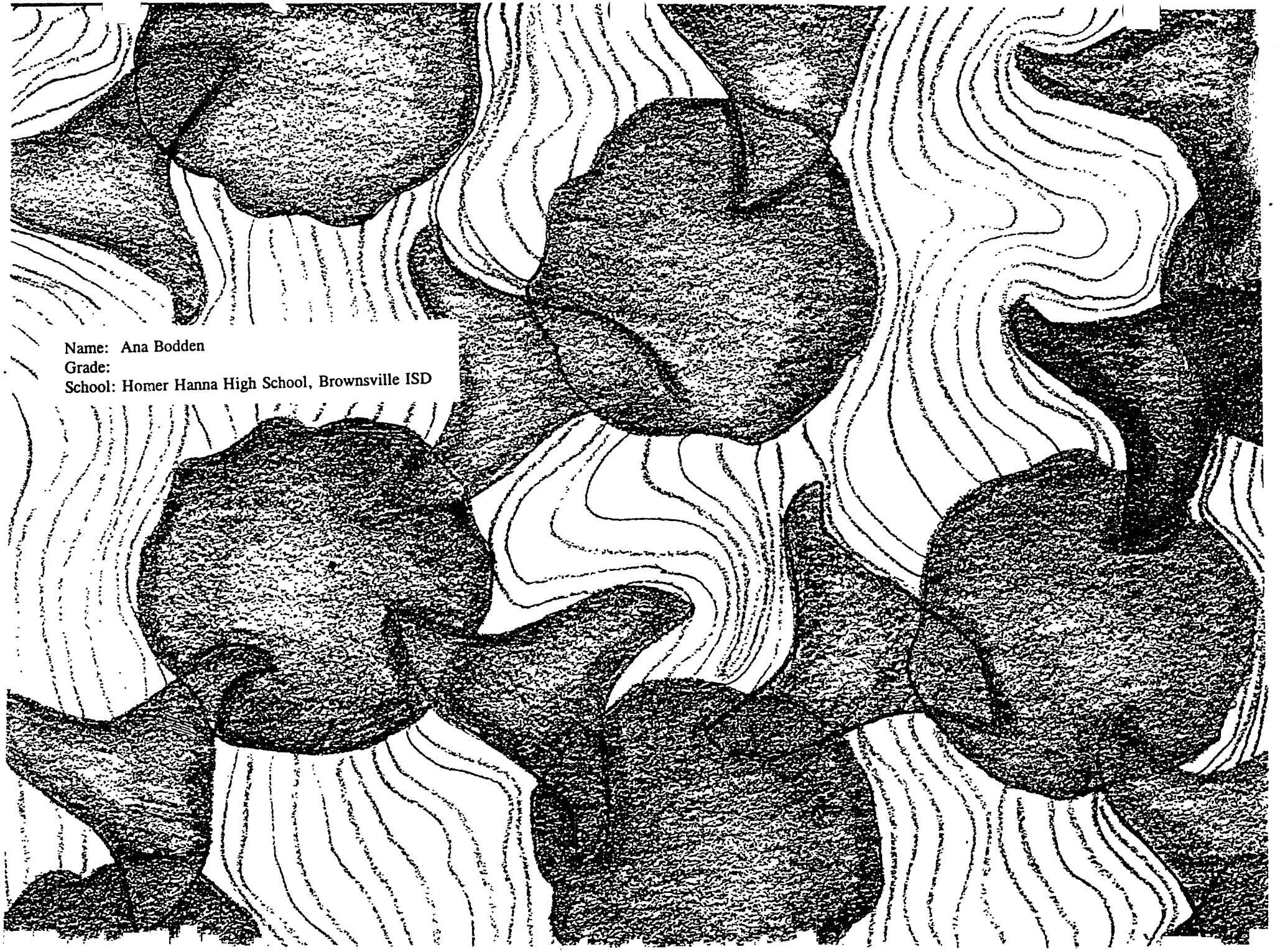
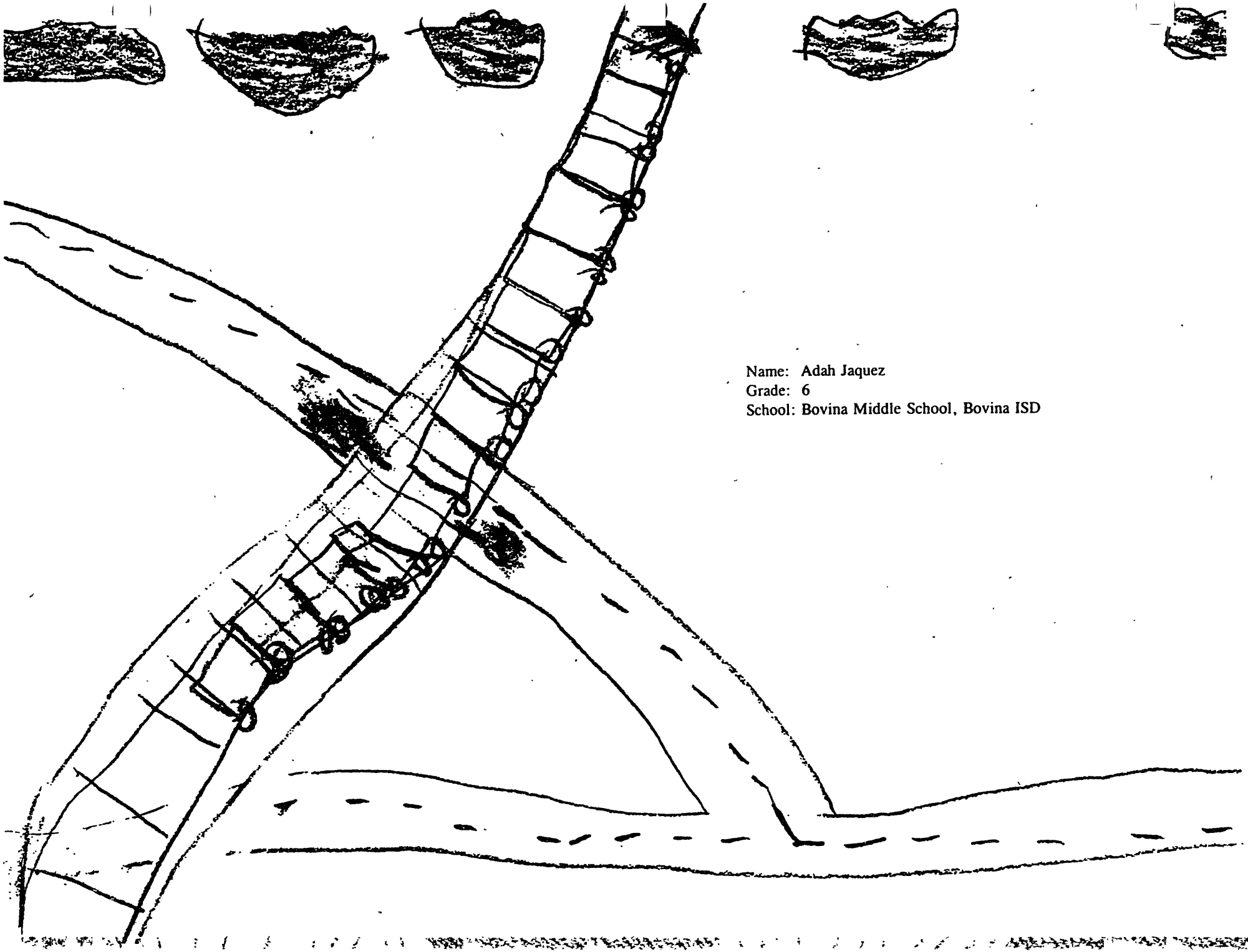
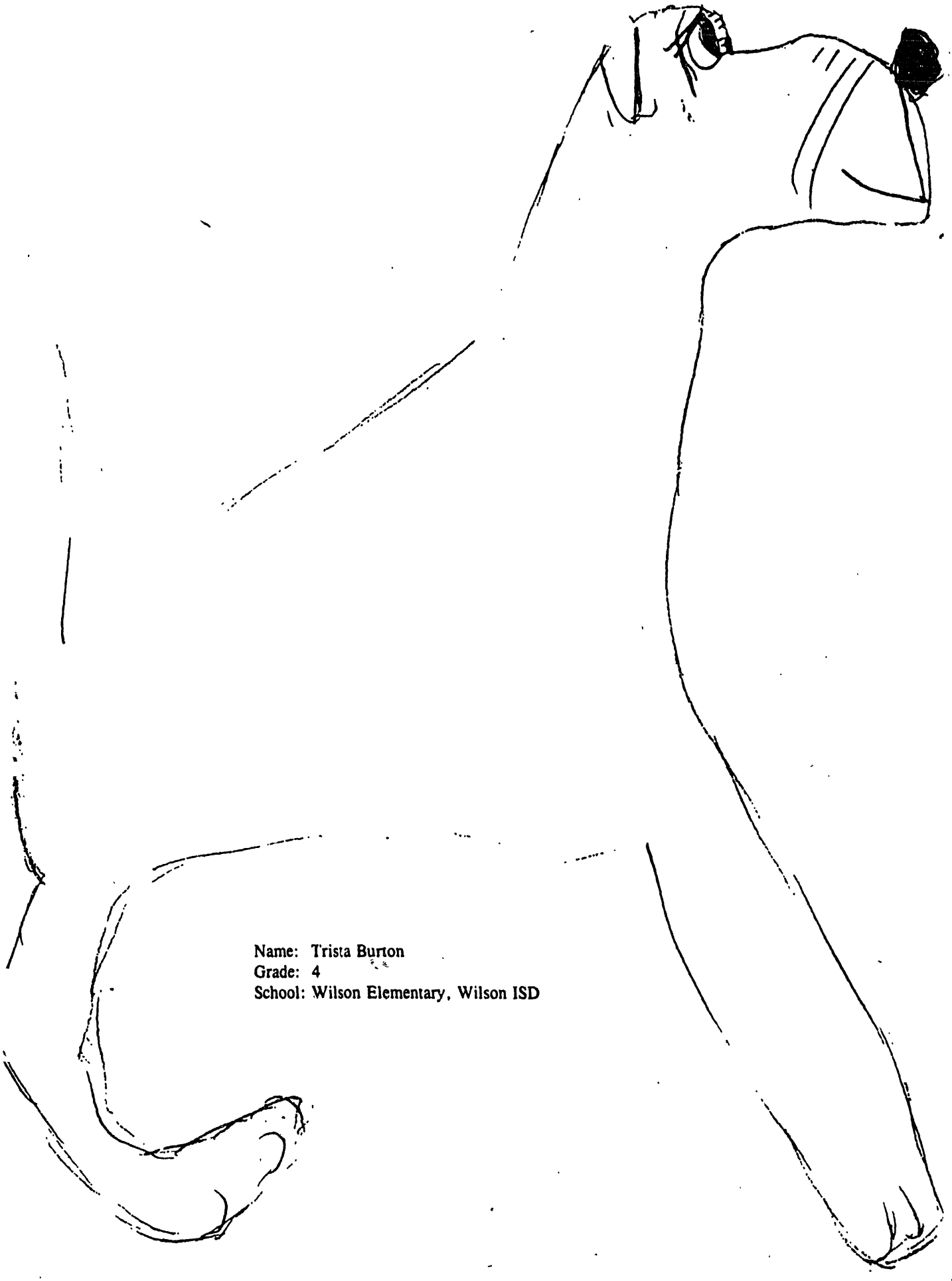
Grade: 8
School: Buffalo Jr. High School, Buffalo ISD



Name: Ana Bodden
Grade:
School: Homer Hanna High School, Brownsville ISD



Name: Adah Jaquez
Grade: 6
School: Bovina Middle School, Bovina ISD



Name: Trista Burton
Grade: 4
School: Wilson Elementary, Wilson ISD

# THE GOVERNOR

As required by Texas Civil Statutes, Article 6252-13a, §6, 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 Made November 10, 1995

To be a member of the **Texas Southern University Board of Regents** for a term to expire February 1, 1999: Willard L. Jackson, Jr., 4119 University Boulevard, Houston, Texas 77005. Mr. Jackson will be replacing Oliver C. Sutton II of San Antonio who resigned.

To be a member of the **Texas Southern University Board of Regents** for a term to expire February 1, 1997: Thomas H. Friedberg, 806 Sugar Creek Boulevard, Sugar Land, Texas 77478. Mr. Friedberg will be filling the unexpired term of Joe M. Bailey of Houston who resigned.

To be a member of the **Texas Low-Level Radioactive Waste Disposal Authority Board of Directors** for a term to expire February 1, 1997: James L. Carrol, 6209 La Posta, El Paso, Texas 79912. Mr. Carroll will be filling the unexpired term of Carmen E. Rodriguez of El Paso who resigned.

## Appointments Made November 13, 1995

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Odis R. Mack, 6403 Smokehouse, Katy, Texas 77449. Mr. Mack will be replacing Jesse W. Locke of Dallas whose term expired.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 1999: William Robert Underdown, Jr., P.O. Drawer LL, George West, Texas 78022. Mr. Underdown is being reappointed.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Donald S. Butler, 4301 Hidden Valley Court, Colleyville, Texas 76034. Mr. Butler will be replacing Jeanette Rogers of Houston whose term expired.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Jimmy L. Barker, P.O. Box 2234, Grandbury, Texas 76048. Mr. Barker will be replacing Michael D. Spence of Dallas whose term expired.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Justin P. LeVasseur, M.D., 2211 Avondale, Wichita Falls, Texas 76308. Dr. LeVasseur will be replacing Dr. Rodolfo Lucas Villarreal of Houston whose term expired.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Earl P. Erdmann, 5006 Sunshine Parkway, Midland, Texas 79707. Mr. Erdmann will be replacing James C. Martin of Duncanville whose term expired.

To be a member of the **Radiation Advisory Board** for a term to expire April 16, 2001: Thomas M. Burnette, 2201 Maple Leaf, Plano, Texas 75075. Mr. Burnette is being reappointed.

To be a member of the **Texas State Board of Examiners of Professional Counselors** for a term to expire February 1, 2001: Dr. Joseph D. Dameron, 400 Pennsylvania Drive, Denton, Texas 76205. Dr. Dameron will be replacing Dr. Julian Lawson Biggers, Jr. of Lubbock whose term expired.

To be a member of the **Texas State Board of Examiners of Professional Counselors** for a term to expire February 1, 2001: Gene Ryder, 1502 Copperfield, San Antonio, Texas 78251-3324. Mr. Ryder will be replacing Norma Lee Walston of Austin whose term expired.

To be a member of the **Texas State Board of Examiners of Professional Counselors** for a term to expire February 1, 2001: Judy Broussard, 2026 Mustang, Levelland, Texas 79336. Mrs. Broussard will be replacing Jane Bock Guzman of Dallas whose term expired.

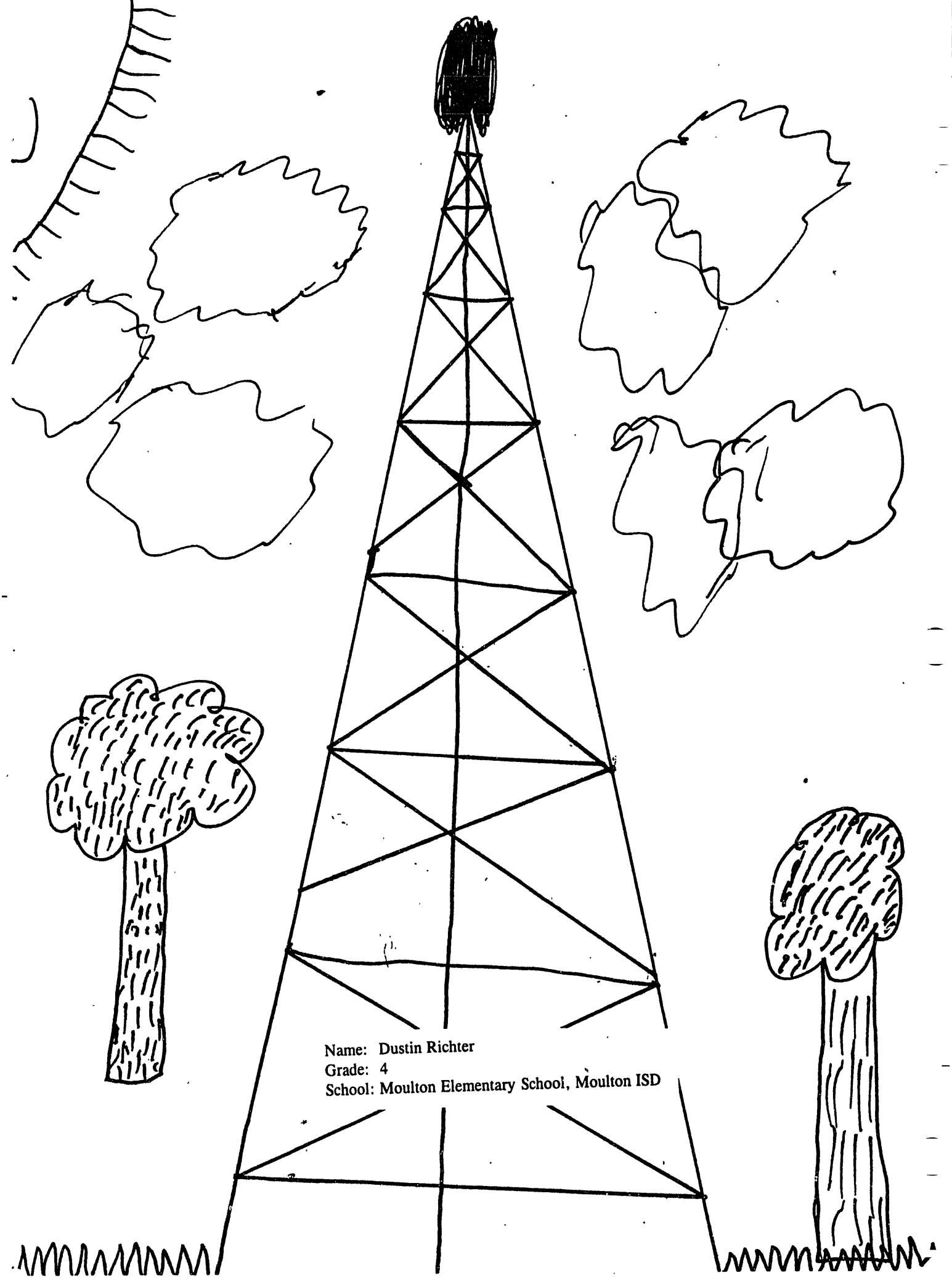
To be a member of the **Texas Advisory Board of Occupational Therapy Examiners** for a term to expire February 1, 1999: Jean E. Polichino, 2740 Arbuckle, Houston, Texas 77005. Mrs. Polichino will be filling the unexpired term of Mary Hurtado Wilson of Spicewood who resigned.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514881

George W. Bush
Governor of Texas

♦ ♦ ♦



Name: Dustin Richter
Grade: 4
School: Moulton Elementary School, Moulton ISD

# EMERGENCY RULES

An agency may adopt a new or amended section or repeal an existing section on an emergency basis if it determines that such action is necessary for the public health, safety, or welfare of this state. The section may become effective immediately upon filing with the ***Texas Register***, or on a stated date less than 20 days after filing and remaining in effect no more than 120 days. The emergency action is renewable once for no more than 60 additional days.

**Symbology in amended emergency sections.** New language added to an existing section is indicated by the use of **bold text.** [Brackets] indicate deletion of existing material within a section.

## TITLE 19. EDUCATION

## Part I. Texas Higher Education Coordinating Board

### Chapter 5. Program Development

### Subchapter H. Approval of Off-Campus and Out-of-District Instruction for Public Colleges and Universities

- **19 TAC §§5.151-5.155, 5.157, 5.158**

The Texas Higher Education Coordinating Board adopts the emergency repeal of §§5.151-5.155, 5.157, and 5.158, concerning Approval of Off-Campus and Out-of-District Instruction for Public Colleges and Universities. A requirement of state law requires adoption of this rule on an emergency basis.

The rules are proposed under Texas Education Code, §61.051 and §130.086.

*§5.151. General Provisions.*

*§5.152. Criteria and Procedures for the Consideration of Upper Level and Graduate Off-Campus Courses.*

*§5.153. Criteria for Consideration of Out-of-District Course Offerings by Community Junior Colleges.*

*§5.154. Criteria and Procedures for Considering Lower-Division Courses Proposed Off-Campus by Senior Institutions and Out-of-District by Community and Technical Colleges.*

*§5.155. Coordination of Adult and Continuing Education Activities.*

*§5.157. Approval of Out-of-State Classes.*

*§5.158. Approval of Degree Programs on Military Bases.*

Issued in Austin, Texas, on November 15, 1995.

TRD-9514911 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Effective date: November 16, 1995

Expiration date: March 15, 1996

For further information, please call: (512) 483-6160

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### Subchapter H. Approval of Distance Learning for Public Colleges and Universities

- **19 TAC §§5.151-5.159**

The Texas Higher Education Coordinating Board adopts emergency new §§5. 151-5.159 concerning Approval of Distance Learning for Public Colleges and Universities. A requirement of state law requires adoption of this rule on an emergency basis .

The rules are proposed under Texas Education Code, §61.051 and §130.086.

*§5.151. Terminology.*

(a) "Distance Learning" refers to instruction delivered by any means to any single or multiple location(s)

(1) other than the "main campus" of a senior institution (or "on campus"), where the primary office of the chief executive officer of the campus is located;

(2) outside the boundaries of the taxing authority of a community/junior college district; or

(3) via instructional telecommunications to any other distance location. For the purposes of this subchapter, health science centers and health-related institutions shall be regarded as senior institutions.

(b) The term "Instructional Telecommunications" (IT) refers to distance learning instruction delivered primarily by telecommunications technology. Delivery systems may include but are not limited to one or more of the following: interactive video, open-channel television, cable television, closed-circuit television, low-power television, communication and/or direct broadcast satellite, satellite master antenna system, microwave, video tape, video disc, computer software, computer networks, and telephone lines.

(c) A "Reception Site" is any location that receives instruction via instructional telecommunications. This may include campuses, health agencies, business and industrial sites, public schools, homes, or any other locations where students may receive instruction.

(d) The term "Program" refers to any certificate or degree program. A program is understood to be "offered via distance learning" if a student may complete the program without taking any courses on the main campus of the senior institution or without physically attending classes within the boundaries of the taxing authority of the community/junior college district.

(e) An "Auxiliary Location" is a site or facility owned by an institution or recognized by the Coordinating Board as qualifying for special treatment under the provisions of this subchapter (see §5.155(b)-(c) of this title (relating to Annual Plan for Distance Learning)).

(f) A "Regional Council" is a cooperative arrangement among representatives of all public and independent higher education institutions within a State Uniform Service Region. (See §5.156 of this title (relating to Procedures for Review and Approval of Lower-Division Distance Learning)).

(g) An "Annual Plan" is a listing by location of distance learning courses and programs planned to be taught during an academic year by an institution. (See §5.155)

*§5.152. General Provisions.*

(a) The provisions of this subchapter are in accordance with Texas Education Code 61.051 and 130.086, and apply to all distance learning instruction provided live or via telecommunication technology for academic credit by a public community/junior college outside of the boundaries of its taxing authority, or by a technical college, university, or health-

related institution at a site other than the main campus. The subchapter also applies to instruction offered at out-of-state or foreign locations.

(b) A class offered both on-campus and through distance learning instruction is subject to the reporting provisions of this subchapter if any student receives more than one-half of the instruction via distance learning delivery systems.

(c) Each course offered under the provisions of this subchapter must be reported annually in accordance with the Board's uniform reporting system. State-funded distance learning instruction which is not reported by location will be disallowed for funding.

(d) No degree or certificate program may be offered via distance learning instruction without prior approval of the Board. In addition, institutions may not offer through distance learning instruction at any site an array of courses that would constitute a degree or certificate program without prior approval by the Board to offer a full program at that site. Courses offered in violation of this provision will be disallowed for formula funding.

(e) No master's degree program may be offered via distance learning instruction without express prior notification to the Southern Association of Colleges and Schools. No distance learning doctoral degree programs will be authorized except through the approval of joint or cooperative degree programs.

(f) As directed by statute, the Board retains final authority for the offering of classes, courses, programs, and degrees, and may take whatever action it deems appropriate to comply with the Texas Education Code.

*§5.153. Standards and Criteria for Distance Learning.*

(a) Distance learning instruction offered by any live or telecommunications delivery system must be comparable to on-campus instruction. It must meet all of the quality standards which an institution requires of similar instruction offered on-campus to regularly enrolled students.

(b) A distance learning course which offers either regular college credit or Continuing Education Units must do so in accordance with the standards of the Commission on Colleges of the Southern Association of Colleges and Schools.

(c) Students enrolled in distance learning must satisfy the same requirements for admission to the institution, to the program of which the course is a part, and to the class/section itself, as are required of on-campus students.

(d) Faculty providing distance learning instruction must be selected and evaluated by the same standards, review, and approval procedures used by the institution to select and evaluate faculty responsible for on-campus instruction. Institutions must provide training and support to enhance the added skills required of faculty teaching classes via instructional telecommunications.

(e) The instructor of record must participate in the delivery of instruction and evaluation of student progress.

(f) Providers of graduate-level distance learning instruction must be approved by the graduate faculty of the institution.

(g) All distance learning instruction must be administered under the authority of the same office or person administering the corresponding on-campus instruction. The supervision, monitoring, and evaluation processes for instructors must be comparable to those for on-campus instruction.

(h) Students must be provided academic support services–including academic advising, counseling, library and other learning resources, tutoring services, and financial aid–that are comparable to those available for on-campus students.

(i) Facilities for distance learning instruction (other than homes as instructional telecommunications reception sites) must be adequate for the purpose of delivering instruction which is comparable in quality to on-campus instruction.

*§5.154. Institutional Plan for Instructional Telecommunications.*

(a) Each institution seeking first-time authority to offer distance learning instruction via telecommunications technology must submit an "Institutional Plan for Instructional Telecommunications" for review by the Coordinating Board's Advisory Committee on Instructional Telecommunications and approval by the Board before offering such instruction, except as noted in §5.154(c) of this section. The plan must include the following:

(1) Institutional policies reflecting a commitment to maintain quality in accordance with the provisions of this subchapter.

(2) A description of institutional arrangements for the operation of instructional telecommunications, including identification of courses to be offered and the location(s) of proposed distance learning instruction.

(b) After an initial Institutional Plan for Instructional Telecommunications has been approved by the Board, an institution must receive additional Board approval to expand beyond the approved plan.

(c) The Commissioner may authorize under experimental authority a one-time offering of a limited number of classes via instructional telecommunications prior to Board approval of an Institutional Plan for Instructional Telecommunications.

*§5.155. Annual Plan for Distance Learning.*

(a) Unless specifically exempted by the Board, all state-funded distance learning instruction must be submitted for annual review by appropriate Regional Councils or peer institutions as provided in this subchapter. The procedure will utilize an Annual Plan for Distance Learning ("Annual Plan") for each requesting institution (See §5.156 of this title (relating to Procedures for Review and Approval of Lower-Division Distance Learning)).

(b) The Board may exempt from annual review courses offered by one public institution on the campus of another public institution, courses taught on military bases or in correctional institutions, student teaching, internships, clinical instruction, practica, cooperative education work stations, field courses (when limited to campus-based students), and other specialized types of distance instruction. Exemption may also be given for distance learning instruction at a designated Auxiliary Location. Instruction offered under all such exemptions, however, must still be reported in accordance with the Board's uniform reporting system and will be subject to monitoring for quality.

(c) If distance learning instruction is provided regularly in an approved cooperative degree program, in a correctional institution, on a military base, or at other sites where an institution needs to utilize resources not normally available on its main campus, the site where the instruction is received may be recognized as an Auxiliary Location by the Board. Auxiliary locations are recognized as having a specific, defined academic mission; expansion beyond the authorized mission requires prior approval of the Board.

(d) The Commissioner may approve, as amendments to an institution's Annual Plan, courses submitted not later than two weeks after the beginning of any semester or summer session. The Commissioner shall not approve additional courses in excess of 20% of the number of courses previously approved as part of the Annual Plan for the requesting institution, or ten courses, whichever is greater. Such courses must first be submitted for consideration by public and independent institutions in the appropriate Regional Council(s).

*§5.156. Procedures for Review and Approval of Lower-Division Distance Learning.*

(a) Each institution must submit for review by all affected Regional Councils an Annual Plan which lists by location all proposed lower-division distance learning instruction. Requests for new locations and/or substantially different classes or programs at previously approved locations must be submitted on application forms provided by the Commissioner for that purpose.

(b) Proposed lower-division distance learning instruction must be reviewed by the Regional Council of the Uniform Service Region containing each proposed site for the receiving of instruction in accordance with the provisions of this subchapter.

(c) The Coordinating Board recognizes Regional Councils in each of the ten state Uniform Service Regions. The presidents–or designated representatives–of each public and independent institution of higher education with its main campus in the Region comprise the Council membership. A Council Chair shall be elected by the members, with term of service to be determined by the respective Council.

(d) Each Regional Council has the following responsibilities:

(1) Develop and file with the Universities and Community and Technical College Divisions of the Coordinating Board its procedures and guidelines for reviewing Annual Plans for proposed lower-division distance learning classes, programs, and locations in the Region.

(2) Facilitate inter-institutional cooperation in the conduct of distance learning instruction, assure that each institution in the Region has notification in advance of all lower-division classes, programs, and locations proposed to be offered in the Region by any other institution, and provide each institution in the Region full opportunity to review and comment on the plans of other institutions.

(3) Make recommendations to the Commissioner regarding Annual Plans for Distance Learning proposed to be offered within its Uniform Service Region in accordance with the consensus views of Council members.

(4) Advise the Commissioner on appropriate policies and procedures for effective state-level administration of lower-division distance learning.

(5) Encourage excellence in the conduct of lower-division distance learning instruction.

(6) Study cooperatively the various methods of providing lower-division distance learning instruction, and promote the use of those methods which support quality and promise the most effective and efficient use of state resources.

(e) Procedures for submitting applications to the Board for authorization to offer lower-division distance learning classes are as follows:

(1) Each Regional Council must meet at least annually in the spring semester to receive and review each institution's Annual Plan for lower-division distance learning instruction proposed within the Region for the following academic year. Distance learning instruction proposed at any other time of the year may be reviewed by Council members by other means.

(2) Distance learning instruction proposed by an institution must be reviewed by the Regional Council and forwarded to the Coordinating Board by a deadline set by the Commissioner, together with the Council's recommendations for approval or disapproval.

(3) If proposed classes could affect an institution which is a member of another Regional Council, the Annual Plan must also be sent to that institution and to the Council to which it belongs. The full membership of that Council must review the proposal and return a recommendation to the originating Council. This recommendation and that of the originating Council must both be sent to the Commissioner.

(4) Distance learning instruction proposed to be offered on a statewide basis must be separately identified.

(5) Recommendations of the Regional Councils must be submitted in a time frame determined by the Commissioner to permit annual consideration by the Board at its April meeting.

(6) The Commissioner will consider the recommendations of Regional Councils as well as any dissenting report filed by an institution. Subject to the following section, the Commissioner has the authority to approve or disapprove courses and Annual Plans, and to resolve disputes between or among institutions which cannot be resolved by the Councils. The Commissioner will report to all affected institutions on approvals and disapprovals of classes proposed under each Annual Plan at least two weeks before the scheduled April Board meeting, at which time the Board may hear appeals to approvals and disapprovals made by the Commissioner.

(f) During the passage of the year it may be necessary for an institution to request approval of lower-division distance learning activities not submitted as part of its Annual Plan. Such proposed amendments to an Annual Plan must be submitted to affected Regional Councils prior to the teaching of any additional classes. Each Council Chair will forward recommendations to the Commissioner regarding the appropriateness of such instruction. Amendments shall be considered by the Commissioner in accordance with §5.155(d) of this title (relating to Annual Plan for Distance Learning).

*§5.157. Procedures for Review and Approval of Upper-Level and Graduate Distance Learning.*

(a) Each January the Commissioner will initiate an exchange of information among all public and independent senior institutions, whether they propose to offer distance learning instruction for the following academic year or not. The exchange will be used to develop long-range plans for meeting state and regional needs, achieving institutional cooperation, and eliminating unnecessary duplication of offerings. Institutions must notify all other potentially affected institutions of their Annual Plans for the next academic year within the time frame prescribed by the Commissioner, and must seek to eliminate any conflicts or duplication.

(b) Institutions must submit their official requests for approval by the Commissioner of distance instruction classes on forms provided by the Commissioner.

(c) The Commissioner has the authority to resolve disputes between or among institutions, and has the authority to approve or disapprove courses and Annual Plans subject to the following section.

(d) The Commissioner will report to all affected institutions on approvals and disapprovals of distance learning activities proposed under each Annual Plan at least two weeks before the scheduled July Board meeting, at which time the Board may hear appeals to approvals and disapprovals made by the Commissioner.

(e) During the passage of the year it may be necessary for an institution to request approval of courses not submitted as part of its annual plan. The Commissioner shall consider such requests in accordance with §5. 155(d) of this subchapter if they are accompanied by documentation of discussions with other public and independent institutions in the affected Uniform Service Region concerning the proposed classes.

*§5.158. Approval of State-Funded Out-of-State and Foreign Courses.*

(a) State-funded out-of-state and foreign courses offered by Texas public institutions of higher education or by an approved consortium composed of Texas public institutions must have prior approval by the Commissioner in order for the semester credit hours or contact hours to be used for formula reimbursement. The following procedures shall apply:

(1) An institution or consortium must submit to the Commissioner an appli-

cation for state funding which demonstrates that the course meets the criteria set forth in subsection (b) of this section.

(2) The Commissioner or designee will review applications in accordance with the standards and criteria outlined in this subchapter, and will notify the requesting institution of approval or denial of course applications, including a written explanation for any denials.

(3) A course that has been previously approved to be offered at an out-of-state or foreign location may be re-approved on the basis of institutional certification that the course is the same as that previously approved.

(b) State-funded out-of-state and foreign courses are subject to the following standards and criteria:

(1) All students enrolled must meet all institutional standards for admission and must be actually admitted to the institution or one of the participating institutions in an approved consortium. All students enrolled must pay the appropriate tuition and fees for their residency category for the total number of credit hours earned. Financial aid must be available to students registering in foreign classes on the same basis as it would be for such students seeking financial aid for on-campus instruction. Additional financial aid may be furnished by the institution as appropriate.

(2) Instruction must be provided by faculty of the institution or one of the consortium institutions and be supervised and evaluated according to appropriate institutional policies. Exceptions may be made by the Commissioner to take advantage of uniquely qualified instructors at an out-of-state or foreign location if the institution provides for individual justification and approval by the appropriate faculty or institutional officials.

(3) Individual courses must meet the following standards and criteria:

(A) Each course must be on the approved course inventory of the main campus of the institution or a consortium institution, must be a part of an approved degree or certificate program, and must be justified in terms of academic, cultural, or other resources available at the specific location(s).

(B) Instruction must conform to all relevant academic policies of the institution. All classes must conform to the institution's workload and enrollment requirements, contact hour/credit ratio, and similar matters.

(C) Courses may not offer credit for activities undertaken primarily for travel, recreation, or pleasure.

(D) Minimum class enrollments must conform to the same standards applicable were the class to be offered on-campus.

(4) Multi-course offerings must meet the following standards and criteria:

(A) A group of courses taught by an individual faculty member and offered in the same time period and in the same out-of-state or foreign location may be considered as an aggregate for approval purposes.

(B) Some courses may be approved within an aggregate request without satisfying paragraph 3(A) of this subsection; however, the Commissioner may approve a multi-course aggregate only if at least one-half of the classes (making up at least one-half of the combined credit hours) comply with paragraph 3(A) of this subsection. All other criteria in this subsection must be fully met by all courses that make up a multi-course aggregate.

(5) Advertising or marketing for out-of-state and foreign classes should emphasize the instructional nature of the classes, and may not emphasize or create the impression that the classes are primarily credit-for-travel experiences.

(6) Faculty and staff may not realize unusual perquisites or unusual financial gain for teaching out-of-state or foreign classes.

(7) Except for funds specifically appropriated for international activities (e.g. state incentive programs, scholarships, etc.), state funds may not be used for faculty or student travel, meals and lodging, or other incidental expenses associated with out-of-state or foreign instruction.

(8) Any free tickets for travel, accommodations, or other expenses provided by travel agents, carriers, or hotels must be used in direct support of the instructional program and may not be made as gifts to faculty or staff members or their families.

(9) No state funding will be provided for courses or credits delivered by Instructional Telecommunications (see §5.151(b) of this title (relating to Terminology)) to reception sites outside state boundaries.

*§5.159. Non-State-Funded Out-of-State and Foreign Classes.*

(a) Out-of-state and foreign courses offered by public universities and health related institutions, for which no state funds are expended, may be taught without prior approval of the Board. However, prior Board approval is required for full degree programs offered under these circumstances. Institutions are expected to ensure that all such instruction meets the quality standards expected of Texas higher education institutions.

(b) Community and technical colleges proposing to offer out-of-state or foreign courses for which no state funds are expended are subject to the provisions of Chapter 9, Subchapter L of these rules and regulations.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514909 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Effective date: November 16, 1995

Expiration date: March 15, 1996

For further information, please call: (512) 483-6160

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## Subchapter J. Instructional Telecommunications

### • 19 TAC §§5.191-5.195

The Texas Higher Education Coordinating Board proposes the emergency repeal of §§5.191-5.195 concerning Instructional Telecommunications. A requirement of state law requires adoption of this rule on an emergency basis for the reason that program implementation must begin in January 1996.

The repeal of the rules is proposed under Texas Education Code, §61.051 and §130.086.

*§5.191. Scope and Purpose.*

*§5.192. Exemptions.*

*§5.193. Institutional Plan.*

*§5.194. Standards and Conditions.*

*§5.195. Statewide Review.*

Issued in Austin, Texas, on November 15, 1995.

TRD-9514913 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Effective date: November 16, 1995

Expiration date: March 15, 1996

For further information, please call: (512) 483-6160

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## Chapter 21. Student Services

## Subchapter HH. Exemption Program For Texas National Guard/ROTC Students

- **19 TAC §§21.1052-21.1069**

**The Texas Higher Education Coordinating Board adopts on an emergency basis §§21.1052-21.1069 concerning tuition exemptions for Texas National Guard/ROTC students. A requirement of state law requires adoption of this rule on an emergency basis for the reason that program implementation must begin in January 1996.**

**The new sections to the rules are proposed under Texas Education §54.212.**

*§21.1052. Purpose.* The purpose of the program is to provide the state additional well-trained commissioned officers for the Texas National Guard.

*§21.1053. Administration.* The Texas Higher Education Coordinating Board shall administer funds appropriated to reimburse institutions for the exemptions and shall assist in the administration of the program.

*§21.1054. Delegation of Powers and Duties.* The board delegates to the Commissioner of Higher Education the powers, duties and functions authorized by Subchapter D, Chapter 54, of the Texas Education Code as provided in this subchapter.

*§21.1055. Definitions.* The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

Adjutant General-The Adjutant General's Office of the Texas National Guard.

Board-The Texas Higher Education Coordinating Board.

Commissioner-The commissioner of higher education, the chief executive officer of the board.

Financial need-The cost of attendance at an eligible institution less the expected family contribution and any gift aid for which the student is eligible. The cost of attendance and family contribution are to be determined in accordance with board guidelines. The cost of attendance includes tuition, fees, books and supplies and living expenses.

Full-time Student-An individual enrolled for the equivalent of at least 12 semester credit hours each semester, including military science courses.

Minority-A student whose ethnic or racial group is Black (Non-Hispanic), Hispanic, American Indian or Alaskan Native, or Asian or Pacific Islander.

Program Officer-The Texas National Guard/ROTC Exemption Program Officer designated by an eligible institution to represent the board for the program on that campus.

Resident-A bona fide resident of the State of Texas as determined by the board. Nonresident students eligible to pay resident tuition rates are excluded from this program.

Room and Board Exemption-An exemption from the payment of an eligible institution's fees and charges for lodging and board as described in §21.1062(b) of this title (relating to Award Amounts).

ROTC Institution-An institution of higher education, as defined by the Texas Education Code, §61.003 that maintains a Reserve Officers' Training Corps (ROTC).

Tuition and Fee Exemption-An exemption from the payment of all of an eligible institution's dues, fees, and enrollment charges, including correspondence courses, general property deposit fees, and student services fees. This does not include fees or charges for clothing, books or supplies.

*§21.1056. Agreement with Adjutant General's Office.* The board shall enter into an agreement with the Adjutant General's Office regarding the two agencies' relative responsibilities for the exemption program. The agreement shall include provisions regarding:

(1) the appointment of Texas National Guardsmen to the institutions' selection committees;

(2) dissemination of program information through the use of National Guard recruiting offices;

(3) the collection of payments made by students failing to complete the contractual obligations of the program; and

(4) projected staffing requirements for the Texas National Guard.

*§21.1057. Selection Committee.*

(a) Membership. Each eligible institution shall create a three-member selection committee. Members of the committee are to be nominated by the institution's Chief Executive Officer. Final members shall be designated by the commissioner. Each committee is to include a military science faculty member and a commissioned officer of the Texas National Guard appointed by the adjutant general.

(b) Duties. The selection committee shall:

(1) review applications and conduct interviews of students who have applied for the exemption and determine which students qualify to receive the exemption, taking the following criteria into consideration:

(A) individual qualifications, with emphasis on the leadership, communication, and organizational abilities and skills required of commissioned officers;

(B) the financial need of the applicant;

(C) the state's ethnic, racial and gender diversity; and

(D) projected staffing requirements for the Texas National Guard.

(2) determine whether an extension of the two-year lodging and board exemption or four-year tuition and fee exemption should be granted for periods of active military duty required of the student, and

(3) determine whether an exemption recipient who loses his/her exempt status may serve the remainder of his/her contractual obligation as an enlisted member of the Texas National Guard, subject to being accepted into and maintaining membership in the Texas National Guard in the same manner as any other person.

*§21.1058. Eligible Institution.*

(a) An eligible institution is a public institution of higher education as defined in the Texas Education Code, §61.003, which maintains a Reserve Officers' Training Corps (ROTC).

(b) The chief executive officer of an eligible institution shall designate a Texas National Guard/ROTC Exemption Program Officer. Unless otherwise specified by the chief executive officer of the institution, the Professor of Military Science of the institution shall be the board's on-campus agent to certify all institutional activities with respect to this program.

*§21.1059. Eligible Student.* An eligible student is an undergraduate student who meets the following requirements:

(1) is admitted to the institution's Reserve Officers' Training Corps program or is a participant in such a program; if the student is attending another public institution of higher education which provides for cross enrollment in the ROTC institution's ROTC program, the student may be considered for selection.

(2) becomes a member of the Texas Army National Guard or the Texas Air National Guard and maintains satisfactory performance as prescribed by the adjutant general's department as a member in

good standing during the term of the student's contractual obligation;

(3) possesses and maintains from the date of enrollment through completion of the degree program the academic and personal conduct standards established by each ROTC institution;

(4) maintains full-time enrollment status;

(5) enters into a contract with the State of Texas to accept a commission in the Texas National Guard as a second lieutenant on graduation from the ROTC institution and serve no less than four years as a commissioned officer;

(6) passes the physical examination requirements required for becoming a commissioned officer in the Texas National Guard.

*§21.1060. Dissemination of Information.* The board shall provide for the distribution of information about the program to eligible institutions and coordinate activities with the adjutant general's office in the distribution of information to high schools.

*§21.1061. Sources of Funding.* Expenditures in the program shall not exceed the amount appropriated by the State of Texas for that purpose.

*§21.1062. Award Amounts.*

(a) Tuition and fee exemption amounts. Selected recipients may receive an exemption for the amount of their actual tuition and fee charges at their institution for up to four years while enrolled as undergraduates. If the student's program of study extends to a fifth year, the exemption will not be extended to that additional year

(b) Room and board exemption amounts. Selected recipients may receive an exemption for an amount equal to their actual dormitory room and board expenses for their first two years at the institution. If the student is not living in campus housing, but the institution does have such housing, the amount to be awarded as a room and board exemption is the average charged for a student in that institution's campus housing. If the institution does not have campus housing, the exemption may equal the average room and board allowance reported to the board by public universities for that year for students who are receiving some type of financial assistance.

(c) Exemptions and reimbursements to students. If student selection is completed prior to the payment of tuition and fees or room and board for a particular term, the institution is to exempt the selected students from the payment of the appropriate charges. If selection is completed after the payment of such charges, the institutions shall reimburse students for the appropriate amounts as indicated in subsections (a) and (b) of this section.

(d) Reimbursements for institutions. Each term, after selected students have enrolled at their institutions, the institutions may send the board, on a form provided by the board, a request for reimbursement for the exempted charges. The board, as soon as possible, will issue checks to the institutions for the indicated amounts.

*§21.1063. Allocation of Exemptions Among Institutions.* The maximum number of exemptions which can be awarded statewide each year is 150. Each ROTC institution shall be allocated at least two exempt students each academic year. The maximum number of exempt students for each ROTC institution will be determined by the percentage of the institution's Army and Air Force Reserve Officers' Training Corps enrollment in relation to statewide Army and Air Force Reserve Officers' Training Reserve Officers' Training Corps enrollment. Percentages shall be calculated during the fall semester of every odd-numbered year. Institutions will have until October 15 of each year to inform the board of their selection of exemption recipients. If they fail to have their full allotment awarded as of that date, the board will reallocate the unused slots to other eligible institutions which have used their full allotments.

*§21.1064. Partial Awards.* An institution's selection committee may re-award the unused portion of an exemption left when an exemption recipient drops out of the program. However, the student selected to fill the unfinished exemption must meet the following criteria:

(1) must have originally applied for an exemption in the same year as the student who dropped out of the program applied; i.e., was an alternate for that year.

(2) meet the eligible student requirements as outlined in §21.1059 of this title (relating to Eligible Student).

(3) agree to meet the same contractual obligations as students receiving the exemptions as entering freshmen; i.e., four years' service as a commissioned officer in the Texas National Guard, or full repayment of the value of the exemptions extended, plus interest, if he/she fails to complete the requirements of the contract.

*§21.1065. The Application Process.*

(a) To apply for an exemption, the student must complete the full application packet for the Texas National Guard/ROTC Exemption Program and submit it to the program officer at the ROTC institution he/she plans to attend.

(b) The selection committee at the institution will review all applications and rank applicants according to a set of criteria developed by the board and the adjutant general's office.

(c) Top candidates will be asked to sit for at least one interview, to be conducted using a set of questions developed by the board and the adjutant general's office.

(d) Candidates who do well on the interview will be required to take the physical examination required for commissioning officers.

(e) The selection committee will finalize its decisions and notify the board of its selections by no later than October 15.

*§21.1066. The Texas National Guard/ROTC Exemption Program Contract.* Each participating student must enter into a contract with the State of Texas. In the contract,

(1) the student must agree to:

(A) be admitted to his/her institution's Reserve Officers' Training Corps program or be a participant in such a program.

(B) become a member of the Texas Army National Guard or the Texas Air National Guard and maintain satisfactory performance as prescribed by the adjutant general's department as a member in good standing during the term of the my contractual obligation.

(C) maintain from the date of first exemption under this program through completion of his/her degree, the academic and personal conduct standards established by the institution.

(D) maintain full-time enrollment or to immediately notify the commanding officer of his/her ROTC unit should he or she drop below the required level of enrollment.

(E) immediately upon graduation from the ROTC institution, accept a commission in the Texas National Guard as a second lieutenant and serve no less than four years as a commissioned officer.

(F) repay to the state the amount of tuition, fees and other charges for which he/she received an exemption and which he/she has not yet repaid through service, plus interest as determined by the board, should the student fail to maintain

exempt status or fail to accept a commission in the Texas National Guard, or otherwise fail to meet the obligations of the contract,

(G) understand that under circumstances requiring repayment, the full amount of his/her obligation is to be repaid by no later than the fifth anniversary of the date of the circumstances which required him/her to make repayment.

(2) the institution must agree to:

(A) provide the students selected for exemptions through this program a statement of the adjutant general's criteria for maintaining satisfactory performance as a member in good standing during the term of the student's contractual obligation,

(B) provide the students selected for exemptions through this program a statement of the institution's required academic and personal conduct standards,

(C) award exemptions for the actual tuition and fees paid by the selected student at this institution for up to four years while the student meets the program's requirements. Should the student be called into active military service during his/her enrollment at this institution, the four year time frame may be extended at the institution's selection committee's discretion.

(D) award exemptions for room and board as indicated in §21.1062(b) of these rules to eligible students enrolled in their first two years at the ROTC institution.

*§21.1067. Noncompliance.* If the student fails to fulfill any obligation outlined in the exemption program contract, he or she shall be in noncompliance with the contract and will be required to repay any remaining portion of the his/her contractual obligation to the state. Such repayment requirements will be outlined in the promissory note signed by the student upon receipt of an exemption under this program.

*§21.1068. Reporting Requirements.*

(a) In the fall of each odd-numbered year, each ROTC institution is required to provide the board enrollment statistics for its ROTC program.

(b) By October 15 of each year, the institution is to notify the board of its selections. If selections have not been made by this date, the unused exemptions will be reallocated by the board to other eligible institutions.

*§21.1069. Program Reviews.* Any institution whose students receive exemptions through this program will be subject to an annual program review.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514915 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Effective date: November 16, 1995

Expiration date: March 15, 1996

For further information, please call: (512) 483-6160

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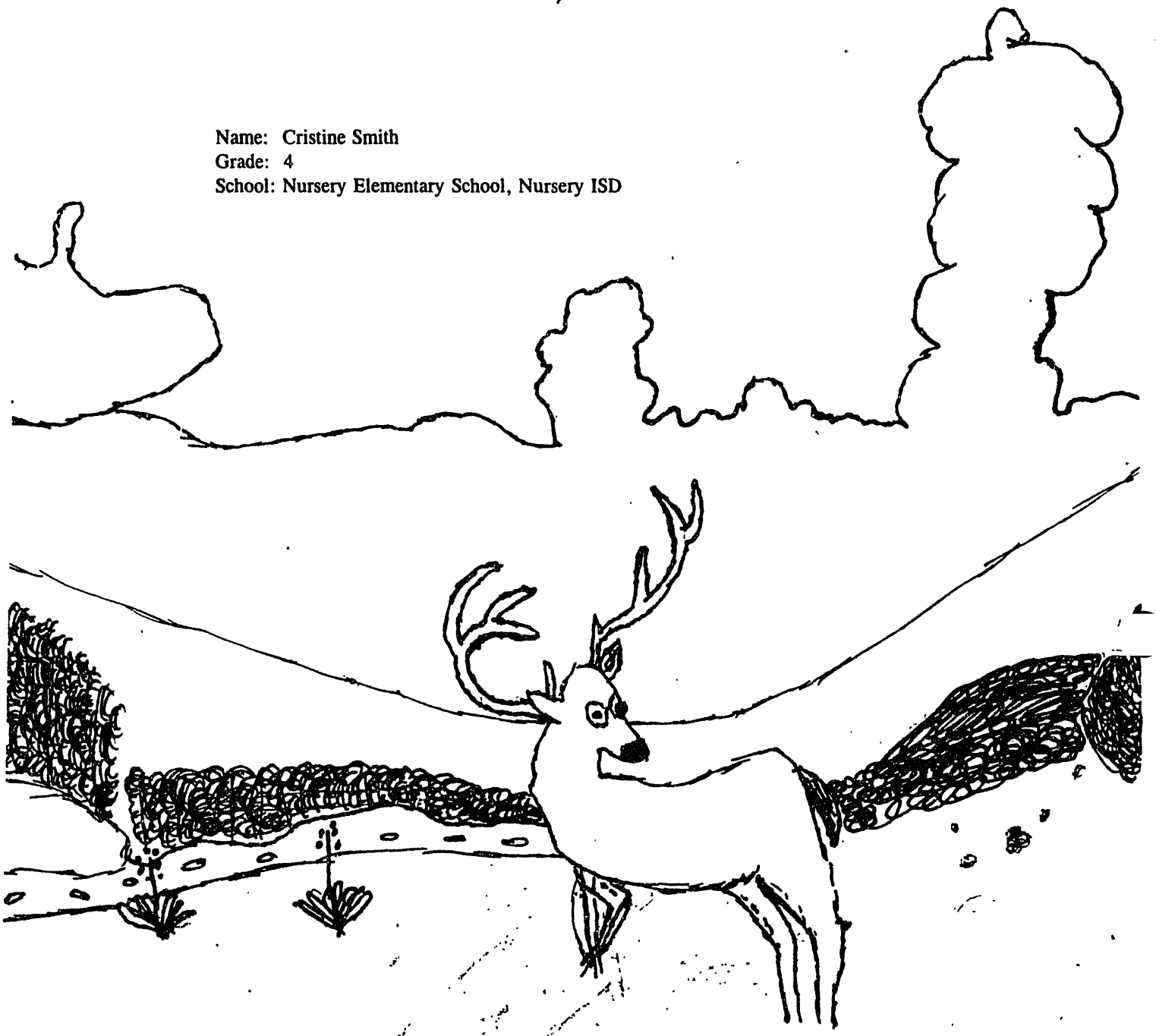
Name: Cristine Smith
Grade: 4
School: Nursery Elementary School, Nursery ISD



# PROPOSED RULES

Before an agency may permanently adopt a new or amended section or repeal an existing section, a proposal detailing the action must be published in the ***Texas Register*** at least 30 days before action is taken. The 30-day time period gives interested persons an opportunity to review and make oral or written comments on the section. Also, in the case of substantive action, a public hearing must be granted if requested by at least 25 persons, a governmental subdivision or agency, or an association having at least 25 members.

**Symbology in proposed amendments.** New language added to an existing section is indicated by the use of **bold text.** [Brackets] indicate deletion of existing material within a section.

## TITLE 1. ADMINISTRATION

## Part VII. State Office of Administrative Hearings

### Chapter 155. Rules of Procedure

#### • 1 TAC §155.5

The State Office of Administrative Hearings (SOAH) proposes an amendment to §155.5 concerning the rules of practice and procedure before the Office by adding new subsection (e). The proposed new subsection concerns the adoption of a seal to certify the agency's official acts, including certification of transcripts of administrative license revocation (ALR) hearings conducted pursuant to Texas Transportation Code, Chapters 522, 524, or 724. The major objective of this proposed new subsection is to allow SOAH to affix its seal on the transcripts of ALR hearings which are appealed. The seal will aid in certifying the transcript as true, correct and complete. The seal will also aid SOAH in certifying other official acts of the agency.

SOAH is a state agency pursuant to Government Code, Chapter 2001, §2001. 003(7) which defines "state agency" as a "state officer, board, commission, or department with statewide jurisdiction that makes rules or determines contested cases" and Chapter 2003, §2003.021(a) which defines SOAH as a state agency. Government Code, Chapter 2051, §2051.001, authorizes the adoption of a seal with which to attest to official document, certificate, or other written paper by a "commission or board created by state law and a commissioner whose office is created by state law". A commissioner is a single administrative or executive officer. See, *Standard Securities Service Corporation v. King, 341 S.W.2d 423 (Tex. 1960).*

The state officer who heads SOAH bears the title "chief administrative law judge". This officer is the functional equivalent of a commissioner since the chief administrative law judge exercises all the powers normally invested in a commissioner-to hire staff, to set and enforce agency policy, to adopt rules, and to coordinate and supervise the operation of the agency's business. As a state officer the chief administrative law judge is also the legal equivalent of a state commission or board under the definition of "state agency" in Government Code, Chapter 2001, §2001.003(7). The chief administrative law judge, like his equivalent, the commissioner, can adopt an agency seal as required to perform agency duties. State agencies may adopt rules which describe the procedure or practice requirements of the agency (pursuant to Government Code, Chapter 2001, §2001.003 and §2001.004) and may exercise powers necessarily implied from duties imposed by statute. *City of Sherman v. Public Utility Commission, 643 S.W.2d 681 (Tex. 1983).*

Chapter 159, §159.37, of this title, (relating to Appeal of Judge's Decision), requires SOAH to certify the record for purposes of appeal of ALR hearings. A court of record affixes its seal to certify the official record of a proceeding. The seal is a safeguard to deter alteration of the record, to distinguish the original of the record, and to ensure the authenticity of the record. SOAH's duty to prepare and certify ALR records implies the ability to do those things which will facilitate the certification of those records. Adoption of an agency seal will allow SOAH to certify its records as done by all other courts of record in the state and will allow SOAH to the benefits conferred by use of a seal.

Steven L. Martin, Chief Administrative Law Judge, has determined that for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule.

Mr. Martin also has determined that for each year of the first five-year period the rule is in effect the public benefit anticipated as a result of enforcing the rule will be that documents embodying official acts of SOAH will be easily recognized by the agency's seal affixed to said documents. Anticipated economic costs are limited to those associated with obtaining the actual seals for use by SOAH. There is no anticipated economic cost to persons who are required to comply with the proposed rule.

Comments may be submitted to Ruth Casarez, Senior Administrative Law Judge, State Office of Administrative Hearings, P.O. Box 13025, Austin, Texas 78711-3025 (512) 475-4993.

The amended rule is proposed under Government Code, Chapter 2003, which authorizes the State Office of Administrative Hearings to conduct contested case hearings; Government Code, Chapter 2001, §2001.004, which requires agencies to adopt rules of practice setting forth the nature and requirements of formal and informal procedures; and under Texas Transportation Code, Chapter 524, §524.002 and Chapter 724, §724.003, which provide that SOAH and the Department of Public Safety shall adopt rules to administer the Administrative License Revocation statute.

The following statutes are affected by this proposed amendment: Texas Transportation Code, Chapters 522, 524 and 724; Texas Penal Code, Chapter 49; and Government Code, Chapters 2001 and 2003.

*§155.5. General.*

(a)-(d) (No change.)

**(e) The Office may obtain a seal to authenticate its official acts, including certifying copies of the transcript of the records made pursuant to hearings under this Chapter and Chapter 159, of this title, (relating to the Rules of Procedure for Administrative License Susupension Hearings) or pursuant to Texas Transportation Code, Chapters 522, 524, or 724. The seal shall have a star with five points and the words "State Office of Administrative Hearings" engraved upon it.**

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

Issued in Austin, Texas, on November 17, 1995

TRD-9515026

Shelia Bailey Taylor
Deputy Chief Administrative Law Judge
State Office of Administrative Hearing

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 475-4993

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# TITLE 10. COMMUNITY DEVELOPMENT

## Part I. Texas Department of Housing and Community Affairs

### Chapter 21. Introductory Provisions

- **10 TAC §21.20**

The Texas Department of Housing and Community Affairs (the Department) proposes new §21.20, concerning the annual reporting requirements for Local Housing Finance Corporations (the "LHFC"). The new section is necessary to provide procedures for the reporting to the Department by the local housing finance corporations or their designees. This new section is proposed pursuant the amendment to the Local Government Code, Chapter 394, §394.027.

David Armstrong, Manager of the Housing Resource Center, 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 or administering the section.

Mr. Armstrong 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 enhancement of the state's ability to provide safe and sanitary housing for Texan's through the coordination of the reporting requirements for the LHFC. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed.

Comments on the proposal may be submitted to David Armstrong, Manager, Housing Resource Center, Texas Department of Housing and Community Affairs, 811 Barton Springs Road, Suite 500, Austin, Texas 78704.

The new section is proposed under the Texas Government Code, Chapter 2306; and Acts of the 74th Legislature, §9 of Chapter 951, amending Subchapter C, Chapter 394, Local Government Code, by adding §394.027, which provisions provide the Department with the authority to adopt rules governing the administration of the Department and its programs.

The Texas Government Code, Chapter 2306 and Local Government Code, Chapter 394, are affected by this new section.

*§21.20. Annual Report from Housing Finance Corporations.*

(a) A Housing Finance Agency subject to the provisions of the Local Government Code, Chapter 394, shall file or cause to be filed with the Texas Department of Housing and Community Affairs, (the "Department"), on or before August 1 of each year, reports in accordance with this section.

(b) The single family report shall include information for each single family mortgage loan made by the housing finance corporation during the preceding 12 months ending June 30 of the year the report is filed. The report shall include data reported by the originating lenders under the Federal Home Mortgage Disclosure Act.

(c) The multifamily report shall include information similar to the geographic and demographic information contained in the Departments multifamily compliance for and tenant income certification (household size, income and project location).

(d) The reports must be in a format and on a form prescribed by the Department. Either the Housing Finance Corporation or a third party designee shall file the report with the Department. The reporting form prescribed by the Department, shall be filed in paper form, as well as in an electronic form acceptable to the Department (computer tape, disk or upload electronically).

(e) On or before August 1 of the reporting year a third party reporting entity, other than a housing finance corporation, shall file the report and notice with the Department. Notice shall also be filed with the Housing Finance Corporation, and the Texas Bond Review Board. The notice shall be in writing certifying compliance with the filing and reporting requirement of this section. If this information is not filed then the third party reporting entity shall file a written notice certifying and explaining the reason for the non compliance, including a date compliance will be achieved with the Department and the Housing Finance Corporation. A housing corporation may include the reporting and notice requirements in the applicable bond transaction documents.

(f) On or before August 1 of the reporting year a Housing Finance Corporation that is not using a third party entity to report shall file the reports required by this section with the Department, or notify the Department of the non-filing and provide a date by which the reports will be filed. A Housing Finance Agency (HFA) when it issues bonds, shall cause the master servicer or similar party in a single family bond transaction to file a form of the HUMDA report and the developer/project owner in a multi family bond transaction to file a multi-family bond compliance report with the Department in electronic form, the HUMDA Report or the multi-family compliance report in a form approved by the Department, may be filed either on computer tape, disk or upload electronically. The reporting entity shall file with the Department, the Housing Finance Corporation, the Trustee and the Texas Bond Review Board written notice certifying compliance with the filing requirement or a written notice certifying and explaining the non compliance, including a date compliance will be achieved. To facilitate this process the applicable bond and transaction documents, including but not limited to, indenture, master resolution, mortgage origination, agreement, servicer's agreement, loan agreement, regulatory agreement, land use restriction agreement, and compliance agreements, shall contain the warranty, representation and covenant that the master servicer/developer can and will comply with the above requirements by filing the information required, in the form required with the notice certifying compliance or non compliance with the Issuer, Texas Department of Housing and Community Affairs, Trustee, and the Texas Bond Review Board. It is agreed that failure to file is deemed a technical default under this provision, curable within ten days of the initial due date. Failure to file is a reportable situation to the State Information Repository (Name).

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515046

Larry Paul Manley
Executive Director
Texas Department of Housing and Community Affairs

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 475-3916

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# TITLE 19. EDUCATION

## Part I. Texas Higher Education Coordinating Board

### Chapter 5. Program Development

### Subchapter H. Approval of Off-Campus and Out-of-District Instruction for Public Colleges and Universities

- **19 TAC §§5.151-5.155, 5.157, 5.158**

*(Editor's Note: The Texas Higher Education Coordinating Board proposes for permanent adoption the repealed sections it adopts on an emergency basis in this issue. The text of the repealed sections may be examined in the offices of the Texas Higher Education Coordinating Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The Texas Higher Education Coordinating Board proposes the repeals of §§5.151-5.155, 5.157, and 5.158, concerning Off-Campus and Out-of-District Instruction for Public Colleges and Universities. The repeals

will: ease constraints on universities and health science centers offering courses on other campuses; enhance the freedom of each community college to use any mode of instruction within the boundaries of its taxing authority; eliminate the "one-third rule" for the delivery of distance instruction (a rule which required one-third of any degree to be taken by a student on campus); omit the limit of three years on approval of off-campus master's programs; and do away with current requirements for initial Institutional Plans for live off-campus instruction and annual financial reports for Instructional Telecommunications.

Dr. Bill Sanford, Assistant Commissioner for Universities has determined that for the first five-year period the repeals are in effect there will be no fiscal implications as a result of enforcing or administering the repeals.

Dr. Sanford also determined that for each year of the first five years the repeals are in effect the public benefit anticipated as a result of enforcing the repeals will be additional emphasis will be given to the systematic review of each institution's annual instructional plan by peer institutions. They would also retain the Board's long-standing requirements to assure quality instruction, and would continue to permit the Commissioner to approve one-time, experimental offerings of a limited number of courses and to address emergency requests. There will be no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the repeals as proposed.

Comments on the proposal may be submitted to Dr. Kenneth H. Ashworth, Commissioner of Higher Education, Texas Higher Education Coordinating Board, P. O. Box 12788, Capitol Station, Austin, Texas 78711.

The repeals are proposed under Texas Education Code, §61.051 and §130. 086 which provides the Texas Higher Education Coordinating Board with the authority to adopt rules concerning Approval of Distance Learning for Public Colleges and Universities.

There were no other sections affected by these repeals.

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514912 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Proposed date of adoption: January 19, 1996

For further information, please call: (512) 483-6160

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## Subchapter H. Approval of Distance Learning for Public Colleges and Universities

### • 19 TAC §§5.151-5.159

*(Editor's Note: The Texas Higher Education Coordinating Board proposes for permanent adoption the new sections it adopts on an emergency basis in this issue. The text of the new sections is in the Emergency Rules section of this issue.)*

The Texas Higher Education Coordinating Board proposes new §§5.151-5. 159, concerning Approval of Distance Learning for Public Colleges and Universities. The amendments will: ease constraints on universities and health science centers offering courses on other campuses; enhance the freedom of each community college to use any mode of instruction within the boundaries of its taxing authority; eliminate the "one-third rule" for the delivery of distance instruction (a rule which required one-third of any degree to be taken by a student on campus); omit the limit of three years on approval of off-campus master's programs; and do away with current requirements for initial Institutional Plans for live off-campus instruction and annual financial reports for Instructional Telecommunications.

Dr. Bill Sanford, Assistant Commissioner for Universities has determined that for the first five-year period the rules are in effect there will be no fiscal implications as a result of enforcing or administering the rules.

Dr. Sanford also has determined that for each year of the first five years the rules are in effect the public benefit anticipated as a result of enforcing the rules will be additional emphasis will be given to the systematic review of each institution's annual instructional plan by peer institutions. They would also retain the Board's long-standing requirements to assure quality instruction, and would continue to permit the Commissioner to approve one-time, experimental offerings of a limited number of courses and to address emergency requests. There will be no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the rules as proposed.

Comments on the proposal may be submitted to Dr. Kenneth H. Ashworth, Commissioner of Higher Education, Texas Higher Education Coordinating Board, P. O. Box 12788, Capitol Station, Austin, Texas 78711.

The new rules are proposed under Texas Education Code, §61.051 and §130. 086, which provides the Texas Higher Education Coordinating Board with the authority to adopt rules concerning Approval of Distance Learning for Public Colleges and Universities.

There were no other sections affected by these rules.

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514910 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Proposed date of adoption: January 19, 1996

For further information, please call: (512) 483-6160

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## Subchapter J. Instructional Telecommunications

### • 19 TAC §§5.191-5.195

*(Editor's Note: The Texas Higher Education Coordinating Board proposes for permanent adoption the repealed sections it adopts on an emergency basis in this issue. The text of the repealed sections may be examined in the offices of the Texas Higher Education Coordinating Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The Texas Higher Education Coordinating Board proposes the repeals of §§5.191-5.195, concerning Instructional Telecommunications. The repeals will: ease constraints on universities and health science centers offering courses on other campuses; enhance the freedom of each community college to use any mode of instruction within the boundaries of its taxing authority; eliminate the "one-third rule" for the delivery of distance instruction (a rule which required one-third of any degree to be taken by a student on campus); omit the limit of three years on approval of off-campus master's programs; and do away with current requirements for initial Institutional Plans for live off-campus instruction and annual financial reports for Instructional Telecommunications.

Dr. Bill Sanford, Assistant Commissioner for Universities has determined that for the first five-year period the repeals are in effect there will be no fiscal implications as a result of enforcing or administering the repeals.

Dr. Bill Sanford also determined that for each year of the first five years the repeals are in effect the public benefit anticipated as a result of enforcing the repeals will be additional emphasis will be given to the systematic review of each institution's annual instructional plan by peer institutions. They would also retain the Board's long-standing requirements to assure quality instruction, and would continue to permit the Commissioner to approve one-time, experimental offerings of a limited number of courses and to address emergency requests. There will be no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the repeals as proposed.

Comments on the proposal may be submitted to Dr. Kenneth H. Ashworth, Commissioner of Higher Education, Texas Higher Education Coordinating Board, P. O. Box 12788, Capitol Station, Austin, Texas 78711.

The repeals are proposed under Texas Education Code, §61.051 and §130. 086 which provides the Texas Higher Education Coordinating Board with the authority to adopt rules concerning Approval of Distance Learning for Public Colleges and Universities.

There were no other sections affected by these repeals.

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514914 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Proposed date of adoption: January 19, 1996

For further information, please call: (512) 483-6160

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## Chapter 21. Student Services

### Subchapter HH. Exemption Pro gram for Texas National Guard/ROTC Students

**• 19 TAC §§21.1052-21.1069**

*(Editor's Note: The Texas Higher Education Coordinating Board proposes for permanent adoption the new sections it adopts on an emergency basis in this issue. The text of the new sections is in the Emergency Rules section of this issue.)*

The Texas Higher Education Coordinating Board proposes new Subchapter HH, §§21.1052-21.1069, concerning Exemption Program For Texas National Guard/ROTC Students. The rules are being proposed to implement §8 of House Bill 1792 passed by the 74th Legislature. The rules will provide scholarships for 150 eligible students each year. The scholarships will cover the cost of tuition, fees and room and board for the first two years.

Sharon Cobb, Assistant Commissioner for Student Services has determined that for the first five-year period the rules are in effect the fiscal implications will be that funds for the program were appropriated from General Revenue and will be $554,226 in 1996 and $589,876 in 1997. Plus the cost of administering the program.

Mrs. Cobb also determined that for each year of the first five years the rules are in effect the public benefit anticipated as a result of enforcing the rules will be to provide the state additional well-trained commissioned officers for the Texas National Guard. There will be no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the rules as proposed.

Comments on the proposal may be submitted to Dr. Kenneth H. Ashworth, Commissioner of Higher Education, Texas Higher Education Coordinating Board, P. O. Box 12788, Capitol Station, Austin, Texas 78711.

The new rules are proposed under Texas Education Code, §54.212, which provides the Texas Higher Education Coordinating Board with the authority to adopt rules concerning Exemption Program For Texas National Guard/ROTC Students.

There were no other sections affected by these rules.

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514916 James McWhorter
Assistant Commissioner for Administration
Texas Higher Education Coordinating Board

Proposed date of adoption: January 19, 1996

For further information, please call: (512) 483-6160

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# TITLE 28. INSURANCE

## Part I. Texas Department of Insurance

### Chapter 3. Life, Accident, and Health Insurance and Accident and Health Insurance and Annunities

### Subchapter JJ. Minimum Registration, Disclosure and Nondiscrimination Requirements for Viatical Settlements

**• 28 TAC §§3.10001-3.10018**

The Texas Department of Insurance proposes new subchapter JJ, §§3. 10001-3.10018, concerning regulation of viatical settlements. The proposed new subchapter implements the provisions of the Texas Insurance Code, Article 3. 50-6A, as amended by Acts 1995, 74th Legislature, in House Bill 2256. The proposed sections are necessary to: provide consumer protection in a viatical settlement transaction for the person with a catastrophic or life-threatening illness who sells or otherwise transfers a life insurance policy, or its death benefit, or who attempts to do so; establish requirements for registration, disclosure and form approval for persons engaged in the business of viatical settlements; define prohibited practices for persons engaged in, or involved in transactions relating to, the business of viatical settlements; ensure that a viator's rights under the Insurance Code and this subchapter remain protected if a viatical settlement company sells or otherwise transfers the life insurance policy or death benefits under the policy to another person; protect the confidentiality of the personal, financial and medical information of persons who sell or otherwise transfer their life insurance policies or death benefits under such policies, or who seek to do so; and provide enforcement mechanisms to ensure that persons engaged in, or involved in transactions relating to, the business of viatical settlements comply with the Insurance Code and this subchapter.

Section 3.10001 sets forth the scope and purpose of the subchapter and includes a severability provision. Section 3.10002 contains definitions used in the subchapter. Section 3.10003 requires all viatical settlement companies and brokers doing business in Texas to register and pay initial fees. Section 3.10004 requires registered viatical settlement companies and brokers to pay annual fees. Section 3.10005 requires companies to file annual audited financial statements and periodic reports containing specified information on viatical settlement transactions during the previous calendar year. The section also requires each viatical settlement broker to file periodic (unaudited) reports regarding its transactions with viatical settlement companies and other brokers. Section 3.10006 requires each viatical settlement company to submit to the department for approval all forms used by the company to effect a viatical settlement with a viator. Section 3.10007 requires companies and brokers to file advertising materials, informational brochures and certain viator-requested revisions to contract with the department for informational purposes. Section 3.10008 requires companies to provide a viator an informational brochure at the time the viator applies for a viatical settlement. Section 3.10009 specifies certain provisions that must be included in applications and contracts used to effect viatical settlements and also delineates prohibited practices related to applications and contracts. Section 3.10010 prohibits companies and brokers from disseminating misleading advertising or other solicitation materials. Section 3.10011 sets forth disclosure requirements and prohibited practices relating to payment of commissions or other compensations. Section 3.10012 places limits on contacting a viator for health status inquiries. Section 3.10013 requires certain disclosures in relation to assignment and resale of policies and prohibits a company from transferring policies to an unregistered person unless that person designates a registered company or broker to make all inquiries to the viator. Section 3.10014 requires companies or others obtaining medical, financial or personal information about viators to maintain such information in strict confidence. Section 3.11015 prohibits operating as, or doing business with, unregistered companies or brokers. Section 3.10016 delineates enforcement procedures for denying applications for or revoking certificates of registration, for alternative sanctions against registered companies or brokers, and for stopping and sanctioning companies or brokers who operate in Texas without a certificate of registration. The section also describes the applicability of Article 1.10D to the department's regulatory authority over viatical settlement companies and brokers, and sets forth additional investigatory powers of the department. Section 3.10017 establishes the procedures for approval and other determinations by the department and the commissioner. Section 3.10018 contains forms for use by viatical settlement companies and brokers which set out the required format for applications and reporting filings. Copies of these forms are on file with the office of the Secretary of State, *Texas Register* Section. Copies of these forms may be obtained from the Texas Department of Insurance, Publication Department, MC 108-5A, P.O. Box 149104, Austin, Texas 78714-9104.

Tyrette P. Hamilton, Acting Deputy Commissioner, Life/Health Group, Texas Department of Insurance, has determined that for each year of the first five years this subchapter is in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering this subchapter. There will be no measurable effect on local employment or local economy.

Ms. Hamilton also has determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of enforcing the new sections will be

to provide consumer protection to persons who sell or transfer or attempt to sell or transfer a life insurance policy or the death benefit thereunder. There is no anticipated difference in cost of compliance between small and large businesses. Ms. Hamilton estimates that for the first year that the sections are in effect, the cost to viatical settlement companies required to comply with the proposal will range from $25, 000 to $175,000. The estimated costs to viatical settlement companies for each of the remaining years of the first five year period the proposed sections are in effect will range from $25,000 to $75,000 annually. Ms. Hamilton estimates that for the first year that the sections are in effect, the cost to viatical settlement brokers required to comply with the proposal will range from $300 to $1,000. The estimated costs to viatical settlement brokers for each of the remaining years of the first five year period the proposed sections are in effect will range from $300 to $5,000 annually. These amounts are estimated on a per company and per broker basis. The agency does not currently have information about how many companies or brokers may choose to transact business in the state. The assumptions on which these costs have been estimated may change as the agency receives data during the comment period.

Comments on the proposal must be submitted within 30 days after publication of the proposed sections in the *Texas Register*, to Alicia M. Fechtel, Chief Clerk, P.O. Box 149104, Mail Code 113-1C, Austin, Texas 78714-9104. An additional copy of the comment must be submitted to Tyrette P. Hamilton, Acting Deputy Commissioner, Life/Health Group, Texas Department of Insurance, 333 Guadalupe Street, P.O. Box 149104, Mail Code 106-1A, Austin, Texas 78714-9104. Comments may also be provided at the public hearing under Docket Number 2192 which has been scheduled for January 9, 1996 at 10.00 a.m. at the Texas Department of Insurance, Room 100, 333 Guadalupe, Austin, Texas. The purpose of this hearing is to receive oral comments on the proposed sections from interested persons.

The new sections are proposed under the Insurance Code, Articles 3.50-6A and 1.03A and Government Code, §§2001.004, et seq. Article 3.50-6A requires the Commissioner to register viatical settlement companies and brokers doing business in Texas and to provide consumer protection to persons with life-threatening illnesses who may sell or otherwise transfer their life insurance policies to viatical settlement companies The article authorizes the Commissioner to adopt reasonable rules to implement and enforce the Article. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected by this proposal: Texas Insurance Code, Articles 3.50-6A, 1.01A, 1.03A, 1.10, 1.10D, 1.10E, 1.19-1, 1.24, 1 33A, and 1. 33B

*§3.10001. Purpose, Scope and Severability*

(a) Scope and purpose. This subchapter implements the provisions of the Insurance Code, Article 3.50-6A. The commissioner enacts these rules for the following purposes.

(1) to provide consumer protection in a viatical settlement transaction for the person with a terminal illness who sells or otherwise transfers a life insurance policy or its death benefit, or who attempts to do so;

(2) to establish requirements for registration, disclosure and form approval for persons engaged in the business of viatical settlements;

(3) to define prohibited practices for persons engaged in, or involved in transactions relating to, the business of viatical settlements;

(4) to ensure that a viator's rights under the Insurance Code and this subchapter remain protected if a viatical settlement company sells or otherwise transfers the life insurance policy or death benefits under the policy to another person;

(5) to protect the confidentiality of the personal, financial and medical information of persons who sell or otherwise transfer their life insurance policies or death benefits under such policies, or who seek to do so; and

(6) to provide enforcement mechanisms to ensure that persons engaged in, or involved in transactions relating to, the business of viatical settlements comply with the Insurance Code and this subchapter.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter is inconsistent with any statutes of this state, is unconstitutional or for any other reason is invalid, the remaining provisions shall remain in full effect. If a court of competent jurisdiction holds that the application of any provision of this subchapter to particular persons, or in particular circumstances, is inconsistent with any statutes of this state, is unconstitutional or for any other reason is invalid, the provision shall remain in full effect as to other persons or circumstances.

*§3.10002. Definitions.*

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

(1) Identity or Identify–The complete name, last known business address and last known business telephone number of a person, and, if the person is an entity rather than an individual, the form of the entity.

(2) Person–An individual, corporation, trust, partnership, association, or any other legal entity.

(3) Policy–An individual life insurance policy, a rider to an individual life insurance policy, a certificate or a rider to a certificate evidencing coverage under a group life insurance policy. The term also is used to refer to the death benefit of a policy (that is, a reference to selling or otherwise transferring a policy also encompasses selling, or otherwise transferring the death benefit of a policy or irrevocably designating a beneficiary to receive the death benefit).

(4) Referral agent–A person who, for compensation, refers or introduces a viator to a viatical settlement company or broker, but does not advertise his or her services or the availability of viatical settlements, or perform services or take part in negotiations relating to effecting a viatical settlement. A referral agent who makes five or more such referrals in a calendar year must register as a viatical settlement broker.

(5) Viatical settlement–An agreement that is solicited, negotiated, offered, entered into, delivered, or issued for delivery in this state, under which a person acquires, through assignment, transfer, sale, devise, bequest, or otherwise, a policy insuring the life of an individual with a catastrophic or life-threatening illness or condition by paying the owner or holder of the policy compensation, or anything of value, that is less than the expected death benefit of the policy.

(6) Viatical settlement broker–A person, including an insurance agent licensed by the commissioner, who is not a viatical settlement company and who for a commission or other form of compensation, or in the hopes of obtaining such compensation:

(A) offers or advertises the availability of viatical settlements;

(B) offers or attempts to negotiate a viatical settlement between a viator and a viatical settlement company;

(C) in regards to a potential viatical settlement, performs services relating to the gathering, organization or analysis of medical, financial or personal information about a viator; or

(D) acting as a referral agent, refers or introduces a viator to a viatical settlement company or broker five or more times in a calendar year. The term does not include: an attorney, accountant, or person

acting under power of attorney from the viator, who is retained to represent the viator and whose compensation is paid entirely by the viator without regard to whether a viatical settlement is effected; a person who solicits only potential investors in viatical settlements, and who does not in any way advertise, solicit or promote viatical settlements in a manner that reasonably could attract viators; or any print, broadcast or other media which prints or broadcasts advertisements of a viatical settlement company or broker.

(7) Viatical settlement company-A person who enters into a viatical settlement with a viator, or who attempts to do so through negotiations, solicitation, or acquisition of medical, financial or personal information from or about a viator. The term does not include:

(A) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a policy as collateral for a loan;

(B) the issuer of a policy that makes a loan or pays benefits, including accelerated benefits, under the policy or in exchange for surrender of the policy; or

(C) any person who, within a three-year period, enters into viatical settlements with no more than one viator, provided that the person enters into no more than three viatical settlements with that viator.

(8) Viator-an individual who:

(A) is the owner or holder of a policy insuring the life of an individual who has a catastrophic or life-threatening illness or condition; and

(B) enters into a viatical settlement with a viatical settlement company, or attempts to do so through inquiry to or negotiation with a viatical settlement company or broker, or through providing, or consenting to the provision of, medical, financial or personal information to a viatical settlement company or broker. The term does not include a viatical settlement company that sells, transfers or pledges a policy that it has purchased from a viator.

(b) The Insurance Code, Article 1.01A, which includes definitions of "department" and "commissioner" and describes the structure of the Texas Department of Insurance, applies to this subchapter and to Article 3.50-6A, Insurance Code.

*§3.10003. Registration and Initial Fees and Reports.*

(a) Subject to the grace period allowed by subsection (e) of this section, a person shall not act as a viatical settlement company or broker unless the person holds a certificate of registration issued by the commissioner.

(b) To obtain a certificate of registration as a viatical settlement company, a person must apply to the department in the format prescribed by the form included as Figure 1 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-CO.APP). The application form must be accompanied by:

(1) a registration fee in the amount of $250, in the form of a cashier's check or money order made payable to the Texas Department of Insurance;

(2) samples of all forms that the company uses or plans to use to enter into viatical settlements with viators, and that must be approved by the department pursuant to §3.10006 of this title (relating to Approval of Forms Relating to Viatical Settlements);

(3) the informational brochure that is required by §3.10008 of this title (relating to Required Informational Brochure), and as must be filed pursuant to §3. 10007 of this title (relating to Required Filings for Informational Purposes);

(4) samples of all advertising or other solicitation materials that the company is disseminating or plans to disseminate either in or from Texas, as must be filed pursuant to §3.10007 of this title (relating to Required Filings for Informational Purposes);

(5) (if the viatical settlement company is applying on or before March 1, 1997) historical data regarding the company's conduct of the business of viatical settlements in or from Texas, in the format prescribed by the form included as Figure 3 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-CO.RPT).

(c) To obtain a certificate of registration as a viatical settlement broker, a person must apply to the department in the format prescribed in the form included as Figure 2 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-BR.APP) The application form must be accompanied by:

(1) a registration fee in the amount of $125, in the form of a cashier's check or money order made payable to the Texas Department of Insurance;

(2) (if the viatical settlement broker is not a referral agent) samples of all advertising or other solicitation materials that the broker is disseminating or plans to disseminate either in or from Texas, as must be filed pursuant to §3.10007 of this title (relating to Required Filings for Informational Purposes);

(3) a list identifying all viatical settlement companies or brokers which have paid or shared commissions with the broker in relation to viatical settlement transactions in or from Texas, or with which the broker intends to transact business in or from Texas during the first year of registration;

(4) (if the viatical settlement broker is applying on or before March 1, 1997) historical data regarding the broker's conduct of the business of viatical settlements in or from Texas, in the format prescribed in the form included as Figure 4 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-BR.RPT).

(d) If a viatical settlement company or broker has complied with all application procedures in subsections (b) and (c) of this section, the commissioner shall issue the viatical settlement company or broker a certificate of registration unless the department determines that the application should be denied based on any one or more of the factors set forth in subsection (a) of §3.10016 of this title (relating to Enforcement). The department shall provide written notice to an applicant of the denial of the application and the applicant may make a written request for a hearing to the Chief Clerk, Texas Department of Insurance, P.O. Box 149104, Mail Code 113-1C, Austin, Texas 78714-9104, within 30 days after denial of the application by the department. The department may use the investigatory or subpoena powers referenced in §3.10016 to perform any investigation of an applicant that the department deems necessary.

(e) Each viatical settlement company or broker which has filed an application for a certificate of registration and has submitted the accompanying materials required in this section on or before April 1, 1996, or the 90th day after the commissioner promulgates the sections of this subchapter, whichever date is earlier:

(1) may do the business of viatical settlements until the commissioner approves the application, or the department issues a notice of denial regarding the application;

(2) may continue to use the forms submitted pursuant to this section and §3.10006 of this title (relating to Approval of Forms Relating to Viatical Settlements), until the commissioner has completed the review of the forms and either has approved or disapproved them.

(f) In complying with the reporting requirements of this section, viatical settle-

ment companies or brokers shall not include the name of the viator, or in any other way compromise the anonymity of the viator, or the viator's family, spouse or significant other.

(g) The registration of any viatical settlement company or broker with a principal place of business outside of Texas shall not be approved unless the application is accompanied by:

(1) a written designation of an agent for service of process in Texas; and

(2) a written irrevocable consent to the jurisdiction of the commissioner and Texas courts.

(h) If there is a material change to any information provided in an application by a viatical settlement company or broker, the company or broker shall submit a new application containing the changed information.

*§3.10004. Annual Fees.*

(a) On or before March 1 of each year, beginning on March 1, 1997, viatical settlement companies shall submit to the department an annual renewal fee in the amount of $250, or, if the company has been registered less then 12 months in the previous calendar year, a prorated amount of $0.68 multiplied by the number of days registered in the previous calendar year, in the form of a cashier's check or money order made payable to the Texas Department of Insurance.

(b) On or before March 1 of each year, beginning on March 1, 1997, viatical settlement brokers must submit to the department an annual renewal fee in the amount of $125, or, if the broker has been registered for less than 12 months in the previous calendar year, a prorated amount of $0.34 multiplied by the number of days registered in the previous calendar year, in the form of a cashier's check or money order made payable to the Texas Department of Insurance.

*§3.10005. Reporting Requirements*

(a) If a viatical settlement company has applied for a certificate of registration on or before March 1, 1997, it shall submit to the department quarterly reports, in the format prescribed by the form included as Figure 3 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-CO.RPT), as such reports become due pursuant to the timetable specified on the first page of Figure 3. The report will consist of data relating to events or transactions that occurred during the three-month period preceding the report. Beginning March 1, 1997, viatical settlement companies shall submit reports to the department annually, as set forth in subsection (b) of this section.

(b) On or before March 1 of each year, beginning on March 1, 1997, viatical settlement companies shall submit to the department an annual report, consisting of the following:

(1) an audited financial statement and accompanying notes for the 12-month period ending December 31 of the previous year, prepared by an independent Certified Public Accountant; and

(2) data relating to events or transactions that occurred during the previous calendar year, as specified in the form included as Figure 3 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-CO.RPT).

(c) If a viatical settlement broker has applied for a certificate of registration on or before March 1, 1997, it shall submit to the department quarterly reports, in the format prescribed by the form included as Figure 4 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-BR.RPT), as such reports become due pursuant to the timetable specified on the first page of Figure 4. The report will consist of data relating to events or transactions that occurred during the three-month period preceding the report. Beginning March 1, 1997, viatical settlement brokers shall submit reports to the department annually, as set forth in subsection (d) of this section.

(d) On or before March 1 of each year, beginning on March 1, 1997, viatical settlement brokers registered in this state must submit to the department data relating to events or transactions that occurred during the previous calendar year, as specified in the form included as Figure 4 in §3.10018 of this title (relating to Application and Reporting Forms) (Form VIAT-BR.RPT).

(e) In complying with the reporting requirements of this section, viatical settlement companies or brokers shall not include the name of the viator, or in any other way compromise the anonymity of the viator, or the viator's family, spouse or significant other.

*§3.10006. Approval of Forms Relating to Viatical Settlements.*

(a) A viatical settlement company shall not enter into a viatical settlement in this state unless all forms used in effecting the settlement with the viator, including the application, have been filed with and approved by the department. Such forms submitted for approval must include any forms prepared and processed by a viatical settlement broker, but relied upon by the viatical settlement company in effecting the settlement.

(b) Except as allowed under the initial grace period set forth in §3.10003(e) of this title (relating to Registration and Initial Fees), all forms that a viatical settlement company proposes to use in effecting viatical settlements must be filed with the department at least sixty days prior to use of the forms. If the forms have not been disapproved, and if corrections have not been requested, the company may use the forms at the end of sixty days from the date the form is received by the department, or the date the department issues a certificate of registration to the company, whichever date is later, provided that an attorney licensed to practice law in this state files a certification on behalf of the company, stating that:

(1) the certification is filed on behalf of the viatical settlement company, which agrees to be bound by it;

(2) the attorney has reviewed and is familiar with all applicable statutes and rules relating to viatical settlements;

(3) the attorney has analyzed the forms filed with the department, and, based on the attorney's best knowledge and belief, the forms comply with all applicable statutes and rules of this state relating to viatical settlements.

(c) If the department disapproves any such form, the viatical settlement company, upon written notice of such disapproval, shall stop using the form immediately. The department may require a viatical settlement company to replace disapproved forms used to effect viatical settlements during the pendency of the department's review with amended or reissued forms that meet the department's approval.

(d) The department may disapprove any form filed pursuant to this section, or, withdraw a previous approval of any form, if:

(1) the form fails to comply with any applicable provision of the Insurance Code or the sections promulgated under this subchapter; or

(2) the content of the form is unjust, encourages misrepresentation or is in any way deceptive.

(e) All forms used in the viatical settlement market shall be submitted in duplicate in accordance with the following procedures:

(1) Transmittal Letter. The transmittal letter shall be submitted in duplicate and shall specify that the form is for use in the viatical settlement market. The transmittal letter must identify the type of form and explain the purpose and use of the form.

(2) Address. Send form filings to the Life/Health Group, Filings Intake, Mail Code 106-3A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701. To expedite the return of notices of proposed disapproval's or approvals, a company may enclose an overnight mail envelope together with either a completed form for transmittal or the company's billing number.

(3) Identification of form type. The form filing must identify the type of filing as a viatical settlement form and explain the purpose and use of the.

(4) Number of copies. All correspondence and forms, including resubmissions and corrections for pending forms, shall be submitted in duplicate.

(5) Specimen language and fill-in material. All forms must be filled in with specimen language and specimen fill-in material

(6) Type of paper Forms shall be submitted on paper that will accept a rubber stamp and that is suitable for permanent filing and microfilming Glossy stock paper is not acceptable.

(7) Print format. All filings must be legible.

(A) Forms and corrections shall be submitted for review on 8 1/2 by 11 paper

(B) Forms and corrections should not be submitted for review in any print format which consists of booklets which are bound or are printed on paper other than 8 1/2 by 11.

(C) They may be submitted in typewritten, computer generated, or printer's proof format.

(D) Handwritten forms or handwritten corrections will not be accepted.

(8) Form numbers Each form shall be designated by a form number sufficient to distinguish it from all other forms used by the viatical settlement company. The form number shall be located in the lower left-hand corner of the cover page or on the first page of the form if the form number would be visible with the cover closed

(9) Contact Person. One person shall be designated as the contact person for each filing submitted. Said submission should provide the name, address and phone number of the contact person for that filing. If the forms are submitted by anyone other than the company itself, the forms shall be accompanied by a dated letter of specific authorization for such forms, designating the consulting firm, actuary, legal counsel, or other designated contact person for that filing.

*§3.10007. Required Filings for Informational Purposes.*

(a) Each viatical company shall file with the department a copy of the informational brochure required by §3.10008 of this title (relating to the Required Informational Brochure), on or before the date the brochure is disseminated to viators.

(b) Each viatical settlement company or broker shall file with the department all advertising or other solicitation materials used to market viatical settlements or the company or broker's services, on or before the date such materials are published or disseminated.

(c) If a viator represented by an attorney requests any substantive revision in a contract effecting a viatical settlement, the viatical settlement company must file the proposed contract, as revised, with the department, redacting all information made confidential by §3.10014 of this title (relating to Confidentiality). Provided that this submission is accompanied by a written certification from the viator's attorney, stating that the viator has requested the substantive revision after consultation with the viator's counsel, the submission of the revised contract will be for informational purposes, rather than for prior approval.

(d) The filings required by this section are for informational purposes only. Viatical settlement companies or brokers may use or disseminate the materials referenced in subsections (a)-(c) of this section without the prior approval of the department.

*§3.10008. Required Informational Brochure.* With each application for a viatical settlement, the viatical settlement company shall deliver to the applicant an information booklet setting forth the company's full name and home office address and explaining:

(1) how viatical settlements operate;

(2) possible alternatives to viatical settlements for persons with life-threatening illnesses or conditions, including accelerated benefits offered by the issuer of the policy, loans secured by the policy and surrender of the policy for cash value;

(3) possible tax consequences of the transaction;

(4) possible consequences of the viatical settlement on the viator's ability to receive public assistance and public medical services;

(5) the viator's right to rescind a viatical settlement not later than the 15th day after the date either that the viator receives the viatical settlement proceeds, or the proceeds are placed in escrow, as allowed by §3.10009 of this title (relating to Application and Contract Forms: Required Provisions and Prohibited Practices);

(6) that the proceeds payable to the viator may not be exempt from the viator's creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court;

(7) the viator's right to know, upon request, the identity of any person who will receive a commission or other form of compensation from the viatical settlement company or broker with respect to the viatical settlement and the amount and terms of such compensation;

(8) the limits and options regarding contacts for determination of health states set forth in §3. 10009(b)(4) of this title (relating to Application and Contract Forms: Required Provisions and Prohibited Practices) and §3.10012 of this title (relating to Contacting the Viator for Health Status Inquires: Limits and Prohibited Practices);

(9) every viator's right to confidentiality under §3.10014 of this title (relating to Confidentiality);

(10) that if the policy that is the subject of a viatical settlement contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of spouses, family members or anyone else other than the person with the catastrophic or life-threatening illness, the viatical settlement contract will affect those provisions or riders and may cause spouses, family members or others to lose the additional benefits afforded by those provisions or riders.

*§3.10009. Application and Contract Forms: Required Provisions and Prohibited Practices.*

(a) Provisions required in applications. All application forms used to effect viatical settlements shall contain:

(1) The following information in English and in Spanish, which must be displayed prominently and in bold print on the front page of the application:

(A) In English: "Receipt of a viatical settlement may affect your eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), sup-

plementary social security income (SSI), and drug assistance programs. The money you receive for your life insurance policy also may be taxable. Before completing a viatical settlement contract, you are urged to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your family, and your spouse's eligibility for public assistance. For more information about viatical settlements generally, contact the Texas Department of Insurance, at 1-800-252-3439."

(B) In Spanish:
Figure 1: 28 TAC §3.10009(a)(1)(B)

(2) A requirement, as a condition of entering into a viatical settlement, that the viator provide a written statement from a licensed attending physician, that the physician knows of no medical conditions that would affect the viator's mental competence to enter into a viatical settlement.

(b) Provisions required in contract forms. All forms of contract used to effect viatical settlements shall contain:

(1) a provision that the viator may rescind the viatical settlement not later than the 15th day after either the date that the viator receives the proceeds of the viatical settlement, or, at the option of the viatical settlement company, the date the proceeds are placed in escrow as provided by paragraph (2)(B) of this subsection;

(2) a provision that upon receipt from the viator of documents to effect the transfer of the policy, the viatical settlement company may at its option either:

(A) make unconditional payment to the viator immediately, either in a lump sum or in installment payments in a manner not prohibited by subsection (c)(5) of this section; or

(B) pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a national or state bank that is a member of the Federal Deposit Insurance Corporation, where such proceeds shall remain until:

(i) the proceeds are disbursed to the viator upon acknowledgment of the transfer of the policy by the issuer of the policy, or the expiration of the rescission period without rescission by the viator, whichever occurs later;

(ii) the first installment payment of the proceeds is made to the viator in a manner not prohibited by subsection (c)(5) of this section;

(iii) the proceeds are returned to the viatical settlement company upon notice of the viator's rescission within the rescission period;

(3) a provision that the forms used to effect the viatical settlement, together with the application, constitute the entire contract between the viatical settlement company and the viator;

(4) a provision that the viator may designate any adult individual in regular contact with the viator as the contact for all inquiries about the viator's health status, and, if such designation is made, a viatical settlement company cannot make such an inquiry to the viator, unless the company is unable, after diligent effort, to contact the designee for more than 30 days. The viator may change this designation at any time, upon written notice to the viatical settlement company;

(5) a provision disclosing that the viatical settlement company could sell or otherwise transfer the policy that is the subject of the viatical settlement to a person unknown to the viator, without the viator's consent;

(6) if the viatical settlement company intends to sell or otherwise transfer the policy that is the subject of the viatical settlement to a particular person or persons, a provision disclosing the company's intent to sell or otherwise transfer the policy, and the identity of the person or persons to whom the initial company proposes to sell or otherwise transfer the policy;

(7) an acknowledgment page, which a prospective viator must sign before a notary, stating that the prospective viator acknowledges that he or she:

(A) has a life-threatening illness;

(B) has received and read the informational brochure required by §3.10008 of this subchapter;

(C) has received and read all of the documents used to effect the viatical settlement;

(D) is entering into the viatical settlement knowingly and voluntarily;

(8) a full disclosure regarding what effect the viatical settlement will have on payment of premiums and disposition of proceeds, cash values and dividends, if the policy that is the subject of the viatical settlement contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of spouses, family members or anyone else other than the person with the life-threatening illness.

(c) Prohibited practices relating to applications and contracts. A viatical settlement company or broker shall not:

(1) condition the consideration of an application on exclusive dealing between the viator and the viatical settlement company or broker;

(2) discriminate in the availability or terms of viatical settlements on the basis of race, color, age, gender, national origin, creed, religion, occupation, geographic location, disability or partial disability (except when such disability affects the life expectancy of the viator), marital or family status or sexual orientation;

(3) discriminate between viators with dependents and those without dependents;

(4) enter into any viatical settlement that provides a payment to the viator that is unjust (In determining whether a payment is unjust, the commissioner may consider, among other factors, the life expectancy of the viator, the applicable rating of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups, and the prevailing discount rates in the viatical settlement market in Texas, or if insufficient data is available for Texas, the prevailing rates nationally or in other states that maintain such data.) or;

(5) enter into a viatical settlement in which payments of proceeds are made in installments, unless the viatical settlement company has been licensed in this state to act as an insurance company and the settlement is effected through the purchase of an annuity, or the viatical settlement company has been licensed as a bank and the settlement is affected through an escrow or trust account providing installment refunds.

*§3.10010. Advertising and Other Solicitation: Prohibited Practices.* No viatical settlement company or broker shall advertise or in other way solicit business in a manner that is untruthful or misleading by fact or implication. In considering whether or not the advertising or other solicitation is untruthful or misleading, the commissioner may use the standards set forth in this subchapter, Article 21.21, Insurance Code, and Subchapter B of Chapter 21, Title 28, Texas Administrative Code (relating to Insurance Advertising, Certain Trade Practices, and Solicitation).

*§3.10011. Payment of Commissions or other Forms of Compensation: Disclosure and Prohibited Practices.*

(a) Upon request of the viator at or before the time a viatical settlement is executed, the viatical settlement company,

viatical settlement broker, or both, shall disclose in writing to the viator:

(1) the identity of any person who will receive a commission or other form of compensation from the viatical settlement company or broker with respect to the viatical settlement; and

(2) the amount and terms of the compensation.

(b) A viatical settlement company or broker shall not pay or offer to pay any referral or finder's fee, commission, or other compensation to a viator's physician, attorney, accountant, social worker, case manager or other person providing medical, social, legal or financial planning or other counseling services to the viator.

*§3.10012. Contacting the Viator for Health Status Inquiries: Limits and Prohibited Practices.*

(a) No person shall contact a viator or the viator's designee (as provided for in subsection (b)(4) of §3.10009 of this title (relating to Application and Contract Forms: Required Provisions and Prohibited Practices)), for determining the viator's health status, unless that person is registered as a viatical settlement company or broker in this state.

(b) No viatical settlement company or broker shall contact the viator, or the viator's designee, to determine the viator's health status more frequently than once every 30 days.

*§3.10013. Assignment or resale of policies: Disclosure and Prohibited Practices.*

(a) As to viatical settlements executed after the effective date of this subchapter, no viatical settlement company shall sell, or otherwise transfer any policy that is the subject of a viatical settlement without the consent of the viator, unless the company has made the applicable disclosures to the viator required by subsections (b)(5) and (b)(6) of §3.10009 of this title (relating to Application and Contract Forms: Required Provisions and Prohibited Practices).

(b) No viatical settlement company shall sell or otherwise transfer its interest in any policy that is the subject of a viatical settlement to any person not registered pursuant to this subchapter, unless the person wishing to obtain the policy first appoints, in writing, either the viatical settlement company that entered into the viatical settlement or a broker who received commissions from the viatical settlement to make all inquiries to the viator, or the viator's designee, regarding health status of the viator or any other matters.

*§3.10014. Confidentiality.*

(a) All medical, financial or personal information solicited or obtained by a viatical settlement company or broker about a viator, including the viator's identity or the identity of family members, a spouse or a significant other, is confidential and shall not be disclosed in any form to any person, unless disclosure:

(1) is necessary to effect any transaction allowed by Article 3.50-6A, Insurance Code, or this subchapter, and the viator provides prior and knowing written consent to the disclosure; or

(2) is provided to the department in the form of statistical data from which the identity of the viator cannot be traced, in response to the reporting requirements set forth in §3.10005 of this title (relating to Annual Reporting Requirements) and in Forms 3 and 4 contained in §3.10017 of this title (relating to Application and Reporting Forms); or

(3) is provided to the department in response to a subpoena from the commissioner, pursuant to the enforcement powers set forth in §3.10016 of this title (relating to Enforcement).

(b) All persons to whom the confidential information referenced in subsection (a) of this section is disclosed pursuant to the viator's consent shall maintain the confidentiality of such information, and not disclose it to any other person in any form, without prior and knowing written consent of the viator.

(c) The confidentiality of information obtained by the department or the commissioner pursuant to the subpoena powers set forth in §3.10016 of this title (relating to Enforcement), is protected by the confidentiality provisions of either Article 1.10D or Article 1.19-1, Insurance Code, depending on which article is used to subpoena the information.

(d) All medical information solicited or obtained by a viatical settlement company or broker about a viator further shall be subject to applicable provisions of the laws of this state, and of the United States, relating to the confidentiality of medical information.

*§3.10015. Prohibition Against Operating As, or Doing Business with, an Unregistered Company or Broker.*

(a) No person shall act as a viatical settlement company or broker without first obtaining a certificate of registration from the Texas Department of Insurance, except as allowed under the grace period set forth in §3.10003(e) of this title (relating to Registration and Initial Fees).

(b) After expiration of the grace period set forth in §3.10003(e) of this title, no viatical settlement company or broker registered pursuant to this subchapter shall participate in a viatical settlement, or pay or share commissions, with a company or broker not registered pursuant to this subchapter.

(c) After expiration of the grace period set forth in §3.10003(e) of this title, no issuer of a policy shall transfer any rights under such policy pursuant to a viatical settlement, unless the viatical settlement company seeking transfer is registered in this state.

*§3.10016. Enforcement.*

(a) Denial of Application or Revocation of Certificate. If a viatical settlement company or broker files a request for hearing on the department's denial of the company or broker's application for a certificate of registration, or if the department seeks revocation of the certificate of registration issued to any company or broker, the commissioner may deny the application or revoke the certificate if the commissioner determines, after notice and opportunity for hearing, that the company or broker, or any officers, directors, controlling shareholders of the company or broker, or any employees or affiliates of a company or broker who themselves are acting as a broker:

(1) misrepresented any fact in its application for the certificate of registration;

(2) has been convicted, within the ten years prior to the date of the application, of a felony or other crime involving fraud in any jurisdiction;

(3) is conducting its financial affairs in such a manner as to jeopardize any viator's rights, under this subchapter or the terms of a viatical settlement, to prompt or full payment of proceeds from a viatical settlement;

(4) is engaging in the business of viatical settlements unlawfully in any other state; or

(5) has violated any provision of Article 3.50-6A, Insurance Code, or this subchapter, or any other insurance law of this state made applicable to viatical settlement companies or brokers by Article 3.50-6A or this subchapter, or any applicable state or federal securities laws.

(b) Alternate Sanctions Against Certificate Holders. After notice and the opportunity for a hearing, if the commissioner finds that a viatical settlement company or broker has committed conduct specified in subsection (a) of this section, the commissioner may, in lieu of revocation, order one or more of the sanctions set forth in subsections (a)(1)-(a)(4) of §7, Arti-

cle 1.10, Insurance Code.

(c) Sanctions Against Persons Acting As a Viatical Settlement Company or Broker Without a Certificate of Registration. If the commissioner determines, after notice and opportunity for a hearing, that any person is acting unlawfully as a viatical settlement company or broker in this state without a certificate of registration, or that such person is violating any other provision of Article 3.50-6A, Insurance Code, or this subchapter, or any other insurance law of this state made applicable to viatical settlement companies or brokers by Article 3.50-6A or this subchapter, the commissioner:

(1) shall order such person to immediately cease and desist from doing the business of viatical settlements until the persons fully complies with all registration requirements of the Insurance Code and this subchapter;

(2) shall order such person to cease and desist from violating any other applicable provisions of the Insurance Code or this subchapter;

(3) may order such person to pay an administrative penalty in accordance with Article 1.10E, Insurance Code; and

(4) may order such person to make complete restitution to all persons in Texas harmed by the person's illegal conduct, in a form and amount, and within a time period, determined by the commissioner.

(d) Sanctions Against Issuers of Policies Who Transfer Rights under such Policies to Unregistered Viatical Settlement Companies. If the commissioner determines, after notice and opportunity for a hearing, that any issuer of a policy has transferred, or is about to transfer, rights under such a policy to an unregistered viatical settlement company pursuant to a viatical settlement in violation of §3. 10015(c) of this title (relating to Prohibition Against Operating as, or Doing Business with an Unregistered Company or Broker), the commissioner:

(1) shall order such issuer to immediately cease and desist from violating §3.10011(c) of this title; and

(2) may order such issuer to pay an administrative penalty in accordance with Article 1.10E, Insurance Code.

(e) Application of Article 1.10D, Insurance Code. If a person violates any penal law while engaging in the business of viatical settlements, or while attempting to defraud a viatical settlement company or broker, the commissioner and the insurance fraud unit of the department shall have all powers against such person under Article 1.10D, Insurance Code, that the commissioner and the fraud unit have against a person who commits a fraudulent insurance act, as defined in Article 1.10D.

(f) Investigatory Powers. In order to facilitate enforcement of Article 3.50-6A, Insurance Code, other applicable insurance laws and this subchapter, the department may utilize the provisions of Articles 1.19-1 and 1.24, Insurance Code, which hereby are made expressly applicable to investigations of viatical settlement companies or brokers (whether registered by the commissioner, applying for a certificate of registration or unlawfully doing business without a certificate of registration), or anyone else engaged in, or conducting transactions relating to, the business of viatical settlements.

(g) Confidential Information. The department shall seek information made confidential by §3. 10014 of this title (relating to Confidentiality) only through use of subpoenas issued pursuant either articles 1.10D or 1.19-1, Insurance Code. Confidential information obtained by the department pursuant to such subpoenas shall remain confidential pursuant to the terms of either §5 of Article 1. 10D, or subsection (1)(d) of article 1.19-1.

(h) Enforcement Actions. Articles 1.33A and 1.33B, Insurance Code, apply to enforcement actions brought pursuant to this section.

(i) Representation by Attorney General. Pursuant to article 1.09-1, Insurance Code, the Attorney General shall represent the department and the commissioner in matters appealed to, or brought in, any state or federal court.

*§3.10017. Procedure for Approval or Other Determination by the Department and Commissioner.* Whenever an approval or other determination by the department is required by this subchapter, the approval or other determination shall be made by the deputy commissioner of the Life/Health Group, or the deputy commissioner's designee. Whenever an approval or other determination by the commissioner is required by this subchapter, the initial approval or other determination shall be made by the deputy commissioner of the Life/Health Group, or the deputy commissioner's designee.

*§3.10018. Adoption by Department of Forms for Application and Reporting.* Form VIAT-CO.APP (containing the format for Application for Registration as a Viatical Settlement Company including the application, Service of Process, and Irrevocable Consent to Jurisdiction); Form VIAT-BR.APP (containing the format for Application for Registration as a Viatical Settlement Broker, including the application, Service of Process, and Irrevocable Consent to Jurisdiction); Form VIAT-CO.RPT (containing the format for Viatical Settlement Company Report); and Form VIAT-BR.RPT (containing the format for Viatical Settlement Broker Report) shall be utilized when applying for registration and filing reports adopted in this subchapter. Each is reproduced in detail in this section. Persons may obtain the forms by making a request to: Texas Department of Insurance; Publication Department, MC 108-5A; P.O. Box 149104; Austin, Texas 78714-9104. The department may provide diskettes containing the application or reporting forms upon which an applicant or registrant would enter the data required by these sections or may otherwise facilitate the receipt of information by the department in a computer compatible manner. The following index refers to the form number, its description and the figure number.

FORM FIGURE Number DESCRIPTION
VIAT-CO.APP 1 Application for Registration as a Viatical Settlement Company
VIAT-BR.APP 2 Application for Registration as a Viatical Settlement Broker
VIAT-CO.RPT 3 Viatical Settlement Company Report
VIAT-BR.RPT 4 Viatical Settlement Broker Report
FIGURE 1: 28 TAC §3.10018
FIGURE 2: 28 TAC §3.10018
FIGURE 3: 28 TAC §3.10018
FIGURE 4: 28 TAC §3.10018

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514867 Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Earliest possible date of adoption: December 22, 1995

For further information, please call: (512) 463-6237

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## Chapter 7. Corporate and Financial Regulation

### Subchapter A. Examination and Corporate Custodian and Tax

### • 28 TAC §7.86

The Texas Department of Insurance proposes new §7.86, concerning the demonstration of ownership of certificated and uncertificated securities. Section 7.86(a) describes the purpose of the new section. Section 7.86(b) provides definitions of terms used in the new section. Section 7.86(c) describes how a domestic insurance company can evidence ownership of securities. Section

7 86(d) establishes requirements for written custodial agreements. The new section is necessary to implement §7 17 of House Bill 1461, enacted by the 73rd Legislature, 1993, which added a new §6 to Article 21.39-B of the Insurance Code The commissioner is directed by Texas Insurance Code, Article 21.39-B, §6 to adopt rules authorizing a domestic insurance company to demonstrate ownership of an uncertificated security consistent with common practices of securities exchanges and markets These rules will establish the manner in which ownership of the security may be demonstrated, and adequate financial safeguards relating to the ownership of securities

Jose Montemayor, associate commissioner for the financial program, has determined that for the first five-year period the new section is in effect, there will be no fiscal implications for state or local government or small business as a result of enforcing or administering the section, and there will be no effect on local employment or local economy.

Mr Montemayor also has determined that, for each year of the first five years the new section is in effect, the public benefit anticipated as a result of compliance with the section will be more efficient and accurate safekeeping of certificated and uncertificated securities held by custodians of securities owned by insurance companies The anticipated economic cost to insurers required to comply with the new section will vary from insurer to insurer for the first year of the first five-year period the new section is in effect. Each insurer will need to review the custodial agreements currently in place and determine whether changes are necessary to comply with the new section. As a result of the responsibilities the new section will place on custodians, it is possible that some custodians may increase the fees currently charged for custodial services, however, the amended Texas Insurance Code, Article 21.39-B, allows securities broker-dealers to act as custodian, in addition to the previously authorized banks and trust companies. Therefore, it is also possible that the additional competition for these custodial services will result in no increase in fees or a reduction in fees In addition to these factors, custodial fees are negotiable and are impacted by other services the insurer may have with the custodian Taking into account all these factors, some insurers may pay increased fees, while others may benefit from a reduction in fees During the first five-year period, there are no other anticipated economic costs to insurers as a result of this new rule.

Comments on the proposal must be submitted in writing within 30 days after publication of the proposal in the *Texas Register* to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O Box 149104, Austin, Texas 78714-9104. An additional copy of the comments should be submitted to Jose Montemayor, Associate Commissioner for the Financial Program, Mail Code 305-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Request for a public hearing on this proposal should be submitted separately to the Office of the Chief Clerk.

The new section is proposed under the authority of the Insurance Code, Articles 21.39-B Article 21.39-B, §6, directs the commissioner to adopt rules authorizing a domestic insurance company to demonstrate ownership of an uncertificated security consistent with common practices of securities exchange markets. Article 21.39-B, §2, authorizes the commissioner to promulgate such regulations as may be deemed necessary to carry out the provisions of Article 21.39-B Article 1.03A authorizes the commissioner to determine rules for general and uniform application for the conduct and execution of the duties and functions of the department only as authorized by statute for general and uniform application.

The proposed new section affects Insurance Code, Articles 21 39-B and 3.33, §7(b) and (c)

*§7 86 Custodied Securities.*

(a) Purpose. The purpose of this section is to enable insurers to demonstrate ownership of securities consistent with the common practices of securities exchanges and markets while protecting the interests of policyholders and shareholders.

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

(1) Clearing corporation–A corporation or system that provides for the book entry settlement and custody of securities and is further defined in Insurance Code, Article 21.39-B, §4(b) and Texas Business and Commerce Code, §8.102(c).

(2) Custodian–A qualified bank, qualified broker/dealer or a clearing corporation that accepts deposits of securities and moneys from an insurer and safeguards, holds and reports on such securities and moneys pursuant to a written custodial or trust agreement with an insurer.

(3) Custodied securities–An insurer's securities, including moneys, deposited with a custodian or redeposited with a subcustodian.

(4) Insurer–A domestic insurance company.

(5) Moneys–Cash held incidental to securities transactions.

(6) Qualified bank–A bank, federal home loan bank, or trust company with trust powers and organized under the laws of the United States or any state thereof and either is a member of the Federal Reserve System, a member of, or is eligible to receive deposits which are insured by, the Federal Deposit Insurance Corporation, or maintains an account with a Federal Reserve Bank and is subject to supervision and examination by the Board of Governors of the Federal Reserve System, or is subject to supervision and examination by the Federal Housing Finance Board, and is no less than "adequately-capitalized" as defined by standards promulgated by the appropriate federal bank regulatory agency

(7) Qualified broker/dealer–A securities firm which has, as shown by its most recent audited financial statement, a tangible net worth of at least $500 million, net capital of at least 120% of the minimum capital required of such securities firm by the Securities and Exchange Commission and a ratio of aggregate indebtedness to net capital of no greater than 12:1, is registered with and subject to the jurisdiction of the Securities and Exchange Commission, and is a member of the Securities Investor Protection Corporation.

(8) Securities–Shares, participations, or other interests in property or an enterprise as defined in the Texas Business & Commerce Code, §8.102(a). The term includes certificated and uncertificated securities.

(9) Securities issuer–The enterprise, organization or other entity which issues securities.

(10) Subcustodian–A qualified bank, qualified broker dealer or a clearing corporation that accepts deposits of securities and/or moneys from a custodian for safeguarding and holding.

(11) Transfer agent–A person or firm which engages on behalf of a securities issuer in transferring record ownership of securities.

(c) Evidence of Securities Ownership. An insurer may demonstrate ownership of its securities by having them held by a custodian pursuant to subsection (d) of this section. In addition, an insurer may demonstrate ownership of its securities by having them registered in the insurer's name on the books of the securities issuer and/or the securities issuer's transfer agent.

(d) Required Provisions For Custodial Agreements. Any arrangement involving an insurer's deposit of its securities and moneys with a custodian must be evidenced by a custodial agreement signed by the insurer and the custodian. The custodial agreement signed by the insurer and the custodian must contain the provisions described in paragraphs (1)-(13) of this subsection.

(1) The intent of the agreement is for the custodied securities to be held by the custodian in a fiduciary relationship with the insurer. The custodian's redeposit of the custodied securities with a subcustodian does not alter the custodian's fiduciary obligations to the insurer.

(2) The custodian shall exercise the same due care expected of a fiduciary with the responsibility for the safeguarding

of the insurer's custodied securities and for compliance with all provisions of the custodial agreement, whether the insurer's custodied securities are in the custodian's possession or have been redeposited by the custodian with a subcustodian.

(3) The custodian shall indemnify the insurer for any loss of custodied securities. In the event of such loss, the custodian must promptly replace the custodied securities or the value thereof, and the value of any loss of rights or privileges resulting from said loss of custodied securities.

(4) Custodied securities shall be segregated at all times from the proprietary assets of the custodian and subcustodian.

(5) The custodian's official records shall separately identify custodied securities owned by the insurer, whether held by the custodian or subcustodian. If held by a subcustodian, the custodian's records shall also identify the subcustodian.

(6) Custodied securities that are in registered form shall be registered only in the name of the insurer, the custodian or its nominee, or the subcustodian or its nominee.

(7) All activities involving the insurer's custodied securities shall be subject to the insurer's instructions and the custodied securities shall be withdrawable upon demand of the insurer. Securities deposited with insurance regulators to satisfy statutory requirements shall not be withdrawn without the approval of the appropriate insurance regulatory authority.

(8) The custodian shall furnish, upon request by the insurer, a confirmation of all transfers of custodied securities to or from the account of the insurer, and reports of custodied securities sufficient to verify information reported in the insurer's annual statement filed with the Texas Department of Insurance and supporting schedules and information required in any audit of the insurer's financial statement whether the custodied securities are held by the custodian or by a subcustodian.

(9) The insurer or its designee shall at all times be entitled to examine all records maintained by the custodian or subcustodian relating to the insurer's custodied securities.

(10) Upon request of the insurer, the custodian shall be required to send to the insurer all reports it receives from a clearing corporation or the Federal Reserve book-entry system on their respective systems of internal accounting control, and all reports prepared on the custodian's and subcustodian's systems of internal accounting control of custodied securities.

(11) The custodian shall not use any of the insurer's custodied securities for the custodian's benefit and none of the insurer's custodied securities shall be loaned, pledged, or hypothecated by the custodian or subcustodian without a written contract executed by the insurer separate and apart from the custodial agreement.

(12) The custodian is authorized and instructed by the insurer to honor any requests made by the Texas Department of Insurance for information concerning the insurer's custodied securities. The department, from time to time, may request, and the custodian shall furnish, a detailed listing of the insurer's custodied securities (whether in the possession of the custodian or with a subcustodian) and an affidavit by the custodian certifying the custodian's safekeeping responsibilities relative to the custodied securities. The custodian's response to such requests shall be made directly to the department and shall encompass all of the insurer's custodied securities (whether in the possession of the custodian or with a subcustodian). The department shall furnish the insurer a copy of the information request and a copy of the custodian's response.

(13) The custodian and subcustodian shall maintain securities all risks coverage at levels considered reasonable and customary for the custodial banking industry covering the custodian's duties and activities as custodian for the insurer's assets and shall describe the nature and extent of such insurance protection. Any change in such insurance protection during the term of the custodial agreement shall be promptly disclosed to the insurer.

(e) Effective Date. All insurers subject to this section shall comply with subsection (d) of this section no later than 180 days after the effective date of this section.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515048 Alicia M Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-6327

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## Chapter 26. Small Employer Health Insurance Regulations

### • 28 TAC §§26.1, 26.4-26.11, 26.13-26.22, 26.27

The Texas Department of Insurance proposes amendments to §§26.1, 26. 4-26.11, 26.13, and 26.19-26.22, and new §§26.14-26.18 and 26.27, concerning small employer health benefit plans. The amendments to these sections and new sections are necessary to add guaranteed issue requirements for small employer health benefit plans, to make new standard benefit plans available to small employer carriers and small employers, to address the minimum requirements for participation by eligible employees and for premium contributions by employers, to establish enrollment requirements and to implement legislation enacted by the 74th Legislature in House Bill 369 relating to the operation and funding of small employer health benefit plans. Simultaneous to this notice of the proposed amendments and proposed new §§26.14-26.18 and §26.27, the department is proposing repeal of existing §§26.14-26.18 and §26 27. Notice of that proposed repeal is published elsewhere in this issue of the *Texas Register*. Proposed §26.1 amends the statement of purpose to delete the reference to three prototype plans required by the rules prior to these amendments. Proposed §26.4 adds definitions of affiliation period and point-of-service contract and amends the definitions of eligible employee, late enrollee, small employer health benefit plan and standard benefit plan. The definition of late enrollee is intended to, among other things, implement legislation enacted by the 74th Legislature in Senate Bill 793 relating to the enforcement of certain child support and medical support obligations. Amendments proposed to §26.5 modify the applicability and scope of the chapter, describe the plans to which these amended sections apply by date of issue or renewal, provide for early voluntary compliance with the amended sections, and require notification to certain small employers of the new standard benefit plans. Section 26.6 is amended to update references to form numbers and statutes. Amendments to §26.7 delete the requirement for additional coverage upon employee election, extend the enrollment period by one day for new entrants and require a small employer carrier to determine small employer eligibility within a specified time. Section 26.8 is to be retitled "Guaranteed Issue; Contribution and Participation Requirements" and is amended to include requirements relating to the guaranteed issue provisions of Insurance Code, Chapter 26 which became effective September 1, 1995. The proposed section also deletes the 75% employer premium contribution requirement and allows a health carrier to require a premium contribution in accordance with its usual and customary practices, if applied uniformly to each small employer, or to use the contribution requirement established by a purchasing cooperative if the carrier is participating in the cooperative. The proposed section also lowers the participation requirement from 90% of eligible employees to 75%, allows a small carrier to offer a lower participation level if the carrier permits the same percentage of participation as the qualifying percentage for each benefit plan offered by that carrier and allows the carrier to offer a participation level that is lower than the carrier's qualifying participation level in limited circumstances. Amended §26.9 provides that late enrollees may be excluded from coverage until the next annual enrollment period and may be subject to a 12-month pre-

existing condition provision The proposed section also allows carriers who do not use a pre-existing condition provision to impose an affiliation period of no more than 90 days for new entrants and no more than 180 days for late enrollees during which premiums are not collected and issued coverage is not effective and it provides that imposition of an affiliation period does not preclude application of a small employer waiting period applicable to all new entrants. Proposed §26 10 prohibits the establishment of a separate class of business based on participation requirements or whether coverage is provided on a guaranteed issue basis. Section 26.11 is amended to allow a health maintenance organization (HMO) participating in a purchasing cooperative that has established a separate class of business and a separate line of business to use rating methods used by other carriers in the cooperative, including rating by age and gender Amendments to §26 13 change references to the standard benefit plans established by the Commissioner of Insurance to the new standard plans and requires small employer carriers to give to each small employer that inquires about purchasing a health benefit plan a written summary of the standard benefit plans which includes a description of the items listed in the section. The amended section also requires a small employer carrier to offer each of the standard benefit plans to each small employer who inquires about purchasing a small employer health benefit plan and to explain the plans to the employer upon request. The proposed section also requires a small employer carrier to give written reasons to the small employer if coverage is denied on any basis. New §26.14 contains the coverage provisions for the new standard benefit plans required to be offered by small employer carriers to small employers as a condition of transacting business in the state New §26.15 contains requirements for renewability of coverage and cancellation. The text of this new section is the text of prior §26 16 except that language has been added providing that misrepresentations of a material fact by a small employer or eligible employee or dependent shall not include misrepresentations related to health status unless the misrepresentations are fraudulent and made during the initial application process New §26.16 describes the circumstances under which a small employer carrier may refuse to renew coverage, prohibits a carrier that has refused to renew coverage from writing small employer health benefit plans in the state or geographic area for a period of five years and establishes a procedure for reentry into the market after five years. The text of this section is the text of prior §26.17 New §26.17 prescribes the notice to covered persons for termination of coverage. The text of this section is the text of prior §26.18. New §26.18 sets forth the procedures for filing an election or application to be a risk-assuming or reinsured carrier. Amendments to §26.19 provide references to the new standard benefit plans, change references to form numbers and sets forth additional requirements for filing forms, contracts and certificates and evidences of coverage. Section 26.20 deletes outdated requirements relating to gross premium filings and provides for an annual filing of this information. The proposed section further requires reporting of the number of standard benefit plans issued and the number of lives covered under these plans. An amendment to §26.21 deletes a statement that HMOs are not subject to Insurance Code, Article 21.52B based upon an amendment to Article 21.52B by the 74th Legislature in Senate Bill 628. Proposed §26.22 requires a purchasing cooperative to file with the Commissioner of Insurance notification of the receipt of a certificate of incorporation or authority from the Secretary of State. Proposed new §26.27 is an appendix containing the new standard benefit plans (the basic coverage benefit plan, the catastrophic care benefit plan and the prototype small employer group health benefit plan) and other forms for use by small employer carriers. Copies of these forms are on file with the Office of the Secretary of State, Texas Register Section Copies of these forms and complete sets of prototype plans may be obtained from the Texas Department of Insurance, Publications Department, MC 108-5A, P.O. Box 149104, Austin, Texas 78714-9104.

Tyrette P. Hamilton, Acting Deputy Commissioner for the Life/Health Group, has determined that for each year of the first five years the sections are 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 local economy.

Ms. Hamilton has determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of enforcing the amended sections will be the increased availability and affordability of health benefit plans to small employers and their employees and dependents as a result of greater flexibility in the contribution and participation requirements and revision of the standard benefit plans. There is no anticipated difference in cost of compliance between small and large businesses. Ms. Hamilton estimates that for the first year that the sections are in effect, the cost to persons required to comply with the proposal will range from $50,000 to $400,000. Estimated costs for each of the remaining years of the first five year period the proposed sections are in effect will range from $10,000 to $150,000. These amounts are the estimated costs per small employer carrier. Approximately 90 small employer carriers currently market small employer health benefit plans in the state.

Comments on the proposal must be submitted within 30 days after publication of the proposed sections in the *Texas Register* to Alicia M Fechtel, 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 submitted to Tyrette P. Hamilton, Acting Deputy Commissioner, Life/Health Group, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104. Comments may also be provided at the public hearing under Docket Number 2190, which has been scheduled for January 9, 1996 at 10:00 a.m. at the Texas Department of Insurance, Room 100, 333 Guadalupe, Austin, Texas. The purpose of this hearing is to receive oral comments on the proposed sections from interested persons.

The amendments and new sections are proposed under the Insurance Code, Chapter 26; Articles 1 03A and 3.96-3 and the Government Code, §§2001.004 et seq (Administrative Procedure Act). Insurance Code, Chapter 26, as amended by the 74th Legislature, establishes the requirements for small employer health benefit plans, including, but not limited to, guaranteed issue and renewability of such health plans; contribution and participation; rating, disclosure, filing and reporting requirements; mandated policy provisions; standard benefit plans; exclusions and limitations; waiting and affiliation periods; pre-existing conditions and fair marketing provisions. Insurance Code, Article 26.04 authorizes the Commissioner of Insurance to adopt rules to implement Chapter 26. Insurance Code, Aarticle 26.75 authorizes the commissioner to adopt rules setting forth additional standards to provide for the fair marketing and broad availability of small employer health benefit plans. Insurance Code, Article 3.96-3, as enacted by the 74th Legislature in Senate Bill 793 establishes requirements for the enrollment of a child whose parent, eligible for dependent health coverage, is required by a court or administrative order to provide health coverage for the child. Insurance Code, Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following statutes are affected by the proposed sections: Texas Insurance Code, Chapter 26. Article 3.96-2 and Family Code, §154.184.

*§26.1. Statement of Purpose.*

(a) This chapter is intended to implement the provisions of the Small Employer Health Insurance Availability Act, Insurance Code, Chapter 26. The general purposes of the Insurance Code, Chapter 26, and this chapter are to provide for the availability of health insurance coverage to small employers and their employees; to ensure renewability of coverage; to regulate rating practices and establish limits on differences in rates between health benefit plans; to establish limitations on underwriting practices, eligibility requirements, and the use of pre-existing condition exclusions; to prescribe standard benefit provisions for the [three] health benefit plans to be offered to all small employers; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small employer health insurance market.

(b) (No change.)

*§26.4. Definitions.* The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

**Affiliation period-A period of time established by a small employer carrier not to exceed 90 days for new enrollees and not to exceed 180 days for late enrollees during which premiums are not collected and the issued coverage is not effective.**

Eligible employee-An employee who works on a full-time basis and who usually works at least 30 hours a week. The term 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 employer. 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;** [or]

***(ii)*** **a self-funded or self-insured** [an] 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 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.**

HMO-A health maintenance organization subject to Insurance Code, Chapter **20** [26]A.

Late enrollee-An eligible employee or dependent who requests enrollment in a small 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 employer **or after the expiration of an open enrollment period under Insurance Code, Article 26.21(h).** An eligible employee or dependent is not a late enrollee if:

(A)-(B) (No change.)

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and

***(i)*** **for coverage to be provided for a spouse,** a request for enrollment is made not later than the 31st day after [issuance of] the date on which the court order is issued; or

***(ii)*** **for coverage to be provided for a child, a request for enrollment is made not later than the 31st day after the date the employer receives notification of the court order.**

**Point-of-service contract-A benefit plan offered through a health maintenance organization that:**

**(A) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital corporations; and**

**(B) permits the insured to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.**

Small employer health benefit plan-**A plan developed by the Commissioner** under [The preventive and primary care benefit plan, the in-hospital benefit plan, or the standard health benefit plan described by] 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** [(d)].

Standard benefit plans-**The basic coverage benefit plan and the catastrophic care benefit plan** [preventive and primary care benefit plan, the in-hospital benefit plan and the standard health 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[s] means the **prototype small employer group health benefit plan** [preventive and primary care benefit plan and the standard health benefit plan] that may be offered by an HMO, as provided under the Insurance Code, Chapter 26, Subchapter E.

*§26.5. Applicability and Scope.*

(a) Except as otherwise provided in this chapter, this chapter shall apply to any health benefit plan providing health care benefits covering three 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:

(1) meets one of the following conditions [or more of the conditions listed in subparagraphs (A)-(C) of this paragraph and the Insurance Code, Article 26.06(a)(1)-(3)]:

(A) a portion of the premium or benefits is paid by [or on behalf of] a small employer[s]; or

[(B) a covered individual is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for a portion of the premium; or]

**(B)**[(C)] the health 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;

(2) (No change.)

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

**(f) Health benefit plans that are offered, marketed, represented, issued or delivered for issue to small employers and their employees on or after September 1, 1993 but before June 1, 1996, must comply with Insurance Code, Chapter 26 as amended by the 74th Legislature and with amendments to this chapter to be adopted January 1, 1996 beginning on the first renewal date of the health benefit plan following June 1, 1996. Small employer carriers may voluntarily comply with the amendments to Insurance Code, Chapter 26 and to this chapter for health benefit plans offered, marketed, represented, issued or delivered for issue or renewed after the effective date of the amendments to this chapter but before June 1, 1996. This section does not permit a small employer carrier to cancel or nonrenew a small employer health benefit plan, including a standard benefit plan, issued before June 1, 1996; however, if the small employer currently was issued a standard benefit plan, the small employer carrier shall give the small employer notice of the standard benefit plans provided for by this chapter as amended at least 30 days prior to the first renewal date. Small employer carriers may use form number 369 SUMM provided at Figure 41 of §26.27 of this title (relating to Appendix) to provide the required notice.**

**(g) Beginning on June 1, 1996, health benefit plans that are offered, marketed, represented, issued or delivered for issue to small employers and their employees on or after June 1, 1996 shall comply with all provisions of the Insurance Code, Chapter 26 as amended by the 74th Legislature, and with amendments to this chapter to be adopted Janu-**

ary 1, 1996.

(h)[(f)] If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects not to continue to offer, deliver, or issue for delivery health benefit plans to small employers and their employees, the health carrier will only be considered a small employer carrier for purposes of renewing such existing plans. In this case, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall state that:

(1) the health carrier (the current health carrier of the small employer's employee health benefit plans) has elected not to continue to offer new health benefit plans in the small employer market; and

(2) other health benefit plans may be available to the small employer through other small employer carriers and that such other plans should be compared against existing plans to determine which plan is more beneficial.

(i)[(g)] If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects to continue to offer, issue, and issue for delivery health benefit plans to small employers and their employees, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall:

(1) offer the small employer the option of continuing the existing health benefit plan or plans or purchasing new small employer benefit plans in accordance with the Insurance Code, Chapter 26, and this chapter; and

(2) provide notice that such other plans should be compared against existing plans to determine which plan is more beneficial.

(j)[(h)] The provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(k)[(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, and this chapter, and the small employer subsequently employs more than 50 eligible employees or less than three eligible employees, the provisions of the Insurance Code, Chapter 26, and this chapter shall continue to apply to that particular health plan. 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 three eligible employees, but not later than the first renewal date occurring after the small employer has ceased to be a small employer, notify the employer that the protections provided under the Insurance Code, Chapter 26, and this chapter shall cease to apply to the employer, if such employer fails to renew its current health benefit plans or elects to enroll in a different health benefit plan.

(l)[(j)] If a health benefit plan is issued on or after September 1, 1993, to an employer that is not a small employer as defined in the Insurance Code, Chapter 26, but subsequently the employer becomes a small employer, the provisions of the Insurance Code, Chapter 26, and this chapter shall apply to the health benefit plan on the first renewal date on or after January 1, 1994. An employer may become a small employer due to several reasons, including, but not limited to, the loss or change of work status of one or more employees, or the employer has moved to this state from another state and has a health benefit plan that was issued in the other state. The health carrier providing a health benefit plan to such an employer:

(1) shall not be considered to have elected to offer, issue, or issue for delivery health benefit plans to small employers under the provisions of the Insurance Code, Chapter 26, and this chapter solely because the health carrier continues to provide coverage under the health benefit plan to the employer and employees of the employer; however, for purposes of such existing health benefit plans, the health carrier will be considered a small employer carrier; and

(2) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the small employer of the options that will be available to the small employer under the Insurance Code, Chapter 26, and this chapter, including the small employer's option to purchase a small employer health benefit plan from the employer's current health carrier, if the carrier is offering such coverage, or from any small employer carrier **currently offering small employer coverage in this state** [willing to accept the group].

(m)[(k)] If a small employer has employees in more than one state, the provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan issued to the small employer if:

(1) the majority of eligible employees of such small employer are employed in this state on the issue date or renewal date; or

(2) the primary business location of the small employer is in this state on the issue date or renewal date and no state contains a majority of the eligible employees of the small employer.

*§26.6. Status of Health Carriers as Small Employer Carriers and Geographic Service Area.*

(a) No later than December 15, 1993, 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, and this chapter. The required filing shall include certification form (Form Number **369** [2055] 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) After December 15, 1993, if a health carrier chooses to change 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 **369** [2055] CERT SEHC STATUS.

(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. The geographic service areas shall be defined in terms of counties or zip codes, to the extent possible, and shall be submitted in conjunction with any filing of a small employer health benefit plan. If the service area cannot be defined by counties or zip code, 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. Service areas by zip code shall be defined in a nondiscriminatory manner and in compliance with the Insurance Code, Articles **21.21-6** [21.21. §4], and Article **21.21-8** [21.21-5]. If the geographic service area of the carrier is the entire state, the carrier

shall define the service area as the state of Texas and no other definition is necessary.

(d)-(e) (No change.)

*§26.7. Requirement To Insure Entire Groups.*

(a) (No change. )

(b) If elected by the small employer, a small employer carrier may offer the eligible employees of a small employer the option of choosing among one or more health benefit plans, provided that each eligible employee may choose any of the plans offered. [If at least 40% of eligible employees elect additional coverage, as provided in §26.15 of this title (relating to Additional Coverage), each eligible employee shall have the option to choose such additional coverage.] Except as provided in the Insurance Code, Article 26.21 and Article 26.49 (with respect to exclusions for pre-existing conditions), the choice among benefit plans may not be limited, restricted, or conditioned based upon the risk characteristics of the eligible employees or their dependents.

(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 eligible employees and dependents of eligible employees as defined in the Insurance Code, Article 26.02. If the small employer carrier requires such list, then the 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. **A determination of eligibility shall be made within five days of receipt of any requested documentation.**

(d)-(f) (No change.)

(g) New entrants in a health benefit plan issued to a small employer group on or after September 1, 1993, shall be offered an opportunity to enroll in the health benefit plan currently held by such employer group or shall be offered an opportunity to enroll in the health benefit plan if the plan is provided through an individual franchise policy or more than one plan is available. If a small employer carrier has offered more than one health benefit plan to eligible employees of a small employer group pursuant to subsection (b) of this section, [or if 40% of the eligible employees of the small employer group have elected to receive additional coverage under §26.15 of this title (relating to Additional Coverage),] the new entrant shall be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the health carrier, provided that the period provided to enroll in the health benefit plan complies with subsection (h) of this section.

(h) 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 enrollment period extends at least **31** [30] days after the date the new entrant begins employment or if the waiting period exceeds **31** [30] days, the date the new entrant becomes eligible for coverage;

(2) the new entrant is notified of his or her opportunity to enroll at least **31** [30] days in advance of the last date enrollment is permitted; [and]

(3) 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 **and;** [.]

(4) **an open enrollment period of at least 31 days is provided on an annual basis.**

(i) A small employer carrier shall not apply a waiting period, **affiliation period,** elimination period, or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with the Insurance Code, Article 26.21 and Article 26.49), with respect to a new entrant, that is longer than 90 days. Any waiting period applied to a new entrant shall be based on the waiting period established by the small employer.

(j)-(m) (No change.)

(n) The opportunity to enroll shall meet the following requirements.

(1) (No change.)

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this section shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with subsection (k)[(j)] of this section.

(3)-(4) (No change.)

*§26.8. Guaranteed Issue; Contribution and Participation Requirements.*

**(a) A small employer carrier shall issue a health benefit plan to any small employer that elects to be covered under the plan and agrees to satisfy other requirements of the plan. A small employer carrier shall provide health benefit plans to small employers without regard to claim experience, health status or medical history.**

(b)[(a)] Health carriers may require small employers to answer questions designed to determine the level of contribution by the small employer, the number of eligible employees of the small employer, and the percentage of participation of eligible employees of the small employer.

(c)[(b)] **A health carrier may require an employer premium contribution for the plan selected by the employer for each eligible employee in accordance with the carrier's usual and customary practices for all employer group health insurance plans in the state.** [Health carriers shall require that small employers pay at least 75% of the premium for the plan selected by the employer for each eligible employee who elects to be covered by at least one of the small employer health benefit plans selected by the employer, in accordance with the Insurance Code, Article 26.21(b).]

**(1) The same premium contribution level shall be applied to each small employer offered or issued coverage by the small employer carrier.**

**(2) If two or more small employer carriers participate in a purchasing cooperative established under the Insurance Code, Article 26.14, the carrier may use the contribution requirement established by the purchasing cooperative for policies marketed by the cooperative.**

(3)[(1)] A health carrier shall treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due to failure of the small employer to meet a [the 75%] contribution requirement.

(4)[(2)] If a small employer fails to meet a [the 75%] contribution requirement for a small 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 26.23, 26.24, and 26.25.

(d)[(c)] Coverage under a small employer health benefit plan is available if at least **75%** [90%] of the eligible employees of a small employer elect to be covered, as provided in the Insurance Code, Article 26.21(b).

**(1) If a small employer makes available multiple health benefit plans to its employees, the collective enrollment of all of those plans must be at least 75% of the small employer's eligible employees or, if applicable, the lower participation level offered by the small employer carrier under subsection (e) of this section.**

**(2) A small employer carrier may elect not to offer health benefit plans to a small employer who offers multiple**

**health benefit plans if such plans are to be provided by more than one carrier and the carrier would have less than 75% of the small employer's eligible employees enrolled in the carrier's health benefit plan unless the coverage is provided through a purchasing cooperative.**

**(e)[(d)] A small employer carrier may offer small employer health benefit plans to a small employer even if less than 75% of the eligible employees of that employer elect to be covered if the small employer carrier permits the same percentage of participation as a qualifying percentage for each small employer benefit plan offered by that carrier in the state.**

**(f) A small employer carrier may offer small employer health benefit plans to a small employer even if the employer's percentage of participation is less than the small employer carrier's qualifying participation level established under subsection (e) of this section if the small employer carrier:**

**(1) obtains the written waiver required by §26.7(d) of this chapter; and**

**(2) accepts or rejects the entire group of eligible employees that choose to participate and excludes only those employees that have declined coverage. A carrier may not provide coverage under this subsection if the circumstances set out in §26.7(e) of this chapter apply and may not use this subsection to circumvent the guaranteed issue and other requirements of Insurance Code, Chapter 26 or this chapter.**

**(g)[(1)]** 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** [90% of the eligible employees of the small employer].

**(h)[(2)]** If a small employer fails to meet the **qualifying** [90%] participation requirement for a small employer health benefit plan, for a period of at least six consecutive months, the 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** [90%] 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** [90%] participation requirement and in accordance with the Insurance Code, Articles 26.23, 26.24, and 26.25.

**(i)[(d)]** In determining whether an employer has **the required percentage** of participation [by 90%] of [the] eligible employees, if **the percentage** [90%] of [the] eligible employees is not a whole number, the result of applying **the percentage** [90%] to the number of eligible employees shall be rounded down to the nearest whole number. [; the result shall represent 90% participation for purposes of compliance with such requirement.] For example: **75%** [90%] of five employees is **3.75** [4.5], so **3.75** [4.5] would be rounded down to **3** [4]; therefore, **75%** [90%] participation by a five employee group will be achieved if **3** [4] of the eligible employees participate.

*§26.9. Exclusions, Limitations, Waiting Periods, **Affiliation Periods** and Pre-existing 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(21), and §26. 4 of this title (relating to Definitions) shall comply with the following requirements. [All such plans issued to small employers on or after January 1, 1994, shall comply with these provisions; plans issued between September 1, 1993, and January 1, 1994, shall be amended to comply with these provisions on the first renewal date after January 1, 1994.]

(1) A small employer carrier shall not exclude any eligible employee or dependent (including a late enrollee, who would otherwise be covered under a small employer's health benefit plan), except to the extent permitted under the Insurance Code, Article 26.21(k)[(g)].

(2) (No change.)

(3) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the **32nd** [31st] day after the date of the birth of the child unless:

(A) (No change.)

(B) notification of the birth and any required additional premium are received by the small employer carrier not later than the **31st** [30th] day after the date of birth. A small employer carrier shall not terminate coverage of a newborn child if such carrier's billing cycle does not coincide with this **31-day** [30-day] premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of such premium.

(4) A late enrollee may be excluded from coverage **until the next annual open enrollment period and** [for 18 months from the date of application or] may be subject to a 12-month pre-existing condition provision as described by the Insurance Code, Article 26.49 [(b), (c), (d) and (e). If both a period of exclusion from coverage and a pre-existing condition provision are applicable to a late enrollee, the combined period of exclusion may not exceed 18 months from the date of the late application].

(5) A pre-existing condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition[:]

[(A)] for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the effective date of coverage. [; or

[(B) that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment during the six months before the effective date of coverage.]

(6) A pre-existing condition provision in a small employer health benefit plan shall not apply to an individual who was continuously covered for a minimum period of 12 months by a health benefit plan that was in effect up to a date not more than 60 days before the effective date of coverage under the small employer health benefit plan, **excluding any waiting period.**

(7)-(8) (No change.)

**(9) A carrier that does not use a pre-existing condition provision in any of its health benefit plans may impose an affiliation period in a small employer health benefit plan not to exceed 90 days for new entrants and not to exceed 180 days for late enrollees during which premiums are not collected and the issued coverage is not effective** [A pre-existing condition provision in a small employer health benefit plan may exclude coverage for a pregnancy existing on the effective date of the coverage, except as provided by paragraph (6) of this subsection.]

**(10) The imposition by a carrier of an affiliation period does not preclude application of any waiting period applicable to all new entrants under a health benefit plan; however, any affiliation period may not exceed 90 days and must be used in lieu of a pre-existing condition provision.**

**(11) An affiliation period provision in a small employer health benefit plan shall not apply to an individual who would not be subject to a pre-existing condition limitation in accordance with paragraphs (6) and (7) of this section.**

(b) (No change.)

*§26.10. Establishment of Classes of Business.*

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

**(c) A health carrier may not establish a separate class of business based on participation requirements or whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.**

*§26.11. Restrictions Relating to Premium Rates.*

(a)-(g) (No change.)

**(h) A HMO participating in a purchasing cooperative that provides employees of small employers a choice of benefit plans, that has established a separate class of business as provided by the Insurance Code, Article 26.31 and that has established a separate line of business as provided under the Insurance Code, Article 26.48(a) and 42 United States Code, §§300e et seq may use rating methods in accordance with this subchapter that are used by other small employer carriers participating in the same purchasing cooperative, including rating by age and gender. This subsection applies to all employer health benefit plans offered, issued or delivered for issue to small employers and their employees on or after September 1, 1995.**

*§26.13. Rules Related to Fair Marketing.*

(a) (No change.)

**(b) Each small employer that has expressed an interest in purchasing a small employer health benefit plan shall be given a written 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; limitations and exclusions and riders that must be offered. Small employer carriers other than HMOs may use form number 369 SUMM at Figure 41 of §26.27 of this title (relating to Appendix) 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)[(b)] 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** [at least] the **basic coverage benefit plan and the catastrophic care benefit plan** [preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier]. 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) a general description of the benefits contained in the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan, as applicable, and any other health benefit plan being offered to the small employer;]

**(1)**[(2)] information describing how the small employer may enroll in the plans; and

**(2)**[(3)] information set out in the Insurance Code, Article 26.40 **and §26.12 of this chapter.**

**(d)**[(c)] A small employer carrier shall provide a price quote to a small employer (directly or through an authorized agent) within ten working days of receiving a request for a quote and such information as is necessary to provide the 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 needed by the small employer carrier to provide the quote.

(e)[(d)] A small employer carrier, other than an HMO, shall not apply more stringent or detailed requirements related to the application process for the standard benefit plans, including the **basic coverage benefit plan and the catastrophic coverage benefit plan** [preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health 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** [standard benefit plans, including any preventive and primary care benefit plan and the standard health benefit plan,] than are applied for other health benefit plans offered by the HMO to small employers.

**(f)**[(e)] If a small employer carrier denies coverage under a health benefit plan to a small employer on **any basis** [the basis of a risk characteristic], 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). [The written denial shall be accompanied by a written explanation of the guaranteed availability of the small employer health benefit plans beginning in September, 1995, when guaranteed issue is required.]

**(g)**[(f)] 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.

**(h)**[(g)] 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.

**(i)**[(h)] 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.

**(j)** [(i)] 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, and this chapter. 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 [or on behalf of] a small employer; **and**

[(2) whether or not a covered individual is reimbursed, whether through wage adjustment or otherwise, by or on behalf of the small employer; and]

**(2)**[(3)] 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 Section 162 or Section 106 of the United States Internal Revenue Code of 1986 (26 United States Code,

§106 or §162).

(k)[(j)] If a **health** [small employer] carrier fails to comply with subsection (j) of this section, the **health** [small employer] carrier shall be deemed to be on notice of any information that could reasonably have been attained if the **health** [small employer] carrier had complied with subsection (i) of this section.

*§26.14. Coverage.*

(a) Until June 1, 1996 every small employer carrier, except HMOs, shall, as a condition of transacting business in this state with small employers, offer to small employers at least three standard benefit plans, including the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan, as provided under the Insurance Code, Articles 26 42-26.49, unless a small employer carrier elects to offer the two standard benefit plans prescribed by this chapter as amended. After June 1, 1996, every small employer carrier, except HMOs, shall, as a condition of transacting business in this state with small employers, offer to small employers two standard benefit plans, the basic coverage benefit plan and the catastrophic care benefit plan, as provided under the Insurance Code, Articles 26.42, 26.43, 26.44, 26.44A, 26.44B, 26.48, and 26.49.

(b) In addition to the standard benefit plans required to be offered to small employers as provided in the Insurance Code, Chapter 26, small employer carriers may, subject to the provisions of the Insurance Code, Article 26.42(c) , and this chapter, offer other health benefit plans to small employers, as provided in the Insurance Code, Article 26.42(c). Such other health benefit plans shall comply with all provisions of the Insurance Code, Chapter 26, and this chapter, except that provisions defining the specific benefits required under the required standard benefit plans are not applicable. The Insurance Code, Article 26.06(c), does not apply to a health benefit plan offered to a small employer as provided under the Insurance Code, Article 26.42(c).

(c) Instead of the standard benefit plans described by this chapter, a health maintenance organization may offer a state-approved health benefit plan that complies with the requirements of Title XIII, Public Health Service Act (42 United States Code, §§300e, et seq) and rules adopted under that Act. An HMO may also offer the prototype small employer group health benefit plan.

(d) All small employer health benefit plans provided by a small employer carrier other than an HMO shall provide an option for conversion/continuation which complies with all provisions of Chapter 3, Subchapter F of this title (relating to Group Health Insurance Mandatory Conversion Privilege). An HMO shall provide coverage for conversion or continuation of any small employer health benefit plan which complies with the requirements of §11.506(7) or (8) of this title (relating to Mandatory Provisions: Group and Non-group Agreement and Group Certificate).

(e) 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 the 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.

(f) Every small employer carrier providing health benefit plans to small employers is required to offer dependent coverage to each employee. Dependent coverage may be paid for by the employer, the employee, or both.

(g) This section contains requirements for optional prototype policy forms. The policy forms described in this subsection are adopted by reference to complete a prototype policy and/or certificate when combined with the required prescribed benefit prototype policy forms outlined in this section. The prototype policy forms have been developed to facilitate implementation of the Insurance Code, Chapter 26, and to streamline the policy approval process. Small employer carriers are encouraged to use all of the prototype policy forms as described in this subsection to expedite the approval process. Each form has a unique form number appearing in the lower left-hand corner and small employer carriers may use one or any number of the prototype forms. Alternate language, except for variables indicated by brackets, must be filed for review and approval under a different form number using 369 as part of the form number. Additional filing requirements are outlined in §26.19 of this title (relating to Filing Requirements).

(1) This paragraph describes policy face pages. The group policy face pages are described in this sub-paragraph. These prototype policies provide for the entire contract to include any applications, the certificate of insurance, and any attached riders. If the small employer carrier elects to use policies other than the prototype forms, this shell format shall be used with any small employer health benefit plan. Each policy face page, whether or not the prototype form is used, shall include the small employer carrier name and address; policyholder name (and industry, if used on a multiple employer trustee basis); policy number; policy effective date; provision for the entire contract to include applications, the certificate of insurance, and any attached riders; workers' compensation disclaimer notice; description of the policy in bold type as a small employer benefit plan; and the form number in the lower left hand corner. The policy face page for the prototype form shall contain the description of the plan in bold type as the Group Small Employer Basic Coverage Benefit Plan or the Group Small Employer Catastrophic Care Benefit Plan. The small employer carrier may include or omit the variable provision addressing the free look period. The group policy face pages for the prototype policies include the following:

(A) Group Small Employer Basic Coverage Benefit Plan (Form Number 369 SE.BASC) for a single employer policy;

(B) Group Small Employer Catastrophic Care Benefit Plan (Form Number 369 SE.CAT) for a single employer policy;

(C) Group Small Employer Basic Coverage Benefit Plan (Form Number 369 ASSN.BASC) for an association policy;

(D) Group Small Employer Catastrophic Care Benefit Plan (Form Number 369 ASSN.CAT) for an association policy;

(E) Group Small Employer Basic Coverage Benefit Plan (Form Number 369 MET.BASC) for a multiple employer trustee policy;

(F) Group Small Employer Catastrophic Care Benefit Plan (Form Number 369 MET.CAT) for a multiple employer trustee policy.

(2) The Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures Form (Form Number TOLLFREE) for group policies is described in this paragraph. This prototype form contains the language prescribed in §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the second or third page of the policy and the certificate of insurance. The variable provisions are optional only to the extent outlined in §1.601 of this title.

(3) The group certificate of insurance face page is described in this paragraph. Each certificate of insurance face page, whether or not the prototype form is

used, shall include the small employer carrier name and address; the certification provision; a provision that the certificate face page, all attached provisions, and any riders shall constitute the entire certificate of insurance; the workers' compensation disclaimer notice; a description of the plan in bold type as a small employer benefit plan; and the form number in the lower left hand corner. The certificate face page for the prototype form shall contain the description of the plan in bold type as the Group Small Employer Basic Coverage Benefit Plan or the Group Small Employer Catastrophic Care Benefit Plan. The identification information (Employee name, ID Number, Certificate Effective Date, Policyholder Name, Policy Number, Policy Effective Date, Dependent Coverage) is variable to the extent that small employer carriers may include all of the information in the certificate of insurance by any appropriate method, such as an insert or as a sticker on the face page or schedule of benefits or printed on the face page as provided in the prototype form. The dependent coverage information is variable for small employer carriers to insert a dependent coverage election. The variable replacement provision is an optional provision which carriers may include as provided in the prototype form or carriers may alter the language in any appropriate manner or may elect to omit the provision in its entirety. The group certificate of insurance face pages include the following:

(A) Certificate of Insurance Face Page for the Group Small Employer Basic Coverage Benefit Plan (Form Number 369 CERT.BASC);

(B) Certificate of Insurance Face Page for the Group Small Employer Catastrophic Care Benefit Plan (Form Number 369 CERT.CAT).

(4) The table of contents for group policies (Form Number 369 TCG) is described in this paragraph. The variable items shall be included or omitted as appropriate for the policy or certificate and page numbers shall be numbered accordingly. If the prototype table of contents is not used, the format and order shall be the same as provided in the prototype.

(5) The General Provisions Form for Group Policies (Form Number 369 GGP) may be used with all group small employer health benefit plans. If the prototype general provisions form is not used, each general provision with same or similar language shall be included in each policy/certificate. Variable language for the general provisions form are described as follows:

(A) The definition of an Eligible Employee under the Eligibility for Coverage (Employee Coverage) provision shall add that an "Eligible Employee also includes an Employee of an Employer member of an association" when the policy is to be issued to an association.

(B) The Initial Enrollment for New Eligible Employees provision under Effective Dates allows a variable for receipt of the application or enrollment form within 31 days of the:

(i) date of employment or

(ii) completion of any waiting period established by the small employer. The length of time for the waiting period is also variable to allow flexibility for small employers to elect a period of time not to exceed 90 days. The reference to Affiliation Period is variable to the extent that it shall be omitted if the small employer carrier uses a pre-existing condition limitation in any of its health benefit plans or if the small employer carrier does not require an affiliation period.

(C) The Newborn Children provision under Effective Dates allows a variable to be included if the small employer carrier requires a premium to be charged for the 31-day period of coverage if the insured person elects not be continue coverage for the newborn child. If no premium will be charged, this provision shall be omitted.

(D) The Late Enrollees provision under Effective Dates shall include one of the two variable provisions to reflect the small employer carrier's election of either a pre-existing condition limitation or an affiliation period. The time periods are variable to allow a shorter period of time, if elected by the small employer carrier.

(E) The Pre-existing Conditions provision is variable only to the extent that it shall be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time if elected by the small employer carrier.

(F) The Affiliation Period provision is variable only to the extent that it shall be omitted in its entirety if the small employer carrier uses a pre-existing condition limitation in any of its health benefit plans or if the small employer carrier does not require an affiliation period. The time period is variable to allow a shorter period of time if elected by the small employer carrier.

(G) The Eligible Employees provision under Termination of Insurance allows variables for continued coverage for an employee who is on an approved leave of absence for a specified period of time to be inserted if the provision remains. This provision shall be included or omitted as appropriate.

(H) The Eligible Employees and Dependents provisions under Termination of Insurance allow a variable to be included if the policy contains a grace period.

(I) The Eligible Employees and Dependents provisions under Termination of Insurance allow variables for coverage to end on either "the date the Employer terminates participation in the Trust" which may be included when the policy is to be issued to a multiple employer trust; or "the date the Employer member terminates membership in the Association" which may be included when the policy is to be issued to an association

(J) The Policyholder and Company provision under Termination of Insurance provides alternate provisions for termination by the Employer as Policyholder; termination by the Association as Policyholder; termination of participation by an Employer (member) under an Association policy, or termination of participation by an Employer under a Multiple Employer Trust policy. Provisions shall be included appropriately for a single employer policy, an association policy or a multiple employer trust policy.

(K) The Policyholder and Company provision under Termination of Insurance allows a variable to be included for the exception to nonpayment of premiums if a grace period is provided. If a grace period is not provided, the variable "Coverage will end at the end of the last period for which premium payment has been made to Us" shall be included. The policy shall contain a provision allowing for termination by the small employer carrier due to fraud or misrepresentation of a material fact by the "Policyholder or" Employer. The phrase "Policyholder or" shall be used when policies are issued to an association or to a multiple employer trust. A variable is allowed to be included if the small employer carrier will terminate the employer's plan for failure to maintain the required minimum participation requirements. A variable is allowed to be included if the small employer carrier will terminate the employer's plan due to failure of the employer to main-

tain status as a small employer as described in §26.5 of this title (Relating to Applicability and Scope).

(6) The Group Provisions Form (Form Number 369 GRP) may be used with all group small employer health benefit plans. If the prototype Group Provisions form is not used, each provision with the same or similar language shall be included in each policy/certificate. Variable provisions for the Group Provisions form include the following:

(A) A variable is provided in the Payment of Premiums provision for the mode of premium to be inserted.

(B) The Representations provision under Time Limit on Certain Defenses shall provide that statements made by the "Policyholder or" Employer shall be considered representations and not warranties and that the "Policyholder or" Employer shall be provided a copy of any statements used to non-renew coverage or adjust premiums. The phrase "Policyholder or" shall be used when policies are issued to an association or to a multiple employer trust.

(C) The Time Limit on Certain Defenses provision allows a variable for Pre-existing Conditions only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time if elected by the small employer carrier.

(D) The Payment to Assignee provision under Payment of Claims is variable only to the extent that Chapter 20 companies may substitute this provision for the alternate Assignment provision.

(E) The Grace Period provision is a variable to be included when a grace period is provided for the specified number of days as determined by the small employer carrier.

(F) Dividends, Right to Recovery/Clerical Error, and Subrogation provisions may be included, omitted, or modified by the small employer carrier. Right to Recovery/Clerical Error provisions shall be considered one provision for purposes of variability and both provisions shall be either included or omitted.

(7) Alternate Cost Containment Provisions for Large Case Management and Second Opinion Requirements (Form Number 369 ACC) are provided as optional provisions for all plans. Small employer carriers may use these provisions or modifications of these provisions. The reduction in Percentage Payable is variable but cannot be more than 50%. Other alternate cost containment provisions, including precertification, pre-authorization, case management and utilization review may be used. Penalties for noncompliance with cost containment provisions shall not reduce benefits more than 50% in the aggregate.

(h) Prescribed benefits are discussed in this subsection. No policy, subscriber contract or certificate shall be issued or delivered for issue in this state to a small employer by a small employer carrier as a Basic Coverage Benefit Plan or a Catastrophic Care Benefit Plan unless such policy, subscriber contract, or certificate contains the prescribed benefit provisions outlined in paragraphs (1)-(4) of this subsection.

(1) The Basic Coverage Benefit Plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets. A small employer carrier shall provide the benefits as described in the following subparagraphs (A) and/or (B) :

(A) The Schedule of Benefits (Non-PPO Plan) for the Basic Coverage Benefit Plan (Form Number 369 SCH.BASC) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A small employer carrier shall offer and make available to the small employer the Basic Coverage Benefit Plan with a Policy Year Deductible of $500 per Insured Person, a Policy Year Coinsurance Maximum of $3,000 per Insured Person and a Percentage Payable of 80%. The amounts are variable to allow the small employer carrier to offer other deductible, coinsurance maximum and percentage payable amounts but the Policy Year Deductible shall not exceed $1,000 per Insured Person, the Policy Year Coinsurance Maximum shall not exceed $5,000 per Insured Person and the Percentage Payable shall not be less than 70%.

(ii) The Schedule of Benefits shall reflect any benefits added by riders and any penalties for failing to comply with any precertification or cost containment provisions. Any such penalties shall not reduce benefits more than 50% in the aggregate.

(B) The Schedule of Benefits (PPO Plan) for the Basic Coverage Benefit Plan (Form Number 369 SCHPPO.BASC) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Office Visit Copayment" may be used in lieu of a Preferred Provider Policy Year Deductible. The deductible may be waived for either option.

(ii) If the small employer carrier elects to include preferred provider benefits, the carrier shall offer and make available to the small employer a Basic Coverage Benefit Plan with a Policy Year Deductible or Non-Preferred Provider Policy Year Deductible of $500 per Insured Person with a Preferred Provider Policy Year Deductible of $250 per Insured Person if a preferred provider deductible is chosen, a Policy Year Coinsurance Maximum of $3,000 per Insured Person and Percentages Payable of 90% for preferred providers and 70% for non-preferred providers. A Per Office Visit Copayment of $10 or $15 can be used in lieu of the Preferred Provider Policy Year Deductible.

(iii) Variability is permitted to allow the small employer carrier to offer other deductible, coinsurance maximum, and percentage payable amounts within the limits set out in the following subclauses:

(I) A variable amount not to exceed $1,000 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible amount shall not be less than one half of the Non-Preferred Provider Policy Year Deductible.

(II) In lieu of the Preferred Provider Policy Year Deductible, A Per Office Visit Copayment of $10 or $15 may be included for the preferred provider option for office visits. A carrier may use an office copayment in combination with a preferred provider policy year deductible which is applicable to other services.

(III) A variable amount not to exceed $5,000 for the Policy Year Coinsurance Maximum may be elected by the small employer carrier or offered as an option to the small employer. The preferred provider and non-preferred

provider amounts shall be combined for the Policy Year Coinsurance Maximum. Office visit copayments are not required to be included in the calculation of coinsurance maximums.

(IV) A variable Percentage Payable of not less than 60% when non-preferred providers are utilized may be elected by the small employer carrier or offered as an option to the small employer. A variable Percentage Payable when preferred providers are utilized may not be more than 30% greater than the Percentage Payable for non-preferred providers as required by §3.3704(1) of this title (relating to Preferred Provider Plans).

(iv) The Schedule of Benefits shall reflect any benefits added by riders and any penalties for failing to comply with any precertification or cost containment provisions. Any such penalties shall not reduce benefits more than 50% in the aggregate.

(C) The Policy Definitions for the Basic Coverage Benefit Plan (Form Number 369 DEF. BASC) shall be in the language and format prescribed.

(i) The term and definition "Affiliation Period" is variable to be included or omitted as appropriate. An Affiliation Period shall be omitted if the small employer carrier uses a pre-existing condition limitation in any of its health benefit plans or if the small employer carrier does not require an Affiliation Period.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variables to be included by Chapter 20 companies only and neither provision shall be used by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provides a variable to include an Employer member of an association when a policy is to be issued to an association.

(iv) The term and definition of "Hospital" is variable only to allow for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory rights, such as Chapter 20 companies.

(v) The alternate language in the definition of "Initial Enrollment Period" is included for use in a policy that contains a waiting period.

(vi) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices. The definition as selected shall be included in the policy/certificate.

(vii) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(viii) The term and definition of "Pre-existing Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, the provision shall be included in its entirety. The time period is variable to allow a shorter period of time to be elected by the small employer carrier or offered as an option to the small employer.

(ix) The term and definition of "Waiting Period" is variable only to the extent that it may be omitted in its entirety if the small employer elects not to impose a waiting period.

(D) The Benefits Provided for the Basic Coverage Benefit Plan (Form Number 369 BEN.BASC) shall be in the language and format prescribed. The Policy Year Coinsurance Maximum amount elected shall be inserted in this provision. Services provided by first assistant at surgery may be included as a covered service if elected by the small employer carrier or offered as an option to the small employer.

(E) The Exclusions and Limitations for the Basic Coverage Benefit Plan (Form Number 369 EXC.BASC) shall be in the language and format prescribed. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and shall be included in the exclusions and limitations of the policy and the certificate. Other variable exclusions may be included by Chapter 20 companies for their Non-PPO products only.

(2) The Catastrophic Care Benefit Plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets. A small employer carrier shall provide the benefits as described in the following subparagraphs (A) and/or (B):

(A) The Schedule of Benefits (Non-PPO Plan) for the Catastrophic Care Benefit Plan (Form Number 369 SCH.CAT) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A small employer carrier shall offer and make available to the small employer Catastrophic Care Benefit Plans with each of the coverage options described in subclauses (I)-(IV) as follows:

(I) A Policy Year Deductible in the amount of $2,500 per Insured Person with a Policy Year Coinsurance Maximum of $5,000 per Insured Person and a Percentage Payable of 80%.

(II) A Policy Year Deductible in the amount of $2,500 per Insured Person with a Policy Year Coinsurance Maximum of $5,000 per Insured Person and a Percentage Payable of 90%.

(III) A Policy Year Deductible in the amount of $5,000 per Insured Person with a Policy Year Coinsurance Maximum of $10,000 and a Percentage Payable of 80%.

(IV) A Policy Year Deductible in the amount of $5,000 per Insured Person with a Policy Year Coinsurance Maximum of $10,000 and a Percentage Payable of 90%.

(ii) Variability is permitted to allow the small employer carrier to offer additional deductible, coinsurance maximum and percentage payable amounts; but the Policy Year Deductible shall not exceed $5, 000 per Insured Person, the Policy Year Coinsurance Maximum shall not exceed $10,000 per Insured Person and the Percentage Payable shall not be less than 70%.

(iii) The Schedule of Benefits shall reflect any benefits added by riders and any penalties for failing to comply with any precertification or cost containment provisions. Any such penalties shall not reduce benefits more than 50% in the aggregate.

(B) The Schedule of Benefits (PPO Plan) for the Catastrophic Care Benefit Plan (Form Number 369 SCHPPO.CAT) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles

will apply

(ii) If the small employer carrier elects to include preferred provider benefits, the carrier shall offer and make available to the small employer the Catastrophic Care Benefit Plan with all of the coverage options described in subclauses (I) and (II) as follows:

(I) A Policy Year Deductible or a Non-Preferred Provider Policy Year Deductible of $2,500 per Insured Person with a Preferred Provider Policy Year Deductible of $1,250 per Insured Person if a preferred provider deductible is chosen and a Policy Year Coinsurance Maximum of $5,000 per Insured Person. Percentages Payable shall be offered at each of the following levels: 80% for preferred providers with 60% for non-preferred providers, and 90% for preferred providers and 70% for non-preferred providers.

(II) A Policy Year Deductible or a Non-Preferred Provider Policy Year Deductible of $5,000 per Insured Person, a Preferred Provider Policy Year Deductible of $2,500 per Insured Person if a preferred provider deductible is chosen, and a Policy Year Coinsurance Maximum of $10,000 per Insured Person. Percentages Payable shall be offered at each of the following levels: 80% for preferred providers with 60% for non-preferred providers, and 90% for preferred providers and 70% for non-preferred providers.

(iii) Variability is permitted to allow the small employer carrier to offer other deductible, coinsurance maximum and percentage payable amounts within the limits set out in the following paragraphs.

(iv) A variable amount not to exceed $10,000 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible shall not be less than one half of the Non-Preferred Provider Policy Year Deductible.

(v) A variable amount not to exceed $15,000 for the Policy Year Coinsurance Maximum may be elected by the small employer carrier or offered as an option to the small employer. The preferred provider and non-preferred provider amounts shall be combined for the Policy Year Coinsurance Maximum.

(vi) A variable Percentage Payable of not less than 60% when non-preferred providers are utilized may be elected by the small employer carrier or offered as an option to the small employer. A variable Percentage Payable when preferred providers are utilized may not be more than 30% greater than the Percentage Payable for non-preferred providers as required by §3.3704(1) of this title (relating to Preferred Provider Plans).

(vii) The Schedule of Benefits shall reflect any benefits added by riders and any penalties for failing to comply with any precertification or cost containment provisions. Any such penalties shall not reduce benefits more than 50% in the aggregate.

(C) The Policy Definitions for the Catastrophic Care Benefit Plan (Form Number 369 DEF. CAT) shall be in the language and format prescribed.

(i) The term and definition "Affiliation Period" is variable to be included or omitted as appropriate. An Affiliation Period shall be omitted if the small employer carrier uses a pre-existing condition limitation in any of its health benefit plans or if the small employer carrier does not require an Affiliation Period.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variables to be included by Chapter 20 companies only and neither provision shall be used by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provides a variable to include an Employer member of an association when a policy is to be issued to an association.

(iv) The term and definition of "Hospital" is variable only to allow for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory rights, such as Chapter 20 companies.

(v) The alternate language in the definition of "Initial Enrollment Period" is included for use in a policy that contains a waiting period.

(vi) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices. The definition as selected shall be included in the policy/certificate.

(vii) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Association or the Trustee of a Multiple Employer Trust.

(viii) The term and definition of "Pre-existing Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, the provision shall be included in its entirety. The time period is variable to allow a shorter period of time to be elected by the small employer carrier or offered as an option to the small employer.

(ix) The term and definition of "Waiting Period" is variable only to the extent that it shall be omitted in its entirety if the small employer elects not to impose a waiting period.

(D) The Benefits Provided for the Catastrophic Care Benefit Plan (Form Number 369 BEN.CAT) shall be in the language and format prescribed. The Policy Year Coinsurance Maximum amount shall be inserted in this provision. Services provided by first assistant at surgery may be included as a covered service if elected by the small employer carrier or offered as an option to the small employer.

(E) The Exclusions and Limitations for the Catastrophic Care Benefit Plan (Form Number 369 EXC.CAT) shall be in the language and format prescribed. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and shall be included in the exclusions and limitations of the policy and the certificate. Other variable exclusions may be included by Chapter 20 companies for their Non-PPO products only.

(3) Riders are discussed in this paragraph. The small employer carrier shall offer and make available to the small employer the riders described in subparagraphs (A)-(D) of this paragraph. Any benefits added by riders shall be reflected on the Schedule of Benefits.

(A) The Alcohol and Drug Abuse Benefit Rider (Form Number 369 ADB) is required to be offered with the Basic Coverage Benefit Plan and the Catastrophic Care Benefit Plan. Variable amounts of five or ten days of care per Insured Person per Policy Year are allowed to be elected by the small employer carrier or offered as an option to the small employer. The coinsurance and deductible amounts are variable.

(B) The Mental Health Benefit Rider (Form Number 369 MHB) is required to be offered with the Basic Coverage Benefit Plan and the Catastrophic Care Benefit Plan. The 30 days of inpatient benefits and the 20 outpatient treatments per Insured Person per Policy Year are variable to allow longer periods of time to be elected by the small employer carrier or offered as an option to the small employer. The coin-

surance and deductible amounts are variable.

(C) The Prescription Drug Benefit Rider (Form Number 369 RX) is required to be offered with the Basic Coverage Benefit Plan and the Catastrophic Care Benefit Plan. Benefits shall be provided at a Percentage Payable of at least 50% but may be provided at a greater Percentage Payable to be elected by the small employer carrier or offered as an option to the small employer. In the alternative the small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a copayment not to exceed $8.00 per prescription or refill for a generic drug, or name brand drug if less than the generic drug, and $12 per prescription or refill for a name brand drug. Exclusions of a prescription drug card program shall not be more restrictive than the exclusions contained in Form Number 369 RX.

(D) The Preventive Care Benefit Rider (Form Number 369 PCR) is required to be offered with the Basic Coverage Benefit Plan. The coinsurance and deductible amounts are variable.

(E) Additional riders may be offered as elected by the small employer carrier. Any such riders must be filed in accordance with Subchapter A of Chapter 3 of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, and Endorsements for Life, Accident and Health Insurance and Annuities).

(4) Forms common to more than one health benefit plan are described in subparagraphs (A)-(C) of this paragraph and shall be included with the benefit provisions of each plan as specified.

(A) The Continuation/Conversion Provisions (Form Number 369 CONV) shall be included with all group plans. This form shall be in the language and format prescribed in accordance with Subchapter F of Chapter 3 of this title (relating to Group Health Insurance Mandatory Conversion Privilege). The small employer carrier shall include one of the variable provisions for continuation upon policy termination.

(B) The Coordination of Benefits (Form Number 369 COB) shall be included with all plans. This form shall be in the language and format prescribed. The variable insert language "This provision will only apply for the duration of your employment with the Employer" is required to be included in the individual policies.

(C) The Preferred Provider Provisions (PPO) (Form Number 369 PPO) shall be included with all plans when preferred provider options are included. This form shall be in the language and format prescribed. Additional provisions may be added as necessary to disclose preferred provider information.

(i) Variable provisions are allowed for the definition of service area to be in terms of counties, zip codes, in terms of a 50 mile radius from the employee's principal place of employment unless there are no providers located within the 50 mile radius, or the service area may be described in a specific document to be referenced in the policy/certificate provision. Service areas by zip codes shall be defined in a non-discriminatory manner and in compliance with Insurance Code, Articles 21.21, §4 and 21.21-6. Service area definitions and descriptions shall be filed with the form filings. The small employer carrier shall obtain approval for any definition of the service area by counties or zip codes where the grouping of counties or zip codes exceed a 50 mile radius from the principal place of employment or for a different definition of a service area.

(ii) Except as provided in §26.21 of this title (relating to Cost Containment) preferred provider arrangements shall comply with Subchapter X of Chapter 3 of this title (relating to Preferred Provider Plans).

(5) Applications are discussed in this paragraph. The Texas Small Employer Group Health Benefit Plan Master Application (Form Number 369 APP) may be used by small employer carriers. Small employer carriers may use any appropriate application, enrollment or participation agreement forms in lieu of this form.

(6) The Compliance Rider for HB369 (Form Number 369 END) may be used as a guide for carriers to bring existing policies into compliance with the requirements of these regulations. Because of the differences in small employer health benefit plans, the compliance rider provisions may not be all encompassing and carriers should amend the rider as needed to achieve compliance with these rules and with the provisions of Chapter 26, Texas Insurance Code. Any variability that was previously discussed in these rules regarding the prototype policies shall be addressed accordingly in this rider.

(7) Individual small employer benefit plans are discussed in this paragraph. Although individual prototype policies were not developed, carriers must develop their own individual small employer policies using the rules for the group small employer prototype forms, amended as necessary to comply with the statutes and regulations pertaining to individual accident and sickness insurance. Prescribed components include the Benefits, Definitions, and Exclusions and Limitations provisions as set out in paragraphs (1)-(4) of this subsection. All forms must be filed with the Department in accordance with Subchapter A of Chapter 3 of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, and Endorsements for Life, Accident and Health Insurance and Annuities).

(i) The HMO forms are as follows:

(1) Prototype contract/certificate of coverage and benefit plans have been developed to facilitate implementation of the Insurance Code, Chapter 26, and to streamline the contract approval process. The required benefit language is provided in the prototype Texas Small Employer Group Health Benefit Plan (Form Numbers 369 HMO-GRP CONT, Contract and Certificate of Coverage; 369 HMO-APP, Group Application; 369 HMO-SCHB, Schedule of Benefits; 369 HMO-RX, Prescription Drugs Benefit Rider; 369 HMO-DAA, Drug and Alcohol Abuse Benefit Rider; 369 HMO-INF, Infertility Benefit Rider; 369 HMO-MHMR, Mental Health Benefit Rider). Variable provisions in these forms are denoted in brackets. HMOs may use various options in accordance with the bracketed provisions. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be in the contract/certificate of coverage in the Exclusions contract provision.

(2) The prototype contracts/certificates of coverage provide for the entire contract to include an application, schedule of benefits, and any attached riders.

(3) If the HMO elects to be a small employer carrier and offers a health benefit plan other than the prototype benefit plan, that plan must be a state approved health benefit plan that complies with the requirements of Title XIII, Public Health Service Act (42 United States Code, §§300 et seq) and the rules adopted under the Act. The following content format shall be used:
A. CONTRACT FACE PAGE This page shall contain the name, address and telephone numbers (800 number, if applicable) of the health maintenance organization. This prototype contract shall be entitled: Texas Small Employer Group Health Benefit Plan Contract/Certificate of coverage The attached benefit plan shall be entitled: Texas Small Employer Group Health Benefit
Plan B. TOLL-FREE NUMBER PAGE This form must contain the language prescribed in §1.601 of Chapter 1 of this title (relating to Notice of Toll-free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the

first, second or third page of the contact. C. CONTRACT PROVISIONS At a minimum, the contract must contain the following provisions:
1. Face Page
2. Benefits
3. Cancellation
4. Claim filing procedure
5. Complaint procedure
6. Conformity with state law
7. Continuation of coverage for certain dependents
8. Conversion privilege
9. Coordination of Benefits
10. Definitions
11. Effective date
12. Eligibility
13. Emergency services
14. Entire contract provisions
15. Exclusions and limitations
16. Grace period
17. Incontestability
18. Schedule of charges
19. Service area
20. Subrogation
21. Termination
D. ORDERS Riders allowing for additional benefits may be attached to the state approved health benefit plan and to the Texas Small Employer Group Health Benefit Plan.

*§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, except for:

(1) nonpayment of a premium as required by the terms of the plan;

(2) fraud or misrepresentation of a material fact by the small employer; or

(3) noncompliance with small employer health benefit plan provisions. Small employer benefit plan [Such] provisions may address requirements such as the level of contribution and participation and failure of an employer to maintain status as a small employer subject to requirements of this chapter. Noncompliance with a small employer health benefit plan with respect to an HMO also includes those items set forth in §11.506(4)(A) of this title (relating to Mandatory Provisions: Group and Nongroup Agreement and Group Certificate). On or after September 1, 1995, a misrepresentation of a material fact shall not include any misrepresentation related to health status, unless it is a fraudulent misrepresentation made by the small employer during the initial application for coverage.

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or misrepresentation of a material fact by that individual. 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, a misrepresentation of a material fact shall not include any misrepresentation related to health status, unless it is a fraudulent misrepresentation made by an eligible employee or dependent during the initial application for coverage.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under the Insurance Code, Article 26.23(a), and subsections (a) and (b) of this section. A small employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under the Insurance Code, Article 26.23(b), and subsections (a) and (b) of this section.

(d) Standard benefit plans, provided through an individual policy, shall be guaranteed renewable for life or until maximum benefits have been paid. 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 chapter, 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 chapter.

*§26.16. Refusal To Renew and Application To Reenter Small Employer Market.*

(a) A small employer carrier may elect to refuse to renew each small employer health benefit plan delivered or issued for delivery by the small employer carrier in this state or in a geographic service area approved under the Insurance Code, Article 26.22. The small employer carrier must notify the commissioner of the election not later than the 180th day before the date coverage under the first small employer health benefit plan terminates under the Insurance Code, Article 26.24(a).

(b) The small employer carrier must notify each affected covered small employer not later than the 180th day before the date on which coverage terminates for that small employer.

(c) A small employer carrier that elects under the Insurance Code, Article 26.24(a), to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date of notice to the commissioner under the Insurance Code, Article 26.24(a).

(d) A small employer carrier that elects not to renew under the Insurance Code, Article 26.24, and this section may not resume offering health benefit plans to small employers in this state or in the geographic area for which the election was made until it has filed a petition with the commissioner to be reinstated as a small employer carrier and the petition has been approved by the commissioner or the commissioner's designee. In reviewing the petition, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

*§26.17. Notice to Covered Persons.* Not later than the 30th day before the date on which termination of coverage is effective, a small employer carrier that cancels or refuses to renew coverage under a small employer health benefit plan under the Insurance Code, Articles 25.23 and 26. 24, shall notify the small employer of the cancellation or refusal to renew. It is the responsibility of the small employer to notify enrollees of the cancellation or refusal to renew the coverage. This notice is in addition to the notice required under the Insurance Code, Article 26.24(b), and §26.16 of this title (relating to Refusal To Renew and Application To Reenter Small Employer Market).

*§26.18. Election and Application to be Risk-Assuming or Reinsured Carrier.*

(a) Each small employer carrier shall file with the commissioner notification of whether the carrier elects to operate as a risk-assuming or a reinsured carrier. The required filing shall use the form provided at Figure 42 of §26.27 of this title (relating to Appendix) (Form Number 369 RISK) for 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 (Form Number 369 RISK) and shall provide information demonstrating good cause why the carrier should be allowed to change its status.

(c) A small employer 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 of this title (relating to Appendix) (Form Number 369 RISK) shall

accompany each application.

*§26.19. Filing Requirements.*

(a) Each 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 Requirements for 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(4) of this title (relating to Filing Requirements) or §11.302(6) of this title (relating to Service Area Expansion Requests), as applicable, except as provided in subsection (b) of this section. A 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. The form provided at Figure 43 of §26.27 **of this title (relating to Appendix)** [of these sections] (Form 369 [2055] CERT ANN LIST-OTHER/SEHBP) 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.

(b) The following certification forms providing information relating to prototype policy forms, marketing in the small employer market and/or other markets, and geographic service areas shall accompany each health benefit plan form filing submitted for use in the small employer market.

(1) A geographic service area certification (Form Number 369 [2055] 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.

(A)-(B) (No change.)

(2) A prototype certification form (Form Number 369 [2055] CERT PROTOTYPES/MRKT) shall accompany each policy form filing and/or certification filing. **A small employer carrier other than an HMO shall complete the** [The] certification form **indicating** [shall]:

(A) **which of the** [state whether the carrier plans to use] prototype policy forms will be used ;

(B) **alternate forms which will be used, where permitted, and their Flesch score.** [specify the prototype forms, if any, that the health carrier plans to use in the small employer market.[; and]

[(C) specify, describe, and explain any variance contained in the forms being filed from the provisions contained in the prototype forms.] 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)[(D)] 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. [The certification form shall also specify whether the carrier will be marketing the form in geographic services areas previously submitted or will be marketing in new geographic service areas. If marketing in new geographic service areas, the filing shall include the certification (Form Number 2055 CERT GEOG) which defines the new geographic service areas.]

**(D) the type of group filing, if applicable;**

**(E) the small employer carrier's required participation amount; 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 and status as a small employer (for group); election of Policy Year definition, Prescription Drug Benefit Rider or Prescription Drug Card Program, Affiliation period or preexisting condition Limitation provision including the time period for the affiliation period or the preexisting limitation; description of PPO service area, if applicable; 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.**

**(3) A prototype certification form (Form 369 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 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)-(6) (No change.)

(7) for the standard benefit forms, which include the **Basic Coverage Benefit Plan and the Catastrophic Care Benefit Plan** [Preventive and Primary Care Benefit Plan, the In-Hospital Benefit Plan, and the Standard Health 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;

(8)-(13) (No change.)

(14) the rate schedule applicable to any individual health benefit plan, as required by **Subchapter A of Chapter 3** [§3.3(d)] of this title (relating to Specific Additional Submission Requirements).

(d) (No change.)

*§26.20. Reporting Requirements.*

[(a) Not later than November 1, 1993, each health carrier subject to the Insurance Code, Chapter 26, shall file a report with the commissioner that states the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers in 1992.

[(b) Each health carrier, subject to the Insurance Code, Chapter 26, shall file a report with the commissioner that states the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers:

[(1) for the period of January 1994 through March 1994, not later than May 15, 1994;

[(2) for the period of April 1994 through June 1994, not later than August 15, 1994;

[(3) for the period of July 1994 through September 1994, not later than November 15, 1994; and

[(4) for the period of October 1994 through December 1994, not later than March 15, 1995.

[(c) Not later than November 1, 1994, each health carrier subject to the Insurance Code, Chapter 26, shall file with the commissioner an update to the report required by subsection (a) of this section.

[(d) For purposes of the reports required under subsections (a), (b), and (c) of this section, 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. Reports under subsections (a)-(c) of this section shall be filed on Form Number 2055 CERT GROSS PREM.]

(a)[(e)] 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 **369 CERT ACTUARIAL** [(Cert 2055 Actuarial)] stating that the underwriting and rating methods of the small employer carrier:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with the provisions of the Insurance Code, Chapter 26, and this chapter.

(b)[(f)] Not later than March 1 of each calendar year, each health carrier shall file a certification **369 CERT ANN LIST-OTHER/SEHBP** [(Cert 2055 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, and this chapter 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 (Form Number 369 [2055] 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.

(c)[(g)] Not later than March 1 of each calendar year, a small employer carrier shall file with the commissioner Form Number 369[2055] CERT DATA, 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 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 the preventive and primary care benefit plan, the in-hospital benefit plan, [and] the standard health benefit plan, **basic coverage benefit plan, catastrophic care benefit plan, HMO preventive and primary care benefit plan, HMO group standard benefit plan and HMO small employer group health benefit plan** in the previous calendar year (separated as to newly issued plans and renewals and to class of business);

(3) the number of small employers that were issued and the number of lives that were covered under a prescription drug rider with the preventive and primary care benefit plan, [and] 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 (separately listed as to newly issued plans and renewals, 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;[and]

(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.**

*§26.21. Cost Containment.*

(a) (No change.)

(b) Health carriers, other than HMOs, utilizing restricted network arrangements shall establish reasonable benefit differentials between participating and nonparticipating providers. A reasonable benefit differential will be considered to exist if the plan complies with the provisions of Chapter 3, Subchapter X of this title (relating to Preferred Provider Plans). For purposes of complying with the cost containment permitted by the Insurance Code, Article 26.08, and this section, health carriers may limit participation in any participating provider network to a selected number of providers of each particular type recognized under the Insurance Code, Articles 20.11, 21.52, and 21.53, but must comply with those articles. This selective contracting for the purposes of complying with the Insurance Code, Article 26.08, and this section shall not be considered a violation of Chapter 3, Subchapter X of this title.

Health carriers may not restrict the participating provider network for pharmacists covered by the Insurance Code, Article 21.52B, and must comply with that article. HMOs are not subject to Chapter 3, Subchapter X of this title [or the Insurance Code, Article 21.52B].

*§26.22. Private Purchasing Cooperatives.*

(a) Two or more small employers may form a cooperative for the purchase of small employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-profit Corporation Act, Texas Civil Statutes, Article 1396-1.01, et seq.

**(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 Group, Mail Code 106-1D, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.**

(c)[(b)] 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 on Form 369 [2055] CERT COOP and shall be mailed to the Life/Health Group, Mail Code 106-1D, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

*§26.27. Appendix.*

(a) The forms adopted and incorporated in §26.2 of this title (relating to Forms Adopted and Incorporated by Reference) are included in the appendix to these sections. The following index refers to the form number, its description, and the figure number in the appendix.
Figure NO. 1: 28 TAC §26.27(a)

(b) Figures No. 1-49: 28 TAC §26.27(b)
Figure NO. 1: 28 TAC §26.27(b)
Figure NO. 2: 28 TAC §26.27(b)
Figure NO. 3: 28 TAC §26.27(b)
Figure NO. 4: 28 TAC §26.27(b)
Figure NO. 5: 28 TAC §26.27(b)
Figure NO. 6: 28 TAC §26.27(b)
Figure NO. 7: 28 TAC §26.27(b)
Figure NO. 8: 28 TAC §26.27(b)
Figure NO. 9: 28 TAC §26.27(b)
Figure NO. 10: 28 TAC §26.27(b)
Figure NO. 11: 28 TAC §26.27(b)
Figure NO. 12: 28 TAC §26.27(b)
Figure NO. 13: 28 TAC §26.27(b)
Figure NO. 14: 28 TAC §26.27(b)
Figure NO. 15: 28 TAC §26.27(b)
Figure NO. 16: 28 TAC §26.27(b)
Figure NO. 17: 28 TAC §26.27(b)
Figure NO. 18: 28 TAC §26.27(b)
Figure NO. 19: 28 TAC §26.27(b)
Figure NO. 20: 28 TAC §26.27(b)
Figure NO. 21: 28 TAC §26.27(b)
Figure NO. 22: 28 TAC §26.27(b)
Figure NO. 23: 28 TAC §26.27(b)
Figure NO. 24: 28 TAC §26.27(b)
Figure NO. 25: 28 TAC §26.27(b)
Figure NO. 26: 28 TAC §26.27(b)
Figure NO. 27: 28 TAC §26.27(b)
Figure NO. 28: 28 TAC §26.27(b)
Figure NO. 29: 28 TAC §26.27(b)
Figure NO. 30: 28 TAC §26.27(b)
Figure NO. 31: 28 TAC §26.27(b)
Figure NO. 32: 28 TAC §26.27(b)
Figure NO. 33: 28 TAC §26.27(b)
Figure NO. 34: 28 TAC §26.27(b)
Figure NO. 35: 28 TAC §26.27(b)
Figure NO. 36: 28 TAC §26.27(b)
Figure NO. 37: 28 TAC §26.27(b)
Figure NO. 38: 28 TAC §26.27(b)
Figure NO. 39: 28 TAC §26.27(b)
Figure NO. 40: 28 TAC §26.27(b)
Figure NO. 41: 28 TAC §26.27(b)
Figure NO. 42: 28 TAC §26.27(b)
Figure NO. 43: 28 TAC §26.27(b)
Figure NO. 44: 28 TAC §26.27(b)
Figure NO. 45: 28 TAC §26.27(b)
Figure NO. 46: 28 TAC §26.27(b)
Figure NO. 47: 28 TAC §26.27(b)
Figure NO. 48: 28 TAC §26.27(b)
Figure NO. 49: 28 TAC §26.27(b)

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514883 Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Earliest possible date of adoption: December 22, 1995

For further information, please call: (512) 463-6327

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## Chapter 26. Small Employer Health Insurance Availability Act Regulation

### • 28 TAC §§26.14-26.18, 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 §§26.14-26.18 and §26.27, concerning small employer health benefit plans. Section 26.14 and §26.27, concerning the coverage for standard benefit plans and the prototype standard benefit plans required to be offered by small employer carriers to small employers as a condition of transacting business in the state. Repeal of the sections are necessary because new §26.14 establishes coverage requirements for the standard benefit plans and new §26.27 is an appendix which contains the prototype standard benefits plans and other forms to be used by small employer carriers. The new sections published elsewhere in the issue of the *Texas Register* will revise, replace and/or supersede existing §26.14 and §26.27 and will implement legislation amending Insurance Code Chapter 26 enacted by the 74th Legislature in House Bill 369 relating to the operation and funding of small employer health benefit plans. Section 26.15 allows employees eligible for coverage under a small employer health benefit plan to obtain additional optional coverage if certain requirements are met. The repeal of this section is necessary to implement provisions of House Bill 369 which deleted the optional coverage provisions from Insurance Code, Article 26.21. Sections 26.16, 26.17, and 26.18 concern renewability of coverage and cancellation, refusal to renew coverage and application to reenter the small employer market after refusal to renew coverage and notice to covered persons of cancellation or refusal to renew coverage. The repeal of these sections is necessary because new §26.15 sets forth requirements concerning renewability of coverage and cancellation; new §26.16 contains provisions concerning refusal to renew coverage and application to reenter the small employer market; new §26.17 establishes requirements concerning notice of termination which must be given to covered persons and new §26.18 sets forth procedures for filing an election or application to be a risk-assuming or reinsured carrier. Simultaneous to this proposed repeal, proposed new §§26.14-26.18 and §26.27 are published elsewhere in this issue of the *Texas Register*. The purpose and objective of the proposed new sections is to specify the coverage requirements for the new standard benefit plans; to make these standard benefit plans available to small employer carriers and small employers; to establish procedures for or limitations on renewability of coverage and cancellation, refusal to renew coverage, application to reenter the small employer market, notice of cancellation or refusal to renew coverage, application to be a risk-assuming or reinsured carrier and to implement legislation from the 74th legislative session in House Bill 369 amending Insurance Code Chapter 26.

Tyrette P. Hamilton, Acting Deputy Commissioner for the Life/Health Group of the Texas Department of Insurance, has determined that for the first five-year period the repeals are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the repeals.

Ms. Hamilton also has determined that for each year of the first five years the repeals are in effect the public benefit anticipated as a result of administration and enforcement of the repeals will be the increased availability and affordability of health benefit plans to

small employers and their employees and dependents as a result of revised standard benefit plans. There is no anticipated difference in cost of compliance between small and large businesses. There is no anticipated economic cost to persons who are required to comply with the proposed repeals.

Comments on the proposal must be submitted within 30 days after publication of the proposed sections in the *Texas Register* to Alicia M. Fechtel, 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 submitted to Tyrette P. Hamilton, Acting Deputy Commissioner, Life/Health Group, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104.

Repeal of §§26.14, 26.15, 26.16, 26.17, 26.18, and 26.27 is proposed pursuant to the Insurance Code, Chapter 26 and Insurance Code, Article 1.03A, and the Government Code, §2001.004, et seq (Administrative Procedures Act). The Insurance Code, Chapter 26, establishes the requirements for small employer health plans including, but not limited to, standard benefit plans as adopted by the commissioner and required to be offered by small employer carriers to small employers. Insurance Code, Article 26.04, authorizes the commission to adopt rules to implement Chapter 26. Article 1.03A authorizes the commissioner of insurance to promulgate and adopt rules and regulations for the conduct and execution of the duties and functions by the department. The Government Code, §2001.004, et seq, authorizes and requires each state agency to adopt rules of practice stating the nature and requirements of all available formal and informal procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The proposed repeals affect the regulation pursuant to the following statutes: The Insurance Code, Chapter 26.

*§26.14. Coverage.*

*§26.15. Additional Coverage.*

*§26.16. Renewability of Coverage and Cancellation.*

*§26.17. Refusal to Renew and Application to Reenter Small Employer Market.*

*§>26.18. Notice to Covered Persons.*

*§26.27. Appendix.*

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

Issued in Austin, Texas, on November 15, 1995.

TRD-9514866 Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Earliest possible date of adoption: December 22, 1995

For further information, please call: (512) 463-6327

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# Part II. Texas Workers' Compensation Commission

## Chapter 125. Education and Training of Ombudsmen

### • 28 TAC §§125.1-125.3

The Texas Workers' Compensation Commission (the commission) proposes new §§125.1-125.3, concerning education and training of ombudsmen, in a new Chapter 125, entitled "Education and Training of Ombudsmen". The new rules are proposed to establish training guidelines and continuing education requirements for commission ombudsmen.

Recent legislation (House Bill 1089, 74th Legislature, 1995) amended the Texas Labor Code, §409.042 to add eligibility requirements for designation as a commission ombudsman and mandated the commission to, by rule, adopt training guidelines and continuing education requirements for ombudsmen. In addition, House Bill 1089 amended Texas Labor Code, §409.041 to add a requirement that ombudsmen meet with an unrepresented claimant privately for a minimum of 15 minutes prior to any formal or informal hearing. New §§125. 1-125.3 address these mandates.

Proposed new §125.1 contains definitions for: "adjusters's license", "commission", "continuing education", "director", "mentor", "ombudsman", and "ombudsman training program".

Proposed new §125.2 sets out guidelines for the ombudsman training program which include: the assignment of an experienced ombudsman as a mentor to each ombudsman in training; formal classroom training; on-the-job training; observation of ombudsmen by a mentor and by central office Ombudsmen Services; comprehensive examinations; and regularly scheduled continuing education training. The rule requires ombudsmen to participate in continuing education and to maintain an adjuster's license. Field office managers and central office Ombudsmen Services are to monitor the stages of training and the continuing education of ombudsmen. Proposed new §125.2 allows field office managers, upon the recommendation of the ombudsman's mentor, to approve an ombudsman to independently assist unrepresented parties in certain duties as it is determined that they have reached an appropriate skill level. When it is determined that an ombudsman has successfully completed each phase of the training program, including the attainment of an adjuster's license, the ombudsman shall be presented with verification of completion. Persons who were serving as ombudsmen immediately prior to September 1, 1995 are allowed to continue to serve as ombudsmen as long as they comply with applicable continuing education requirements and complete the Ombudsmen Training Program.

Proposed new §125.3 requires appropriate field office staff to send a list of unrepresented claimants who have been notified of a hearing to an ombudsman. The ombudsman is required to meet for at least 15 minutes with the unrepresented claimant prior to the hearing and if an unrepresented client has not met with an ombudsman, the rule requires the benefit review officer or benefit contested case hearing officer to recess the proceeding to allow such a meeting. In the event a claimant refuses to meet with an ombudsman, the rule requires the presiding officer to make a record of the refusal, and proceed with the hearing.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Ms. Chamness also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be well-trained ombudsmen who are more prepared to assist unrepresented claimants.

There will be anticipated economic costs to persons who are required to comply with the rule as proposed. There will be an expense to ombudsmen candidates to obtain an adjuster's license. There will be no costs to businesses as a result of this rule.

Comments on the proposal or requests for public hearing must be received by 5:00 p.m. on Wednesday, December 27, 1995, and submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The new rules are proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §409.041, which mandates the commission to maintain an ombudsman program to assist injured workers and persons claiming death benefits and sets out the responsibilities of an ombudsman, including the requirement that to meet with an unrepresented claimant privately for a minimum of 15 minutes prior to any formal or informal hearing; and the Texas Labor Code, §409.042, which requires each field office to employ at least one ombudsman, sets qualifications for ombudsmen, mandates the commission to adopt training guidelines and continuing education requirements for ombudsmen, and sets out minimum requirements for training.

These proposed new rules affect the following statutes: the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §409.041, as amended by House Bill 1089, 74th Legislature, 1995, which mandates the commission to maintain an ombudsman program to assist

injured workers and persons claiming death benefits, and sets out the responsibilities of an ombudsman, including the requirement that to meet with an unrepresented claimant privately for a minimum of 15 minutes prior to any formal or informal hearing; the Texas Labor Code, §409.042, which requires each field office to employ at least one ombudsman, sets qualifications for ombudsmen, mandates the commission to adopt training guidelines and continuing education requirements for ombudsmen, and sets out minimum requirements for training; the Texas Labor Code, §409.043, which requires each employer to notify its employees of the ombudsman program; and the Texas Labor Code, §409.044, which mandates the commission to widely disseminate information about the ombudsman program.

*§125.1. Definitions.* The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

Adjuster's license–A Type 03 adjuster's license (workers' compensation) issued by the Texas Department of Insurance.

Commission–The Texas Workers' Compensation Commission.

Continuing education–Training required by the commission to maintain designation as an ombudsman and by the Texas Department of Insurance to maintain an adjuster's license.

Director–The director of the division of Employee/Employer Services.

Mentor–An experienced ombudsman who observes and monitors the training of and serves as advisor to ombudsmen who have not completed the training program. A mentor:

(A) is selected by the director or his or her designee;

(B) must have completed the Ombudsman Training Program; and

(C) must have been performing all of the duties of an ombudsman for a minimum of one year.

Ombudsman–A commission employee who has been designated by the director to perform some or all of the duties described in Texas Labor Code, §409.041. Employees designated as ombudsmen on or after September 1, 1995 shall have at least three years demonstrated experience in the field of workers' compensation.

Ombudsman Training Program–Mandatory classroom instruction, on-the-job training and regularly scheduled observations by mentors and central office ombudsmen. The term includes continuing education and the requirements for obtaining and retaining an adjuster's license.

*§125.2. Ombudsman Training Program/Continuing Education.*

(a) The commission shall develop and maintain an Ombudsman Training Program which shall include, but is not necessarily limited to the following:

(1) selection by the director of a mentor who will observe and monitor the progress of ombudsmen who are in training;

(2) formal classroom training conducted by commission staff;

(3) on-the-job training monitored by a mentor and central office Ombudsman Services;

(4) observations of ombudsmen by central office Ombudsmen Services;

(5) comprehensive examinations developed and administered by commission staff that demonstrate the knowledge, experience, and skills required by the Texas Labor Code, §409.042(b); and

(6) regularly scheduled continuing education with emphasis on benefits, the dispute resolution process, updates in the law, the rules, appeals panel decisions, commission policy and ombudsman procedures.

(b) When the field office manager and the mentor determine that the ombudsman has attained sufficient skills, they will recommend the ombudsman to the director or his or her designee for approval to independently assist unrepresented parties in specific ombudsman duties.

(c) When the director determines, upon recommendation of the field office manager and the mentor, that the ombudsman has obtained an adjuster's license and successfully completed each phase of the Ombudsman Training Program, the director shall present the ombudsman with verification of completion.

(d) To maintain status as an ombudsman, he or she shall:

(1) participate in continuing education as described in the Ombudsman Training Program;

(2) retain an adjuster's license; and

(3) maintain technical and professional skills sufficient to perform all of the duties of an ombudsman.

(e) Field office managers and central office Ombudsman Services shall monitor the stages of training and continuing education of each ombudsman.

(f) A person serving as an ombudsman immediately before September 1, 1995 shall be allowed to continue to serve as an ombudsman regardless of whether he or she has three years of demonstrated experience in the field of workers' compensation or has successfully completed each phase of the Ombudsman Training Program; however, he or she must comply with the provisions of subsection (d) of this section and complete the Ombudsman Training Program as required by the director.

*§125.3. Private Meetings With Unrepresented Claimants.*

(a) Appropriate field office staff shall forward to each ombudsman in the field office a list of unrepresented claimants who have been notified of a benefit review conference or a benefit contested case hearing. The ombudsman shall maintain an up to date calendar of pending benefit review conferences and benefit contested case hearings.

(b) An ombudsman shall meet privately with an unrepresented claimant for a minimum of 15 minutes prior to each benefit review conference and benefit contested case hearing.

(c) The 15 minute meeting shall include an overview of the dispute resolution process, a review of the claimant's disputed issues and the application of the workers' compensation statute, the rules of the commission and appeals panel decisions.

(d) If, at the beginning of a benefit review conference or benefit contested case hearing, the benefit review officer or benefit contested case hearing officer determines that the unrepresented claimant has not met with an ombudsman for a minimum of 15 minutes prior to the proceeding, the benefit review officer or benefit contested case hearing officer shall recess the proceeding to allow for the private meeting as described in this rule.

(e) If the claimant refuses to attend the required meeting prior to a benefit review conference, the claimant shall acknowledge such refusal in writing. If the claimant refuses to sign the acknowledgement of his or her refusal, the benefit review officer shall:

(1) provide the claimant a copy of Texas Labor Code, §409.041(b)(5); and

(2) make a notation of the claimant's refusal in the claim file, and proceed with the hearing.

(f) If the claimant refuses to attend the required meeting prior to a benefit contested case hearing, the claimant shall acknowledge such refusal in writing. If the claimant refuses to sign the acknowledgement of his or her refusal, the benefit contested case hearing officer shall:

(1) provide the claimant a copy of Texas Labor Code, §409.041(b)(5); and

(2) make a record of the claim-

ant's refusal to comply with §409. 041(b)(5) and the provisions of this rule, and proceed with the hearing.

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

Issued in Austin, Texas, on November 16, 1995.

TRD-9514947 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 440-3700

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# TITLE 30. ENVIRONMENTAL QUALITY

## Part I. Texas Natural Resource Conservation Commission

### Chapter 305. Consolidated Permits

### Subchapter M. Waste Treatment Inspection Fee Program

- **30 TAC §305.503**

The Texas Natural Resource Conservation Commission (TNRCC or commission) proposes an amendment to §305.503, relating to Fee Assessment.

This amendment will increase the annual inspection fee for wastewater treatment facilities. Such increase is limited to that level authorized by House Bill (HB) 2015, Acts of the 74th Legislature, 1995, and only as necessary to acquire and implement federal delegation of the National Pollutant Discharge Elimination System (NPDES) pursuant to the Federal Clean Water Act, §402.

In accordance with HB 2015, such fee increase shall be effective only upon NPDES delegation. Also in accordance with HB 2015, treatment works owned by a local government shall be exempt from such fee increase until August 31, 1999. In addition to the exemption of publicly-owned domestic wastewater treatment facilities provided by HB 2015, exempt facilities shall also include privately-owned domestic wastewater facilities and confined/concentrated animal feeding operations. These latter exemptions are based upon those factors provided under Texas Water Code, §26.0291(b) including flow volume, toxic pollutant potential, level of traditional pollutant, and heat load. Upon expiration of these exemptions in 1999, the fee rate schedule will be re-examined.

The Federal Clean Water Act provides for an NPDES wastewater discharge permitting program, currently administered in Texas by the United States Environmental Protection Agency (EPA) Region 6 Office. Texas also has a wastewater permitting program authorized by Chapter 26 of the Texas Water Code and administered by the TNRCC. Section 402 of the Clean Water Act allows delegation of the NPDES program to a state if the state has the ability and authority to administer a permitting program substantially equivalent to that of the federal program. The regulated community has urged the TNRCC to seek NPDES delegation to eliminate the duplication and resulting additional cost and burden of dual permitting requirements.

In 1995, the Texas Legislature enacted HB 2015 to address statutory changes needed to obtain NPDES delegation, thus indicating legislative intent that the TNRCC seek delegation. In addition to addressing any remaining, potential legal issues necessary for delegation, the bill also provided that the Texas Water Code, §26.0291 be amended to authorize the commission to assess an annual wastewater facility inspection fee not to exceed $25,000. The bill further provided that the commission may not adopt any rule designed to increase fees for facilities owned by local governments before August 31, 1999. Therefore, any increase in funding required to implement the NPDES program would have to be borne primarily by industrial wastewater permit holders at least until 1999.

Currently, state wastewater permitting, inspections, and related modeling and water quality monitoring cost approximately $19.56 million annually. Existing wastewater facility inspection fees generate approximately $7.2 million annually. General revenue, federal grant monies, and $5 million from the Clean Rivers Program, Texas Water Code, §26.0135(h), fund the remaining amount. The additional cost of delegation is estimated to be approximately $2. 8 million. To provide for this additional cost, the Texas Legislature appropriated to the TNRCC an amount not to exceed $2,861,102 for fiscal year 1996 and $2,517,102 for fiscal year 1997 out of additional revenues generated by fee increases authorized by HB 2015.

The additional $2.8 million annual cost, the $25,000 fee cap, and the fee increase exemption provided to all but the industrial facilities will require taking the existing formula as it is applied to industrial facilities and multiplying that result by a factor based upon the ratio of the difference between the old and new fee caps to determine the new fees for industrial facilities. The current fee rate schedule is based in part upon the assignment of "points" as a measure of pollutant potential, flow volume, contamination, and pollutant parameters (e.g., ammonia, suspended solids, oxygen demand, etc.) . The maximum fee amount is also determined by an administratively set maximum number of points per facility and the statutory maximum fee amount. To generate an additional $2.5 to $2.8 million in additional annual revenue will require an average increase in fees of $3,125 per facility for the approximately 800 industrial permittees in the state, almost doubling the current average fee.

Accordingly, the proposed rule would amend §305.503 by increasing the maximum annual fee from $11,000 to $25,000. Additionally, the proposed amendment would establish a new rate schedule for fees not exempted from increase by HB 2015 by providing that the fee shall be determined by multiplying the previous fee by a factor not to exceed 2.3, which is the ratio of the difference between the new maximum fee amount of $25,000 and the old maximum fee of $11,000. Finally, the proposed amendment would provide that the minimum fee shall not add less than $150 to the previous fee amount.

Stephen Minick, Strategic Planning and Appropriations Division, has determined that for the first five-year period this section as proposed is in effect, there will be fiscal implications as a result of administration and enforcement of the section. The effect on state government will be an increase in revenue of approximately $2.8 million annually. This increase is contingent on the delegation of the federal wastewater program to the state by the EPA. The state will also incur additional costs to offset the anticipated increase in revenue based on the same contingency. The effect on local government will be a cost savings for operators of wastewater treatment facilities, indirectly related to this proposed rule, due to the elimination of duplicative federal and state water quality regulatory requirements. The proposed rule will have no direct effect on the costs of local governments from annual wastewater facility fees for the period of fiscal year 1996-1999. In the fifth year, fiscal year 2000, the increased maximum annual wastewater facility fee of $25, 000 will be applicable to facilities operated by local governments. The actual cost increases for local governments will be based on subsequent program costs, legislative appropriations and rate structures and cannot be determined at this time.

Mr. Minick also has determined that for the first five years this section is in effect, the public benefit anticipated as a result of enforcement of and compliance with the section will be more cost-effective regulation of wastewater treatment and water quality, improvement in the consistency of federal and state regulations, and the elimination of duplicative water quality regulatory requirements. The economic costs to persons required to comply with the section as proposed are related to the increase in the maximum annual wastewater facility fee. The increase in the maximum fee to $25,000 will result in increased fee payments of up to approximately $14,000 annually for all affected permit holders. The average annual cost increase from current assessment levels will be approximately $3,125 and the minimum increase $150. The indirect effects of the delegation of permitting authority, upon which the increased costs are contingent, will be a costs savings to operators of wastewater facilities which currently require federal operating permits. These indirect cost savings have not been determined in conjunction with this rule proposal.

Written comments on the proposed rules should reference Rule Log Number 95163-305-WT and may be submitted to Lutrecia Oshoko, Texas Natural Resource Conservation Commission, Office of Policy and Regulatory Development, MC-20i, Post

Office Box 13087, Austin, Texas 78711-3087, (512) 239-4640. Written comments must be received by 5:00 p.m., 30 days from the date of publication of this proposal in the *Texas Register*. For further information, please contact Warren Davis, Director, Agriculture and Watershed Management Division, (512) 239-1072.

The amendment is proposed under the Texas Water Code, §26.0291, relating to waste treatment inspection fees, and the Texas Water Code, §5.103, which provides the commission the authority to adopt any rules necessary to carry out its powers and duties under the Texas Water Code and other state law.

There are no other rules, statutes or codes that will be affected by this amendment.

*§305.503. Fee Assessment.*

(a) An annual waste treatment fee is assessed against each person holding a permit or other authorization issued under the authority of the Water Code, Chapter 26. The amount of the fee is determined by specific permit parameters for which a facility is authorized as of each September 1. The maximum fee which may be assessed each permit is $11,000, except that for Texas Pollutant Discharge Elimination Systems (TPDES) permits, the maximum fee which may be assessed is **$25, 000** [$15,000].

(b) (No change.)

(c) Except as provided in **subsections** [subsection] (g) **and (j)** of this section, the commission shall assign a point value to each of the permit parameters in subsection (b) of this section. The assigned value(s) shall be weighted according to the specific permit limits and the weighted values summed. The sum of the variable point values under subsection (f) of this section and the set values established under subsection (g) of this section are multiplied by the current fee rate under subsection (h) of this section to determine the fee to be assessed.

(d)-(i) (No change.)

**(j) Upon delegation of the National Pollutant Discharge Elimination System, a fee shall be determined by multiplying the base fee provided by subsection (c) of this section by a factor not to exceed 2.3. The minimum fee shall not be less than $150 more than the pre-existing fee. This subsection shall not apply to domestic wastewater treatment facilities or confined/concentrated animal feeding operations until August 31, 1999.**

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515037 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 239-4640

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## Subchapter O. Additional Conditions for Wastewater Discharge Permits

### • 30 TAC §305.533

The Texas Natural Resource Conservation Commission (TNRCC) proposes an amendment to §305.533, relating to adoption of the U.S. Environmental Protection Agency (EPA) issued permits and pretreatment programs.

The purpose of amendment of §305.533 is also related to the commission's assumption of the National Pollutant Discharge Elimination System (NPDES) program. Existing §305.533 became effective in 1990 at a time when the commission previously was anticipating NPDES program authorization in 1991. The amendment proposed today seeks to update the regulation in a manner that will more accurately reflect how the commission will adopt NPDES permits after it assumes the NPDES program from the EPA.

Section 305.533 (relating to Adoption of Environmental Protection Agency Issued Permits and Pretreatment Programs) is proposed for amendment to include the correct fiscal year of 1996. The commission also is proposing to remove special reference to classified major NPDES permits. No other substantial changes are proposed to this regulation.

Stephen Minick, Strategic Planning and Appropriations Division, has determined that for the first five years the proposed rule is in effect, there will be no significant fiscal implications as a result of the administration or enforcement of the rule. Notwithstanding the potential costs to the state of the assumption of the federal wastewater permitting and compliance monitoring programs, the adoption of these rules will have no significant direct fiscal implications for state or local government.

Mr. Minick also has determined that for the first five years the rule is in effect, the public benefit anticipated as a result of enforcement of and compliance with the rule will be improvement in the consistency of state and federal regulations, the enhanced opportunity for assumption of federal regulatory authority by the state, and more cost-effective operation of water quality programs. There will be no economic costs anticipated to any person, including any business, to comply with the rule as proposed.

Written comments on the proposal should reference Log Number 95171-337-WT and may be submitted to Lutrecia Oshoko, Texas Natural Resource Conservation Commission, Office of Policy and Regulatory Development, MC-201, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4640. Written comments must be received by 5:00 p.m., 30 days from the date of publication of this proposal in the *Texas Register*. For further information or questions concerning this proposal, please contact Thomas Weber, Wastewater Permits Section, (512) 239-4554.

The amendment is proposed under the Texas Water Code (Vernon 1992), §5. 103, which provides the TNRCC with the authority to adopt any rules necessary to carry out the powers and duties under the provisions of the Texas Water Code and other laws of this state.

There are no other codes, statutes or regulations that will be effected by this proposal.

*§305.533. Adoption of Environmental Protection Agency Issued Permits and Pretreatment Programs.* On the date of **TNRCC assumption of the administration of the Texas Pollutant Discharge Elimination System (TPDES) permit program, after** the Environmental Protection Agency (EPA) approves the **TPDES** [Texas pollutant discharge elimination system (TPDES)] permit program, and issuance of national pollutant discharge elimination system (NPDES) permits is delegated from the EPA to the state, the state adopts all EPA permits and pretreatment programs. This provision does not affect the right of the EPA to issue NPDES permits for [classified major] facilities which expired in fiscal year **1996** [1990] or to modify NPDES permits under Clean Water Act, §304(l). If the requirements of a state permit and an EPA permit issued to the same permittee or for the same facility are not of equal stringency, the more stringent requirements shall apply.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515035 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 239-4640

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## Chapter 309. Effluent Limitations

## Subchapter D. Criteria for Classification of Solid Waste Disposal Facilities and Practices

### • 30 TAC §309.30

*(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 Natural Resource Conservation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The Texas Natural Resource Conservation Commission (TNRCC) proposes the repeal of §309.30, relating to criteria for classification of solid waste disposal facilities and practices.

The purpose of the repeal of §309.30 is to eliminate a regulation which is no longer needed due to the promulgation of new criteria relating to sewage sludge and water treatment sludge. As written, §309.30 would have adopted certain federal regulations on the date of program authorization of the National Pollutant Discharge Elimination System (NPDES). The commission proposes this repeal to prevent the commission from adopting 40 Code of Federal Regulations (CFR), Part 257, as specified in §309.30. There is currently no need for the commission to adopt 40 CFR Part 257 because it has been superseded by new 30 TAC Chapter 312, effective on October 13, 1995. The commission is currently seeking program assumption of NPDES and has a need to repeal §309.30, which would cause confusion with the commission's Chapter 312 if left in place.

Stephen Minick, Strategic Planning and Appropriations Division, has determined that for the first five years the proposed repeal is in effect, there will be no significant fiscal implications as a result of the administration or enforcement of the repeal. Notwithstanding the potential costs to the state of the assumption of the federal wastewater permitting and compliance monitoring programs, the adoption of these rules will have no significant direct fiscal implications for state or local government.

Mr. Minick also has determined that for the first five years the repeal is in effect, the public benefit anticipated as a result of enforcement of and compliance with the repeal will be improvement in the consistency of state and federal regulations, the enhanced opportunity for assumption of federal regulatory authority by the state, and more cost-effective operation of water quality programs. There will be no economic costs anticipated to any person, including any business, to comply with the repeal as proposed.

Written comments on the proposal should mention Log Number 95171-337-WT and may be submitted to Lutrecia Oshoko, Texas Natural Resource Conservation Commission, Office of Policy and Regulatory Development, MC-201, Post Office Box 13087, Austin, Texas 78711-3087, (512) 239-4640. Written comments must be received by 5:00 p.m., 30 days from the date of publication of this proposal in the *Texas Register*. For further information or questions concerning this proposal, please contact Thomas Weber, Wastewater Permits Section, (512) 239-4554.

The repeal is proposed under the Texas Water Code (Vernon 1992), §5.103, which provides the TNRCC with the authority to adopt any rules necessary to carry out the powers and duties under the provisions of the Texas Water Code and other laws of this state.

There are no other codes, statutes or regulations that will be affected by this proposal.

*§309.30. Criteria for Classification of Solid Waste Disposal Facilities and Practices.*

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515034 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 239-4640

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## Chapter 337. Enforcement

## Subchapter A. Enforcement Generally

### • 30 TAC §337.7

The Texas Natural Resource Conservation Commission (TNRCC or commission) proposes new §337.7, relating to Enforcement.

Proposed new §337.7 would reinstate the provision allowing an affirmative defense to the violation of a permit if such violation is the result of actions which are beyond the reasonable control of the permittee and could not have been avoided by the exercise of due care, i.e., *force majeure* or "act of God." Such rule is based upon Texas Water Code, §26.132 and was inadvertently omitted during recent amendments to Chapter 337.

Stephen Minick, Strategic Planning and Appropriations Division, has determined that for the first five-year period the section as proposed is in effect there will be no significant fiscal implications to state or local government as a result of administration or enforcement of the section.

Mr. Minick also has determined that for the first five years these section as proposed is in effect the public benefit anticipated as a result of enforcement of and compliance with the section will be the clarification and consistency of TNRCC regulations with related Water Code provisions. There are no direct economic costs anticipated to any person, including any business, to comply with the rule as proposed.

Written comments on the proposed rules should reference Rule Log Number 95171-337-WT and may be submitted to Lutrecia Oshoko, Texas Natural Resource Conservation Commission, Office of Policy and Regulatory Development, MC-201, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4640. Written comments must be received no later than 5:00 p.m. on the 30th date from the date of the publication of these proposed rules in the *Texas Register*. For further information, please contact Margaret Hoffman, Staff Attorney, Legal Services Division, at (512) 239-0455.

The new section is proposed under Texas Water Code §5.103, which provides the commission the authority to adopt any rules necessary to carry out its powers and duties under the Texas Water Code and other state law and the Texas Water Code, §5.104, which provides the commission the authority to enter into memoranda of understanding necessary to carry out is duties and functions.

There are no other codes, statutes or regulations that will be affected by this proposal.

*§337.7. Force Majeure.*

(a) Any pollution, or any discharge of waste without a permit or in violation of a permit, shall not constitute a violation under this chapter if such pollution or discharge is the result of causes which are outside the control of the permittee or the permittee's agents and could not be avoided by the exercise of due care. Such acts include, but are not limited to, an act of God, war, strike, riot, or other catastrophe.

(b) The owner or operator of the affected facility shall have the burden of proof to demonstrate that any pollution or discharge is not a violation as provided by subsection (a) of this section.

(c) If *force majeure* is claimed as an affirmative defense to an action brought under this chapter, the permittee must submit notice to the executive director as provided by §305.125(9) of this title (relating to Standard Permit Conditions).

(d) The executive director shall respond in writing within 30 days from receipt of the notification provided under subsection (c) of this section with a determination as to whether the event constituted a *force majeure* and an affirmative defense to an enforcement action as provided by 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 authority to adopt.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515036 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 239-4640

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# TITLE 34. PUBLIC FINANCE

# Part I. Comptroller of Public Accounts

## Chapter 1. Central Administration

## Subchapter A. Practice and Procedure

### • 34 TAC §1.13

The Comptroller of Public Accounts proposes new §1.13, concerning initiation of an expedited hearing process. The new section gives a taxpayer the option of choosing an expedited hearing by complying with the requirements of subsection (b). Use of this process will permit the agency to issue a taxpayer a final decision within 105 to 135 days from the date a compliant request for expedited hearing is received.

Mike Reissig, chief revenue estimator, has determined that for the first five-year period the rule is in effect there will be no significant revenue impact on the state or local government.

Mr. Reissig also has determined that for each year of the first five years the rule is in effect the public benefit anticipated as a result of enforcing the rule will be in providing new information regarding tax responsibilities. This rule is adopted under the Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses. There is no significant anticipated economic cost to persons who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Michael J. Borkland, Chief Hearings Attorney, Legal Services Division, P.O. Box 13528, Austin, Texas 78711.

This new section is proposed under the 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 the Tax Code, Title 2.

The new section implements the Tax Code, §111.009 and §111.105.

*§1.13. Initiation of an Expedited Hearing.*

(a) A taxpayer may request an expedited hearing at the time a petition for redetermination or written request for refund hearing is filed. An expedited hearing is one conducted under the accelerated prehearing and hearing timetable set forth in this section.

(b) To obtain an expedited hearing, a taxpayer must do the following at the time the petition for redetermination or written request for refund hearing is filed:

(1) request in writing the election of the expedited procedure and specify whether an oral hearing or a hearing on written submissions is preferred;

(2) pre-file its statement of grounds and all evidence (other than resale and exemption certificates) on which it intends to rely at the hearing, including summaries of testimony of witnesses expected to be called at an oral hearing. Contentions and evidence not pre-filed by the taxpayer shall be deemed inadmissible;

(3) agree to abbreviated discovery timetables in the event the tax division should initiate discovery during the prehearing phase;

(4) request an extended oral hearing, if desired;

(5) agree to file resale and exemption certificates no later than the date of hearing or by the 60th day from the date of the hearing request, whichever occurs first, and to waive in writing the requirement of written notice and the 60-day period for the presentation of certificates as provided in Tax Code, §151.054(e); and

(6) waive in writing the issuance of a proposed decision.

(c) The Chief Hearings Attorney shall, within ten days of his receipt of a request for an expedited hearing, make a determination as to whether the request qualifies for an expedited hearing. If it does not, the taxpayer will be so notified in writing, and advised that either with the filing of additional curative documentation the case can proceed on an expedited basis or that the case will be placed on the agency's regular hearings docket.

(d) For good cause shown, a request for an expedited hearing may be withdrawn; however, the waiver of the 60-day period pursuant to subsection (b) (5) of this section cannot be withdrawn. A taxpayer's request for continuance, or a request for an extended oral hearing filed after the initial request for an expedited hearing, shall not be granted unless there is a showing of good cause. Withdrawal of the request for an expedited hearing, or the granting of a motion for continuance or an extended oral hearing, shall cause the hearing to be set on the agency's regular hearings docket.

(e) The tax division may petition the Administrative Law Judge for conversion from an expedited to a regular hearing for good cause shown, including, but not limited to, the need for additional policy consideration of issues raised, the need for extended discovery, for reasons of agency policy or court case hold, or for extended examination of records presented by the taxpayer. The Administrative Law Judge shall rule on such motion on the basis of written pleadings submitted by the parties.

(f) A compliant expedited hearing request shall be set and decided on the following timetable:

(1) within 20 days of receipt of the request by the Chief Hearings Attorney an oral hearing or written submission closing date not to exceed 60 days from the date of receipt of the request shall be set by the Chief Administrative Law Judge;

(2) a date, not to exceed 50 days from the date of receipt of the request by the Chief Hearings Attorney, shall be set as a deadline for the Tax Division to file a written response to the taxpayer's statement of grounds and pre-filed evidence;

(3) a final decision shall be issued as follows:

(A) if no audit amendment is required in order to issue the final decision, within 45 days of the date of the oral hearing or the date the written submission record closes; or

(B) if an audit amendment is required in order to issue the final decision, within 75 days of the date of the oral hearing or the date the written submission record closes; and

(4) a motion for rehearing may be filed as provided in §1.29 of this title (relating to Motion for Rehearing).

(g) Hearings conducted pursuant to the expedited timetable established in this section shall not be subject to the provisions of §§1.9, 1.10, 1.11, 1.12, 1.14, 1.15, 1.16, 1.20, and 1.27 of this title (relating to Rules of Practice and Procedure).

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515020

Martin Cherry
Chief, General Law
Comptroller of Public Accounts

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-4028

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## Chapter 3. Tax Administration

## Subchapter Q. Franchise Tax

### • 34 TAC §3.411

*(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 Comptroller of Public Accounts or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The Comptroller of Public Accounts proposes the repeal of §3.411, concerning banking corporations. This section is being repealed in order that it can be adopted under the Texas Administrative Code, Title 34, Part I, Chapter 3, Subchapter V. The section will be replaced with a new 34 TAC §3. 560, concerning banking corporations.

Mike Reissig, chief revenue estimator, has determined that for the first five-year period the repeal is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the repeal.

Mr. Reissig also has determined that for each year of the first five years the repeal is in effect the public benefit anticipated as a result of enforcing the repeal will be in eliminating duplicative rules. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the repeal as proposed.

Comments on the proposal may be submitted to Karey W. Barton, Manager, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711.

The repeal is proposed under the 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 the Tax Code, Title 2.

The repeal implements the Tax Code, §§171.001 et seq and the repeal of the Government Code, §403.105.

*§3.411. Banking Corporations.*

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

Issued in Austin, Texas, on November 17, 1995.

TRD-9514948 Martin Cherry
Chief, General Law
Comptroller of Public Accounts

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-3725

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## • 34 TAC §3.560

The Comptroller of Public Accounts proposes new §3.560, concerning banking corporations. This new section replaces 34 TAC §3.411, concerning the same subject matter, which is being repealed in order that it can be adopted under the Texas Administrative Code, Title 34, Part I, Chapter 3, Subchapter V. This new section provides guidelines to banking corporations for computing their franchise tax.

Mike Reissig, chief revenue estimator, 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 or administering the section.

Mr. Reissig 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 in the clarification of comptroller policy. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the sections as proposed.

Comments on the proposal may be submitted to Karey W. Barton, Manager, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711.

The new section is proposed under the 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 the Tax Code, Title 2.

The new section implements the Tax Code, §§171.00 et seq and the repeal of the Government Code, §403.105.

*§3.560. Banking Corporations.*

(a) Effective date. Except as otherwise provided in this section, the provisions of this section apply to franchise tax reports originally due on or after January 1, 1992.

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

(1) Banking corporation (bank)-Each state, national, domestic, or foreign bank, including a limited banking association, as defined by the Banking Act, §1.002(a), and each bank organized under the Federal Reserve Act, §25(a), (12 United States Code, §§611-631) (edge corporations), but does not include a bank holding company as that term is defined by the Bank Holding Company Act of 1956 (12 United States Code, §1841).

(2) Commercial domicile-The principal place from which the trade or business of the entity is directed.

(c) Banking corporations subject to tax. The following banking corporations are subject to Texas franchise tax.

(1) All banking corporations that are chartered, authorized to do business, or doing business in Texas beginning May 1, 1985, unless specifically listed as not subject to tax under subsection (d) of this section.

(2) Beginning January 1, 1996, the following banking corporations are subject to Texas franchise tax:

(A) non-Texas banking corporations doing business in Texas solely in a fiduciary capacity and registered with the Texas Secretary of State's Office under the Probate Code, §105A; and

(B) banking corporations doing business solely on federal enclaves in Texas.

(3) For those banking corporations subject to tax pursuant to paragraph (2) of this subsection, January 1, 1996, is considered the banking corporation's beginning date for purposes of determining the banking corporation's privilege periods and for all other purposes of the Tax Code, Chapter 171.

(d) Banks not subject to tax. Unincorporated private banks, other than limited banking associations, doing business in Texas are not subject to Texas franchise tax.

(e) Other franchise tax provisions apply. All provisions of this subchapter, concerning the Texas franchise tax, are applicable to banking corporations. However, this section will control if it conflicts with another section of this subchapter.

(f) Apportionment of dividends and interest.

(1) If a banking corporation has its commercial domicile in Texas, all dividends and interest received, including interest from the federal government unless otherwise excluded by §3.555(k) of this title (relating to Earned Surplus: Compensation), are considered to be Texas gross receipts and gross receipts everywhere.

(2) If a banking corporation's commercial domicile is not in Texas, no dividends or interest received are considered to be Texas gross receipts but all are considered to be gross receipts everywhere.

(g) Earned surplus. Regarding the add-back of compensation of executive officers and directors of banking corporations and directors, managers, and participants of a limited banking association, see §3.558 of this title (relating to Earned Surplus: Officer and Director Compensation).

(h) Enforcement.

(1) All taxes, penalties, and interest due by a banking corporation are secured by a lien on all of the bank's property that is subject to execution. The lien attaches to all of the property of the bank liable for the taxes.

(2) The attorney general may bring suit in the name of the state to recover delinquent taxes, penalties, and interest.

(3) The comptroller may ask that the Banking Department of Texas issue a cease and desist order requiring a bank to pay all taxes, penalties, and interest. To the extent not preempted by federal law, the Texas Department of Banking is required to appoint a conservator under the Banking Act, Chapter 6, Subchapter B, to pay the franchise tax of any banking corporation certified by the comptroller as being delinquent in the payment of its franchise tax.

(4) Except as provided in paragraph (3) of this subsection, no banking corporation will have its corporate privileges or charter forfeited by the comptroller for not paying its franchise tax.

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

Issued in Austin, Texas, on November 17, 1995.

TRD-9514949 Martin Cherry
Chief, General Law
Comptroller of Public Accounts

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-3725

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## Subchapter GG. Insurance Tax

### • 34 TAC §3.832

The Comptroller of Public Accounts proposes new §3.832, concerning the assessment for the Office of Public Insurance Counsel (O.P.I.C.). This new section defines the premiums to be included in the calculation of the assessment. The new section clarifies the tax base for the purpose of the assessment.

Mike Reissig, chief revenue estimator, has determined that for the first five-year period the rule is in effect there will be no significant revenue impact on the state or local government.

Mr. Reissig also has determined that for each year of the first five years the rule is in effect the public benefit anticipated as a result of enforcing the rule will be in clarifying current law. This rule is adopted under the Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses. There is no significant anticipated economic cost to persons who are required to comply with the proposed rule.

Comments on the new section may be submitted to Karey W. Barton, Manager, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711.

This new section is proposed under the 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 the Tax Code, Title 2.

The new section implements the Insurance Code, Article 1.35B.

*§3.832. Assessment for the Office of Public Insurance Counsel (O.P. I.C.).*

(a) Property and casualty insurance. Each property and casualty insurer authorized to do business in this state must pay an annual assessment of $.057 on each property and casualty insurance policy or each certificate of insurance evidencing coverage under a group policy covering property and/or risks located in Texas which is in force on December 31.

(b) Life, health and accident insurance. Each life; health; accident; life and accident; accident and health; or life, accident and health insurer; and each health maintenance organization authorized to do business in this state must pay an annual assessment of $.03 on each individual policy or each certificate of insurance evidencing coverage under a group policy placed in force in this state with an initial premium paid during the year. For the purpose of determining this assessment, a certificate of insurance includes subscriber certificates issued under a group policy. A subscriber certificate may be for an individual or the individual and his/her family. Individual policy renewals or certificate of insurance renewals are not to be included in calculating the assessment. A term life policy which is converted to a whole life or universal life policy will be considered a new policy for purposes of the assessment unless the term life policy specifically contains a conversion option.

(c) Title insurance. Each title insurer authorized to do business in this state must pay an annual assessment of $.057 on each owner policy and each mortgage policy written during the year for property located in Texas for which the full premium is charged. In instances where two or more companies co-insure a portion of the risk, each policy is subject to the assessment. For the purpose of determining this assessment, any policies on which discounted premiums are charged will not be included.

(d) Purchase of a block of business. In instances where a block of business is purchased by another company, the following will apply:

(1) Property and casualty insurance policies–The acquiring company is responsible for the assessment on each of the policies in force on December 31.

(2) Life, accident, and health insurance policies–The original insurer is responsible for the assessment on the new policies which were ceded.

(3) Title insurance policies–The original insurer is responsible for the assessment on the policies written on which full premium is charged.

(e) Due date of report and payment. The assessment must be reported and paid on or before March 1 following the end of the tax year for which the assessment is due.

(f) Penalty. A penalty equal to 5.0% of the assessment due, or any portion of the assessment not paid, shall be assessed on all payments received 1-30 days after the due date. An additional penalty equal to 5.0% of the assessment, or any portion of the assessment not paid, shall be assessed on payments received more than 30 days after the due date.

(g) Interest. Interest will accrue at the rate of 12% beginning on the 61st day following the due date of the assessment on any portion of the assessment not paid and will continue through the date of payment.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515021 Martin Cherry
Chief, General Law
Comptroller of Public Accounts

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-4028

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# TITLE 37. PUBLIC SAFETY AND CORRECTIONS

## Part VI. Texas Department of Criminal Justice

## Chapter 152. Institutional Division

## Subchapter C. Maximum System Capacity of the Institutional Division

### • 37 TAC §152.12

The Texas Department of Criminal Justice proposes an amendment to §152. 12, concerning the maximum capacity of certain units of the Institutional Division. The amendment is permitted by Chapter 499, Subchapter E, Government Code, and by the Final Judgment in Ruiz v. Collins CN. H-78-987 (Southern District of Texas, Houston Division), which appeared in Volume 17, *Texas Register*, page 8269 (November 27, 1992).

The effect of the proposed amendment is to initiate the formal process described and authorized by Chapter 499, Subchapter E, Government Code, ultimately to allow the Institutional Division to increase unit capacities by constructing permanent additions to the units.

David P. McNutt, Assistant Director for Budget and Management has determined that the effect on state government for the first five-year period of operations will be as follows: zero in 1996; $11,540,888 in 1997; $106,797, 205 in 1998; $130,590,905 in 1999; and $130,590,905 in the year 2000.

Mr. McNutt has further determined that the effect on local government for the next five-year period cannot be determined with certainty. While the increased population in the institutional division will affect the number of inmates awaiting transfer held in county jails, the magnitude and duration of the impact cannot be accurately ascertained, given the importance of parole releases to the population dynamics of the system.

Mr. McNutt also has determined that the public benefit anticipated as a result of enforcing

the section as proposed will be cost effective additions to prison capacity, allowing state incarceration of convicted felons for appropriate lengths of time.

The implementation of this amendment will have no effect on small businesses, as they will not have to comply with the rule and compliance with this amendment and new section will not impose any economic costs on individuals, as no individuals have a duty to comply.

Comments should be directed to Carl Reynolds, General Counsel, Texas Board of Criminal Justice, P.O. Box 13084, Austin, Texas 78711. Written comments from the general public should be received within 30 days of the publication of this proposed amendment.

The amendment is proposed under the Government Code, §492.013, which grants general rulemaking authority to the Board. The amendment is permitted by Chapter 499, Subchapter E, Government Code. In conformity with that statute, the proposed amendment cannot take effect after adoption by the Board of Criminal Justice without the further approval of the governor and the attorney general.

Cross Reference to Statute: Chapter 499, Subchapter E, Government Code.

*§152.12. Methodology for Changing the Maximum System Population.*

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

**(i) In this subsection, "close custody facility" refers to a 668-cell, two-bed-per-cell facility with its own areas for administration, recreation, meal distribution, and visitation. The institutional division shall undertake the review described by the Government Code, §499.102, to determine whether the division can increase the maximum capacity of the following units by the addition of a close custody facility: Allred Unit, Wichita Falls; Clements Unit, Amarillo; Connally Unit, Karnes County; Stiles Unit, Beaumont; Hughes Unit, Gatesville; Smith Unit, LaMesa; Lewis Unit, Woodville; and Wallace Unit, Mitchell County.**

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515016 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-9693

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## Subchapter D. Other Rules

### • 37 TAC §152.51

The Texas Department of Criminal Justice proposes new §152.51, concerning authorized witnesses to the execution of an inmate sentenced to death.

The new section is permitted by the Code of Criminal Procedure, Article 43. 20, and Attorney General's Letter Opinion Number 95-059 (September 26, 1995).

The new section will specify those persons authorized to witness the execution of an inmate sentenced to death.

David P. McNutt, Assistant Director for Budget and Management has determined that there will be no fiscal implications for state or local government as a result of enforcing this section as proposed.

Mr. McNutt also has determined that the public benefit anticipated as a result of enforcing the section as proposed will be potential closure for family members of murder victims.

The implementation of the new section will have no effect on small businesses, as they will not have to comply with the rule and new section will not impose any economic costs on individuals, as no individuals have a duty to comply.

Comments should be directed to Debbie Liles, Assistant Director for Operational Review, P.O. Box 99, Huntsville, Texas 77342-0099. Written comments from the general public should be received within 30 days of the publication of this proposed new section.

The new section is proposed under the Government Code, §492.013, which grants general rulemaking authority to the Board. The new section is permitted by the Code of Criminal Procedure, Article 43.20, and Attorney General's Letter Opinion Number 95-059 (September 26, 1995).

Cross Reference to Statute: Code of Criminal Procedure, Article 43.20.

*§152.51. Authorized Witnesses to the Execution of an Inmate Sentenced to Death.*

(a) Purpose. The purpose of this rule is to specify those persons authorized to witness the execution of an inmate sentenced to death.

(b) Definition. "Close relative of the deceased victim" means the following persons in relation to the victim for whose death an inmate is sentenced to death:

(1) the spouse of the victim at the time of the victim's death;

(2) a parent or stepparent of the deceased victim; or

(3) an adult brother, sister, child, or stepchild of the deceased victim (adult is defined as anyone 18 years of age or older); or

(4) another individual with a close relationship to the deceased victim, upon approval by the Director of the Institutional Division Texas Department of Criminal Justice Institutional Division (TDCJ-ID).

(c) Witnesses. The only persons authorized to witness an execution are as follows:

(1) departmental staff as deemed necessary by the Director of the TDCJ-ID;

(2) members of the Texas Board of Criminal Justice;

(3) chaplains of the Texas Department of Criminal Justice;

(4) Walker County Judge;

(5) Walker County Sheriff;

(6) media pool representatives consisting of:

(A) one reporter from the Huntsville Item;

(B) one reporter from the United Press International and the Associated Press;

(C) one additional print media representative and one broadcast representative selected from rotating lists of applicants maintained by the TDCJ-ID Public Information Office.

(7) relatives or friends requested by the condemned inmate, not to exceed five in number, and who are eligible under the following procedure in subsection (d) of this section;

(8) close relatives of the deceased victim not to exceed five in number; and

(9) if there are fewer than five close relatives of the deceased victim, additional close relatives of a victim for whose death the inmate has been convicted but for whose death the inmate is not sentenced to death, up to a total of five close relatives under this paragraph and paragraph (8) of this subsection.

(d) Relatives or friends of the inmate.

(1) Relatives or friends requested by the condemned inmate are eligible to attend the execution of the condemned inmate if:

(A) the condemned inmate provides a list of witnesses he/she wishes to attend the execution to the Bureau of Classification at least 14 days prior to the date of execution; and

(B) witnesses requested by the inmate are on the inmate's approved "Visitor's List."

(2) If less than 14 days prior to the scheduled execution, the condemned inmate wishes to change the names of his/her witnesses, the inmate shall submit a request in writing to the Director of TDCJ-ID who shall approve or disapprove the changes.

(3) The condemned inmate may have as a witness an official minister who must be a bonafide pastor of the church of the condemned inmate's elected religion.

(e) Prohibition on attendance. Any inmate currently confined within the TDCJ-ID is specifically denied authorization to witness the execution of an inmate sentenced to death.

(f) Victim Notification.

(1) The TDCJ-ID Victim Services Liaison (VSL) shall be responsible for maintaining a list of scheduled executions.

(2) The VSL/Emergency Action Center (EAC) shall provide a list of scheduled executions to the TDCJ Victim Services Office (VSO). Subsequent updates regarding significant changes pertaining to the execution (e.g., dates, court rulings, etc.) shall also be provided to the TDCJ VSO by the VSL/EAC in an expedient manner.

(3) The VSO is responsible for notifying the relatives of the victim of the scheduled execution date, time, and location, upon request. It is the responsibility of the relative to notify the TDCJ VSO of any subsequent address changes and their intent to attend.

(4) The relative of the victim must be identified and approved by the VSO.

(5) It is the responsibility of the VSO to notify the VSL, no later than five days prior to the scheduled execution date, of the names and contact numbers for those persons planning to attend.

(6) The VSO shall contact the relative of the victim and provide information regarding the written procedures affecting their participation.

(g) Requirements for the execution chamber. The room provided for the execution shall be arranged so that:

(1) there is sight and sound separation between any relative or friend of the condemned inmate and any close relative of a deceased victim; and

(2) there is sound separation between the condemned inmate and those in attendance, except that arrangements shall be provided that allow those in attendance to hear the statements of the condemned inmate.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515019 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-9693

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# TITLE 40. SOCIAL SERVICES AND ASSISTANCE

## Part I. Texas Department of Human Services

### Chapter 11. Food Distribution and Processing

### Food Distribution Program

**• 40 TAC §§11.103, 11.107, 11.121**

The Texas Department of Human Services (DHS) proposes amendments to §§11.103, 11.107, and 11.121 in its Food Distribution and Processing chapter. The purpose of the amendments is to provide a technical correction and clarifications regarding the Food Distribution Program.

Burton F. Raiford, commissioner, has determined that for the first five-year period the proposed sections will be in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be that policy will be correct and clear. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

Questions about the content of the proposal may be directed to Johnny D. Adams at (512) 467-5822 in DHS's Special Nutrition Program. Written comments on the proposal may be submitted to Nancy Murphy, Agency Liaison, Media and Policy Services-002, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register.*

The amendments are proposed under the Human Resources Code, Title 2, Chapters 22 and 33, which provides the department with the authority to administer public and nutritional assistance programs.

The amendments implement the Human Resources Code §§22.001-22.024 and §§33.001-33.024.

*§11.103. Eligibility Determination for Recipient Agencies and Recipients.*

(a) (No change.)

(b) DHS requires recipient agencies to submit documentation of compliance with the requirements of the Single Audit Act **(31 U.S.C. 7501-07) as required by 7 Code of Federal Regulations §250.18.** Recipient agencies must submit as proof of eligibility one or more of the forms of documentation of compliance specified in paragraphs (1)-(3) of this subsection:

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

*§11.107. Warehousing and Distribution of Donated Foods.*

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

(d) For an individual recipient agency to qualify for direct shipments of United States Department of Agriculture (USDA) -donated commodities, the recipient agency must:

(1)-(8) (No change.)

(9) comply with the requirements **issued by USDA,** [of] Food and **Consumer Services (FCS), in** [Nutrition Services (FNS)] **FNS** Instruction 709-5, titled "Shipment and Receipt of Food," and comply with other requirements for receiving and storing commodities as specified by DHS;

(10)-(18) (No change.)

(e)-(f) (No change.)

*§11.121. Nonresidential Child and Adult Care Institutions.* **The Texas Department of Human Services** [DHS] distributes donated foods to eligible nonresidential child **and adult** care institutions in quantities, values, and types according to 7 Code of Federal Regulations §250.49.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515027 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Proposed date of adoption: February 1, 1996

For further information, please call: (512) 438-3765

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## Part XIX. Texas Department of Protective and Regulatory Services

### Chapter 700. Child Protective Services

## Subchapter Y. Contracting with Licensed Residential Child-Care Providers

### • 40 TAC §§700.2501-700.2505

The Texas Department of Protective and Regulatory Services (TDPRS) proposes new §§700 2501-700 2505, concerning contracting with licensed residential child-care providers, in its child protective services chapter. The new sections are proposed in new Subchapter Y, Contracting with Licensed Residential Child-Care Providers. The purpose of the new sections is to set forth TDPRS's requirements for contracting with licensed residential child-care providers to provide substitute care to children in TDPRS's managing conservatorship The sections describe general organizational, contractual, and service requirements; identify additional requirements that prospective contractors must meet at the time of their enrollment, establish appropriate staff requirements; and limit the number of children that can be placed in licensed foster family-homes and group-homes under substitute-care contracts with TDPRS. The sections also describe TDPRS's authority to remove children and stop making placements if conditions in a contracted facility constitute an immediate threat to the health, safety, or welfare of any child currently or prospectively in placement there

Jerry Abel, chief fiscal officer, has determined that for the first five-year period the proposed sections will be in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections It is anticipated that some providers, mainly child-placing agencies, may incur additional expenses if these proposed rules are adopted. There may be increased costs related to recruiting, training, and supervising additional foster parents These additional expenses could possibly affect future foster care reimbursement rates.

Mr Abel also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be to improve the quality and effectiveness of the residential care support provided to children in TDPRS's managing conservatorship who have been removed from their homes to protect them from abuse and neglect The sections will do so by clarifying TDPRS's requirements for contracting with licensed residential child-care providers to provide substitute care to such children. There is no anticipated economic cost to persons who are required to comply with the proposed sections, except as mentioned previously

Questions about the content of the proposal may be directed to Margaret Monk at (512) 438-5326 in TDPRS's Protective Services for Families and Children department Written comments on the proposal may be submitted to Nancy Murphy, Agency Liaison, Media and Policy Services-064, Texas Department of Protective and Regulatory Services E-205, P O Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*

The new sections are proposed under the Texas Family Code, Title 5, Chapters 261 and 264, which authorizes the department to provide services to alleviate the effects of child abuse and neglect. In addition, the new sections are proposed under Public Law Number 96-272, Title I, which authorizes the department to administer foster-care and adoption assistance programs provided for under the Social Security Act, Title IV-E.

The new sections are also proposed under the Human Resources Code (HRC), Chapter 40, which describes the services authorized to be provided by the Texas Department of Protective and Regulatory Services, and authorizes the department to enter into agreements with federal, state, or other public or private agencies or individuals to accomplish the purposes of the programs authorized by the HRC; and grants authority to contract to that Department.

The new sections implement the HRC, Chapter 40, which authorizes the department to enter into agreements with federal, state, or other public or private agencies or individuals to accomplish the purposes of the programs authorized by the HRC and which authorizes the department to enter into contracts as necessary to perform any of its powers or duties.

*§700.2501. General Requirements for Contracting with Licensed Residential Child-Care Providers.*

(a) Program description. The Texas Department of Protective and Regulatory Services (TDPRS) contracts with licensed residential child-care providers to provide substitute care to children in TDPRS's managing conservatorship.

(b) Organizational and licensing requirements. To enter into a contract with TDPRS to provide substitute care to children in TDPRS's managing conservatorship, a licensed residential child-care provider must meet the following organizational and licensing requirements:

(1) Requirement for nonprofit status. The provider must be a legally incorporated nonprofit entity. Exception: If a child requires level-06 care at the time of placement as specified in §700. 2307 of this title (relating to Definition of Level 06), TDPRS has the authority to place the child with a for-profit residential child-care provider that provides care at level 06. If the child's level of care is subsequently reduced to level 05, the for- profit provider may continue to care for the child, if doing so is in the child's best interest, until the child's functioning stabilizes and TDPRS can arrange a planned transfer to a nonprofit caregiver. The director of the Office of Protective Services for Families and Children (PSFC) must approve each contract with a for-profit provider.

(2) Licensing. The provider must have a current, valid license to provide 24-hour residential child care in Texas. The license must be issued by:

(A) TDPRS's Office of Child-Care Licensing (CCL); or

(B) one of the state agencies specified in §700.1321(e) of this title (relating to Types of Licensed Caregivers).

(3) Types of CCL-licensed caregivers. If the provider is licensed by CCL, the provider must:

(A) be:

(i) a foster family-home;

(ii) a foster group-home;

(iii) a residential group-care facility; or

(iv) an emergency shelter, as specified in §700.1321(a)-(d) of this title (relating to Types of Licensed Caregivers); or

(B) be a child-placing agency with the authority to verify foster caregivers as specified in Chapter 42, Human Resources Code.

(c) General service requirements. In addition to meeting applicable licensing requirements, the provider must ensure that its organizational structure, its staff, and the services it provides to children in TDPRS's managing conservatorship satisfy all applicable requirements set forth in:

(1) Subchapter M of Chapter 700 of this title (relating to Substitute-Care Services);

(2) Subchapter W of Chapter 700 of this title (relating to Definitions of Levels of Care); and

(3) Subchapter X of this title (relating to Level-of-Care Standards for Foster Caregivers). Exception. Subchapter X of this title (relating to Level-of-Care Standards for Foster Caregivers) does not include requirements that apply to CCL-Licensed emergency shelters as defined in §700.1321(d) of this title (relating to Types of Licensed Caregivers).

(d) Contract term, renewal, and amendment. The term of a contract for residential child care cannot exceed two years, but the contract can be renewed whenever it expires if both parties agree to renew it. The only way to revise a current contract for substitute-care services is to execute a formal, written contract amendment.

*§700.2502. Enrollment Requirements.* At the time of a provider's enrollment and acceptance as a Texas Department of Protective and Regulatory Services (TDPRS) residential child-care contractor, each of the following prerequisites must be satisfied.

(1) The provider must be in full compliance with every applicable requirement set forth in Subchapter X of this title (relating to Level-of-Care Standards for Foster Caregivers).

(2) PSFC must directly inspect and approve the provider's physical facilities and operations. The inspection must include assessments of the provider's:

(A) usable space and equipment;

(B) proximity and access to needed resources and services; and

(C) capacity to protect the health and safety of children in the provider's care.

(3) The provider must agree to abide by all the terms of the contract.

*§700.2503. Staff Requirements.*

(a) Level-of-care definitions and standards. Every licensed residential child-care provider that contracts with the Texas Department of Protective and Regulatory Services (TDPRS) to provide substitute care must meet all applicable requirements governing staff qualifications, staff training, personnel management, staff-to-child ratios, and other personnel matters set forth in:

(1) Subchapter W of Chapter 700 of this title (relating to Definitions of Levels of Care);

(2) Subchapter X of Chapter 700 of this title (relating to Level-of-Care Standards for Foster Caregivers); and

(3) either:

(A) TDPRS's Office of Child-Care Licensing's (CCL's) *Minimum Standards for Child-Placing Agencies*, if the provider is licensed by CCL, or

(B) the licensing requirements of the state agency that licenses the provider, if the provider is not licensed by CCL.

(b) Additional requirements for CCL-licensed foster family-homes and group-homes. In addition to meeting the requirements specified in subsection (a) of this section, CCL-licensed foster family-homes and group-homes must ensure that the following requirements are satisfied.

(1) Every foster parent who provides direct child care must be 21 years of age.

(2) Every foster parent and other staff member solely responsible for direct full-time child care must have at least three years experience in providing the levels of care that the home is authorized to provide. The experience must be documented by at least three written references.

(3) Every staff member who directly supervises child-care staff must be at least 25 years old.

(c) Child-placing agencies. In addition to meeting the requirements specified in subsection (a) of this section, child-placing agencies must ensure that the following requirements are satisfied.

(1) Foster parent's age. Every foster parent who provides direct child care in a subcontracted foster family-home or group-home must be at least 21 years old.

(2) Supervisor's age. Every foster parent and other staff member who directly supervises child-care staff in a subcontracted foster family-home or group-home must be at least 25 years old.

*§700.2504. Number of Children in Care.*

(a) Limits. When a licensed residential child-care provider contracts with the Texas Department of Protective and Regulatory Services (TDPRS) to provide substitute care in a foster family-home or group-home, the number of children served in the home must be limited as specified in paragraphs (1)-(4) of this subsection.

(1) Foster family-homes. No foster family-home may simultaneously serve more than two children who require care at level-03 (or higher), unless the director of the Office of Protective Services for Families and Children (PSFC) or the director's designee approves an exception.

(2) Approving exceptions. Before approving a waiver that constitutes an exception to the limit specified in paragraph (1) of this subsection, the director of PSFC (or the director's designee) must confirm that the extraordinary abilities of a particular family are such that they have demonstrated an ability to care for additional children.

(3) Foster group-homes. No foster group-home may serve more than nine children at the same time, including the foster parents' own children, unless the director of PSFC or the director's designee approves an exception.

(4) Approving exceptions. Before approving a waiver that constitutes an exception to the limit specified in paragraph (3) of this subsection, the director of PSFC (or the director's designee) must confirm that the extraordinary abilities of a particular family are such that they have demonstrated an ability to care for additional children.

(b) Delayed application to current contractors. If, at the time this section takes effect, a foster family-home or group-home is serving more children under an existing contract for licensed residential child-care than subsection (a) of this section permits, the home may continue serving all the children currently in placement there. The home must not accept any additional placements, however, until the number of children in the home falls below the limits specified in subsection (a) of this section through the normal process of transfers and discharges made in the children's best interest. Once the number of children in the home meets the limits specified in subsection (a) of this section, the home must comply with the subsection's requirements.

*§700.2505. Authority to Remove Children and Stop Making Placements.*

(a) Immediate threat to a child's health, safety, or welfare. When a licensed residential child-care provider contracts with the Texas Department of Protective and Regulatory Services (TDPRS) to provide substitute care to children in TDPRS's managing conservatorship, the provider must ensure that each child-care facility operating under the contract secures and protects the health, safety, and welfare of each child in placement there. If at any time TDPRS discovers that conditions exist in a contracted or subcontracted residential child-care facility which constitute an immediate threat to the health, safety, or welfare of any child currently or prospectively in placement there, TDPRS has the authority to take any actions necessary to protect that child. The actions that TDPRS can take in such circumstances include, but are not limited to:

(1) the immediate removal from the facility of any or all of the children whom TDPRS has placed there; and/or

(2) the cessation of any or all new TDPRS placements in the facility.

(b) Immediate action. TDPRS has the authority to take the actions specified in subsection (a) of this section immediately, without regard to the timing of the protections afforded to contractors throughout Chapters 730 and 732 of this title (relating to Legal Services and Contracted Services), including but not limited to the protections available in connection with:

(1) adverse actions;

(2) contract suspensions and terminations; and

(3) the abeyance and removal of current or potential contractual rights.

(c) Notice of removal. When TDPRS removes a child from a contracted or subcontracted residential-care facility as

specified in paragraph (1) of subsection (a) of this section, TDPRS must give one of the facility's adult staff members written notice of the removal. The notice must be provided at the time of removal on a form designated for that purpose by TDPRS.

(d) Notice of cessation of placements. When TDPRS stops any or all placements in a contracted or subcontracted residential-care facility as specified in paragraph (2) of subsection (a) of this section, TDPRS must give the facility written notice of the decision to stop placement. The notice must be provided at the time of the decision on a form designated for that purpose by TDPRS. TDPRS must either:

(1) send the notice to the facility by certified mail, return receipt requested; or

(2) give the notice to one of the facility's adult staff members.

(e) Notice of adverse action. Within 10 working days after removing a child or stopping a placement as specified in subsection (a) of this section, TDPRS must furnish the contracted provider with a notice of adverse action as specified in §730.1604 of this title (relating to Notice of Adverse Action). For purposes of appeal, the notice of adverse action required in this subsection constitutes TDPRS's official notice of action, and the time allowed for requesting a hearing runs from the date of that notice.

(f) Status of decision during appeal. If the provider appeals TDPRS's decision to remove a child or stop a placement, TDPRS's decision remains in effect while the appeal is pending.

(g) Lesser penalties. In addition to taking the actions specified in subsection (a) of this section, TDPRS has the authority to impose any lesser penalties available to it to remove conditions constituting a threat to the health, safety, or welfare of children in the care of a licensed residential child-care provider operating under a contract with TDPRS.

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

Issued in Austin, Texas, on November 20, 1995.

TRD-9515028 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Protective and Regulatory Services

Proposed date of adoption: February 1, 1996

For further information, please call: (512) 438-3765

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# Part XX. Texas Workforce Commission

## Chapter 801. Local Workforce Development Boards

### • 40 TAC §801.1

The Texas Workforce Commission proposes new §801.1, concerning the process for establishing local workforce development boards. This section provides guidance for the formation of local workforce development boards. The chief elected officials in each designated local workforce development area must submit an application and provide the information required to the Commission. Upon approval by the Commission, the application will be submitted to the Governor. This section will apply to local workforce development boards to be formed on or after September 1, 1995.

The Workforce and Economic Competitiveness Act, as amended by Chapter 655, Acts of the 74th Legislature, 1995, requires the Commission to establish rules for the formation of local workforce development boards to plan and oversee the delivery of all workforce training and services programs and evaluate all workforce development programs in the local workforce development areas.

C. Ed Davis, Deputy Administrator for Legal Affairs, has determined, that for the first five years the section as proposed will be in effect, there will be minimal fiscal implications as a result of enforcing or administering the rule. There will be no additional costs for state government as a result of enforcing or administering the rule. Reductions in costs to the state will depend on program consolidation and local involvement and cannot be estimated. Any costs to local governments choosing to create a local workforce development board are entirely within the control of the local government and cannot be estimated.

Mr. Davis also has determined that for the first five years the section as proposed will be in effect the public benefit anticipated as a result of enforcing the section will be improved coordination of and access to workforce training and services programs at the local level. There will be no economic cost to persons who are required to comply with the section as proposed.

Comments on the proposal may be submitted to Leslie Geballe, Intergovernmental Relations, Texas Workforce Commission Building, 101 East 15th Street, Room 602 Austin, Texas 78778, (512) 463-2213.

The section is proposed under Texas Civil Statutes, Article 5190.7a, as amended by Chapter 655, Acts of the 74th Legislature, 1995, which provides the Texas Workforce Commission with the authority to establish rules for the formation of local workforce development boards.

No other statute, article or code will be affected by this proposal,

*§801.1. Requirements for Formation of Local Workforce Development Boards.*

(a) Purpose of Rule.

(1) Upon application by the chief elected officials (CEOs) and approval of the Texas Workforce Commission, (Commission) the Commission will forward an application to form a local workforce development board to the Governor.

(2) Before an application may be submitted to the Governor, all requirements of this section must be met.

(b) State and Federal Law. The formation of local workforce development boards is governed by the following federal statutes and regulations and state statutes:

(1) The Job Training Partnership Act, as amended, 29 United States Code, §1501, et seq;

(2) 20 Code of Federal Regulation Part 628; and

(3) The Workforce and Economic Competitiveness Act, Texas Civil Statutes, Article 5190.7a, as amended.

(c) Chief Elected Official Agreement. Creation of a board requires agreement by at least three-fourths of the CEOs in the workforce development area who represent units of general local government, including all of the CEOs who represent units of general local government having populations of at least 200,000. The elected officials agreeing to the creation of the board must represent at least 75% of the population of the workforce development area.

(d) Chief Elected Officials. The CEOs may, and are encouraged to, consult with local officials other than the ones delineated below. The following officials are designated as the chief elected officials for the purpose of establishing agreements to form local workforce development boards:

(1) The mayor of each city that meets the criteria for a central city within a Metropolitan Statistical Area, defined as an urban area that has a city of 50,000 inhabitants or more, within corporate limits, or that contains an urbanized area of at least 50,000 and has a total population of at least 100,000, according to the last federal census in a workforce development area; and

(2) The mayor of each city with a population of at least 100,000 as reported by the Texas State Data Center.

(3) All county judges included in a workforce development area as designated by the Governor.

(e) Time of Application. CEOs in an area may not establish a local board until the Governor has designated that area as a local workforce development area as provided in the Workforce and Economic Competitiveness Act, Texas Civil Statutes, Article 5190.7a, as amended.

(f) Applications must meet all

Governor-approved criteria for the establishment of local workforce development boards.

(g) Procedure for Formation of a Local Workforce Development Board. The CEOs must comply with the following to apply for the formation of a local workforce development board:

(1) Pre-application procedure. If a majority of the CEOs, as defined in subsection (d) of this section, agree to initiate procedures to establish a local workforce development board, they must send a letter to the Executive Director of the Commission requesting pre-application status. The Commission staff will be available to work with local officials during the development of the application. During the pre-application process and prior to applying to the Commission for approval, the CEOs must:

(A) Conduct a public process to consider the views of all affected local organizations, including private industry councils, quality workforce planning committees, and other affected organizations before making a final decision to form a local workforce development board.

(B) Hold a public meeting to discuss and gather information concerning the establishment of a local workforce development board prior to the submission of the application.

(2) Application procedure.

(A) The CEOs must submit an application to the Commission. This application must include evidence of the actions required by the pre-application process as identified in paragraph (1) of this subsection. As a part of the application, each of the CEOs agreeing to the formation of a local workforce development board must sign an agreement that includes the following:

(i) an interlocal agreement delineating:

(I) the purpose of the agreement;

(II) the process that will be used to select the CEO who will act on behalf of the other CEOs and the name of such CEO if the person has been selected;

(III) the process that will be followed to keep those CEOs informed regarding local workforce development activities;

(IV) the initial size of the local workforce development board;

(V) how resources allocated to the local workforce development area will be shared among the parties to the agreement;

(VI) the process to be used to appoint the board members, which must be consistent with applicable federal and state laws; and

(VII) the terms of office of the members of the board.

(ii) the following notice: Figure 1: 40TAC §801.1(g)(2)(A)(ii)

(B) CEOs in the area must provide evidence that the private industry council(s) as currently constituted has agreed to dissolve and be replaced by the proposed local workforce development board upon certification. When the partnership agreement and private industry council(s) by-laws allow, the CEOs must present evidence that they have dissolved the current private industry council(s) in accordance with the provisions of said agreement and by-laws.

(C) The application shall include the names and affiliations of individuals recommended for board membership, with documentation that CEOs followed the nomination process specified in applicable state and federal law.

(i) Private sector members shall be owners of business concerns, chief executives or chief operating officers of nongovernmental employers or other private sector executives who have substantial management or policy responsibility.

(ii) Private sector members must reasonably represent the industrial and demographic composition of the business community as described in workforce development area profiles provided by the Commission. Private sector employers, not directly providing employment and training services to the general public, shall receive primary consideration for Board membership.

(iii) Private sector members must include two representatives from workforce development area businesses in each of the following size categories: 1-99 employees, 100-249 employees, 250-500 employees, 501+ employees. Whenever possible, at least one-half of business and industry representatives shall be representatives of small business, including minority business. Small business means private for profit enterprises employing 500 or fewer employees. Whenever possible, at least one-fourth of business and industry representatives shall be representatives of employers with 501 or more employees.

(iv) Not less than 15% of the membership of the board shall be representatives of organized labor and community-based organizations. Every effort shall be made to ensure that both labor and community-based organizations shall be represented. Labor members shall be selected from individuals recommended by local central labor councils or recognized state and local labor federations. If the federations fail to nominate a sufficient number of individuals to meet the labor representation requirements of this subsection, individual workers may be included on the council to complete the labor representation. For purposes of this section, a labor federation is an alliance of two or more organized labor unions for the purpose of mutual support and action. An example of a recognized labor federation is the AFL-CIO.

(D) Evidence for the items in the application may consist of written documents, written agreements, minutes of public meetings, copies of correspondence, and such other documentation as may be appropriate.

(E) CEOs who have submitted complete applications to the Texas Council on Workforce and Economic Competitiveness may supplement those applications with documentation of any actions necessary to meet the provisions in these rules.

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

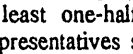
Issued in Austin, Texas, on November 20, 1995.

TRD-9515022

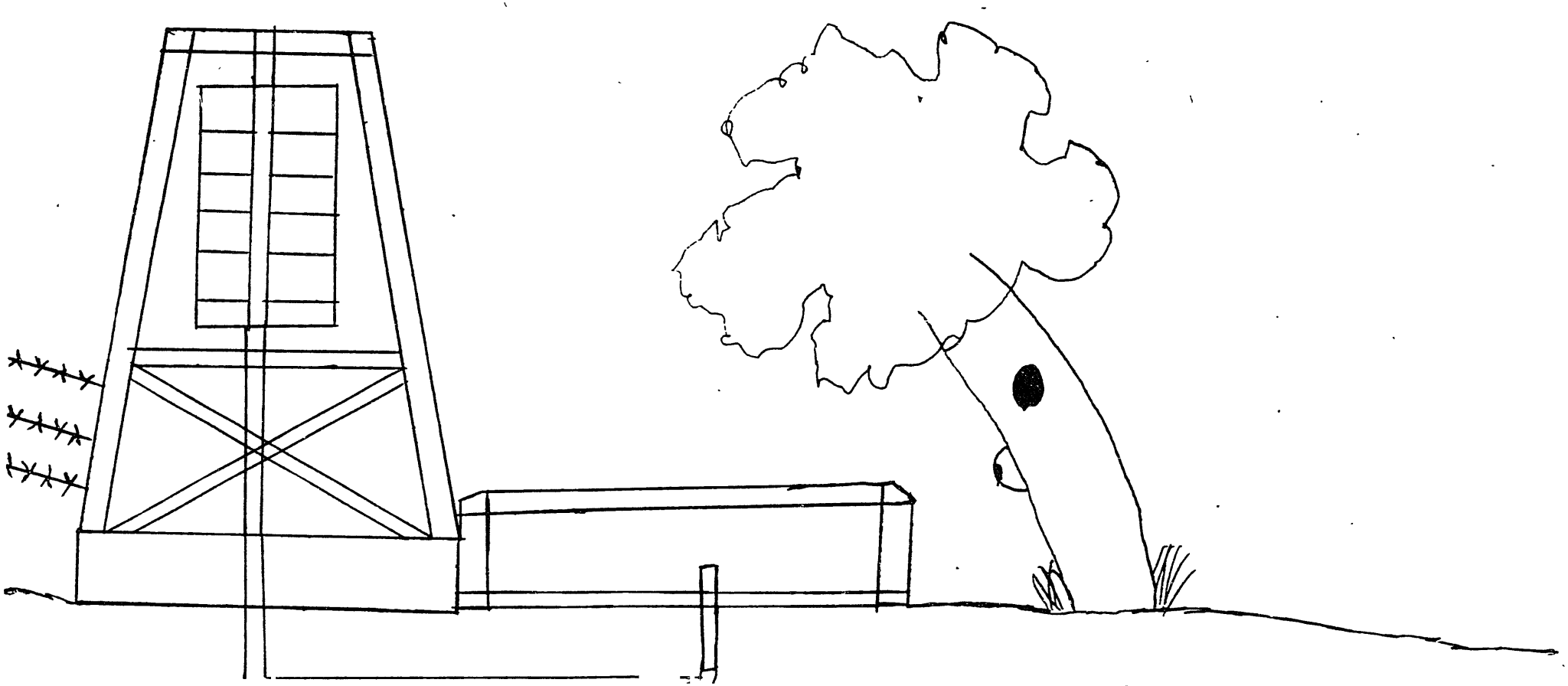
C. Ed Davis
Deputy Administrator for Legal Affairs
Texas Workforce Commission

Earliest possible date of adoption: December 25, 1995

For further information, please call: (512) 463-2291



Name: Cody Kloesel
Grade: 4
School: Moulton Elementary School, Moulton ISD



# WITHDRAWN RULES

An agency may withdraw a proposed action or the remaining effectiveness of an emergency action by filing a notice of withdrawal with the ***Texas Register***. The notice is effective immediately upon filling or 20 days after filing as specified by the agency withdrawing the action. If a proposal is not adopted or withdrawn within six months of the date of publication in the ***Texas Register***, it will automatically be withdrawn by the office of the Texas Register and a notice of the withdrawal will appear in the ***Texas Register***.

## TITLE 25. HEALTH SERVICES

## Part I. Texas Department of Health

### Chapter 35. Pharmacy Services

### Subchapter U. Support Documents

**• 25 TAC §35.901**

The Texas Department of Health has withdrawn from consideration for permanent adoption a proposed repeal to §35.901, which appeared in the June 16, 1995, issue of the *Texas Register* (20 TexReg 4393). The effective date of this withdrawal is November 16, 1995.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514906 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: November 16, 1995

For further information, please call: (512) 458-7236

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The Texas Department of Health has withdrawn from consideration for permanent adoption a proposed new §35.901, which appeared in the June 16, 1995, issue of the *Texas Register* (20 TexReg 4393). The effective date of this withdrawal is November 16, 1995.

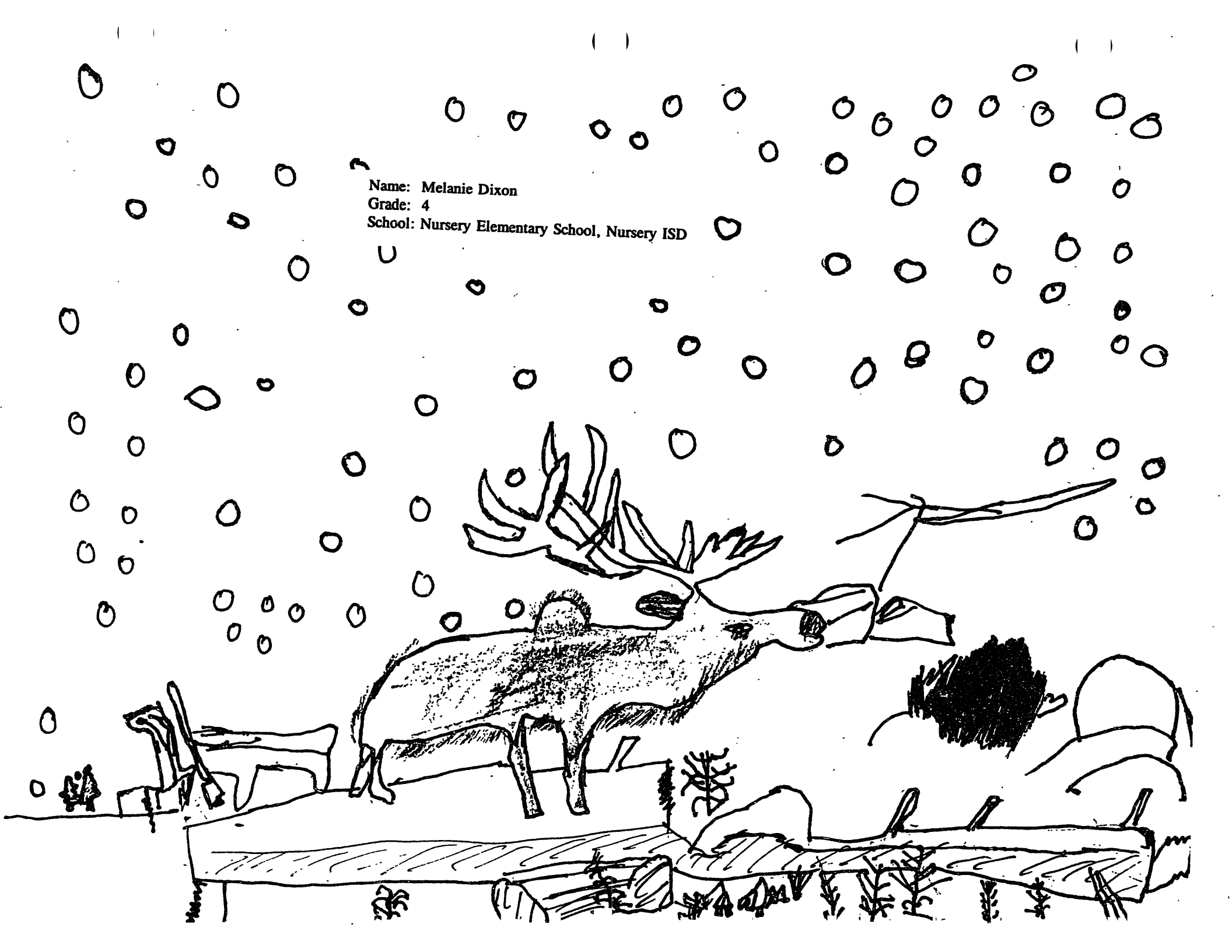
Issued in Austin, Texas, on November 15, 1995.

TRD-9514907 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: November 16, 1995

For further information, please call: (512) 458-7236

♦ ♦ ♦


Name: Melanie Dixon
Grade: 4
School: Nursery Elementary School, Nursery ISD

# ADOPTED RULES

An agency may take final action on a section 30 days after a proposal has been published in the ***Texas Register***. The section becomes effective 20 days after the agency files the correct document with the ***Texas Register***, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice.

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published. If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes.

## TITLE 22. EXAMINING BOARDS

## Part I. Texas Board of Architectural Examiners

### Chapter 1. Architects

### Subchapter A. Scope; Definitions

#### • 22 TAC §§1.3, 1.5, 1.8

The Texas Board of Architectural Examiners adopts amendments to §§1.3, 1.5, and 1.8, concerning legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6787).

The rules are being amended to conform to the legislative changes.

The rules will clarify terminology.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249a, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514892 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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#### • 22 TAC §1.9

The Texas Board of Architectural Examiners adopts an amendment to §1.9, concerning signatures on expenditure vouchers, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8055).

This rule is being adopted to expedite voucher processing when the executive director is absent.

This rule is being amended to expedite the processing of expenditure vouchers.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 249a, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515006 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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### Subchapter B. Registration

#### • 22 TAC §§1.21, 1.23, 1.25

The Texas Board of Architectural Examiners adopts amendments to §§1.21, 1.23, and 1.25, to avoid duplication of applications, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8056).

These rules are being amended to prevent applicants submitting the same material to the board office and the National Council of Architectural Registration Boards.

These rules will clarify confusing terminology and duplication of applications.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249a, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515007 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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### Subchapter C . Examinations

#### • 22 TAC §1.45

The Texas Board of Architectural Examiners adopts an amendment to §1.45, concerning the conditions for administration of the Architect Registration Examination, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8056).

This rule is being amended to clarify the process if the results of the examination cannot be provided to the candidate.

This rule will provide the candidates with the retake of examination process should the agency be unable to provide examination results.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249a, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515001 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter I. Charges Against Architects: Action

### • 22 TAC §1.165, §1.174

The Texas Board of Architectural Examiners adopts amendments to §1.165 and §1.174, concerning legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* 20 TexReg 6787).

The rules are being amended to conform to the legislative changes.

The rules will clarify terminology.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249a, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514893 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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# Chapter 3. Landscape Architects

## Subchapter A. Scope; Definitions

### • 22 TAC §§3.3, 3.5, 3.8

The Texas Board of Architectural Examiners adopts amendments to §§3.3, 3.5, and 3.8, concerning legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6788).

The rules are being amended to conform to the legislative changes.

The rules will clarify terminology.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules consistent with the Code.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514890 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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### • 22 TAC §3.9

The Texas Board of Architectural Examiners adopts an amendment to §3.9, concerning signatures on expenditure vouchers, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8057).

This rule is being amended to expedite voucher processing when the executive director is absent.

This rule will expedite the processing of expenditure vouchers.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515010 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter C. Written Examinations

### • 22 TAC §3.45

The Texas Board of Architectural Examiners adopts an amendment to §3.45, concerning the conditions for administration of the Landscape Architect Registration Examination, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8057).

This rule is being amended to clarify the process if the results of the examination cannot be provided to the candidate.

This rule will provide candidates with the retake of examination process should the agency be unable to provide examination results.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515002 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter C. Written Examinations

### • 22 TAC §3.46

The Texas Board of Architectural Examiners adopts an amendment to §3.46, concerning examination review for landscape architectural candidates, without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6788).

The rule is being amended to conform to the Council of Landscape Architectural Registration Boards requirements.

The rule will clarify confusing terminology.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514889 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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## Subchapter E. Fees

### • 22 TAC §3.86

The Texas Board of Architectural Examiners adopts an amendment to §3.86, regarding Reciprocal Transfer fees, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 9057).

This rule is being amended to increase revenue for increased appropriations.

This rule will allow the agency to be more responsive to requests from the public due to the upgrading of the information resources system and allow the agency to furnish the public updated consumer information.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515012 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter I. Charges Against Landscape Architects: Action

### • 22 TAC §3.161, §3.164

The Texas Board of Architectural Examiners adopts amendments to §3.161, and §3.164, concerning legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6789).

The rules are being amended to conform to the legislative changes.

The rules will clarify terminology.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249c, which provide the Texas Board of Architectural Examiners with authority to promulgate rules consistent with the code.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514891 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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# Chapter 5. Interior Designers

## Subchapter A. Scope; Definitions

### • 22 TAC §§5.3, 5.5, 5.8

The Texas Board of Architectural Examiners adopts amendments to §§5.3, 5.5, and 5.8, concerning legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6789).

The rules are being amended to conform to the legislative changes.

The rules will clarify terminology.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514894 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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### • 22 TAC §5.9

The Texas Board of Architectural Examiners adopts an amendment to §5.9, concerning signatures on expenditure vouchers, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8058).

This rule is being amended to expedite voucher processing when the executive director is absent.

This rule will expedite processing of vouchers.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515008 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter C. Examinations

### • 22 TAC §5.55

The Texas Board of Architectural Examiners adopts an amendment to §5.55, concerning the conditions for administration of the National Council for Interior Design Qualification, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8058).

This rule is being amended to clarify the process if the results of the examination cannot be provided for the candidate.

This rule will provide candidates with the retake of examination process should the agency be unable to provide examination results.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with the authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515005 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## Subchapter E. Fees

### • 22 TAC §5.92

The Texas Board of Architectural Examiners adopts the repeal of §5.92, regarding regis-

tration without examination fee, without changes as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8058).

This repeal is necessary to comply with the cut off date of August 31, 1994 set by the Texas State Legislature for Grandfather applications.

This rule will require all future candidates to pass the registration exam to better protect the public health, safety and welfare.

No comments were received regarding adoption of the repeal.

The repeal is adopted under Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515009 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## • 22 TAC §5.93

The Texas Board of Architectural Examiners adopts an amendment to §5.93, regarding application and examination fees, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8059).

This rule is being amended to increase the fees the agency must charge in order to increase revenue for increased appropriations.

This rule will allow the agency to be more responsive to requests from the public due to the upgrading of the information resources system and allow the agency to process information more efficiently.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515011 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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## • 22 TAC §5.97

The Texas Board of Architectural Examiners adopts an amendment to §5.97, regarding reciprocal transfer fees, without changes to the proposed text as published in the October 3, 1995, issue of the *Texas Register* (20 TexReg 8059).

This rule is being amended to increase the fees the agency must charge in order to increase revenue for increased appropriations.

This rule will allow the agency to be more responsive to requests from the public due to the upgrading of the information resources system and allow the agency to process information more efficiently.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515013 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 8, 1995

Proposal publication date: October 3, 1995

For further information, please call: (512) 305-8535

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# Subchapter I. Charges Against Interior Designers: Action

## • 22 TAC §5.174

The Texas Board of Architectural Examiners adopts an amendment to §5. 174, to reflect legislative changes from Administrative Procedure and Texas Register Act (APTRA) to Administrative Procedure Act (APA), without changes to the proposed text as published in the September 1, 1995, issue of the *Texas Register* (20 TexReg 6789).

The rule is being amended to conform to the legislative changes.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Civil Statutes, Article 249e, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514895 Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners

Effective date: December 6, 1995

Proposal publication date: September 1, 1995

For further information, please call: (512) 305-8535

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# Part XII. Board of Vocational Nurse Examiners

# Chapter 231. Administration

# General Provisions

## • 22 TAC §231.1

The Board of Vocational Nurse Examiners adopts an amendment to §231.1, relative to definitions, without changes to the proposed text as published in the September 22, 1995, issue of the *Texas Register* (20 TexReg 7572).

The rule is amended to add definitions for the term "current license" and "delinquent license".

The definitions will clarify these terms for individuals applying for licensure.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514964 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 22, 1995

For further information, please call: (512) 835-2071

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# Chapter 233. Education

# Vocational Nursing Education Standards

## • 22 TAC §233.65

The Board of Vocational Nurse Examiners adopts an amendment to §233.65, relative to admission criteria, without changes to the proposed text as published in the September

22, 1995, issue of the *Texas Register* (20 TexReg 7572).

The rule is adopted to comply with changes in the Vocational Nurse Act.

Each school already sets there own education requirements for admission and the amendment of this rule will make it consistent with those of the schools.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514965 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 22, 1995

For further information, please call: (512) 835-2071

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## Chapter 235. Licensing

### Issuance of Licenses

### • 22 TAC §235.48

The Board of Vocational Nurse Examiners adopts an amendment to §235.48, relative to reactivation of a license, without changes to the proposed text as published in the September 22, 1995, issue of the *Texas Register* (20 TexReg 7252).

The rule is amended to comply with changes in the Vocational Nurse Act and to make rules consistent.

The amendment will assure that nurses who have not practice for specific periods of time will have to go back to school and/or re-test prior to renewing their license.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514966 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 22, 1995

For further information, please call: (512) 835-2071

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## Chapter 237. Continuing Education

### Continuing Education

### • 22 TAC §237.19

The Board of Vocational Nurse Examiners adopts an amendment to §237.19, relative to relicensure process, without changes to the proposed text as published in the September 29, 1995, issue of the *Texas Register* (20 TexReg 7917).

The rule is amended to create consistency in the rules and to comply with changes in the statute.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514968 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 29, 1995

For further information, please call: (512) 835-2071

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## Chapter 239. Contested Case Procedure

### Definitions

### • 22 TAC §239.1

The Board of Vocational Nurse Examiners adopts an amendment to §239.1, relating to definitions of language as used in the Rules and Regulations, without changes to the proposed text as published in the September 22, 1995, issue of the *Texas Register* (20 TexReg 7573).

The rule is amended to reflect changes in the Vocational Nurse Act and for consistency with other sections of the rules and regulations.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514967 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 22, 1995

For further information, please call: (512) 835-2071

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### Enforcement

### • 22 TAC §§239.11-239.13

The Board of Vocational Nurse Examiners adopts amendments to §239.11, relating to Unprofessional Conduct, §239.12, relating to Licensure of Persons With Criminal Convictions, and §239.13, relating to Licensure of Persons With a History of Psychiatric Episodes, without changes to the proposed text as published in the September 29, 1995, issue of the *Texas Register* (20 TexReg 7918).

Section 239.11 is amended to clarify the language and to eliminate excessive wording. Section 239.12 is amended to comply with the changes in the Vocational Nurse Act. Section 239.13 is amended for clarity.

Section 239.12 relating to Licensure of Persons With Criminal Convictions will become effective January 1, 1996. However, students enrolled in a vocational nursing program who graduate prior to December 31, 1996, will be reviewed under the rules in effect prior to January 1, 1996.

No comments were received regarding adoption of the amendments.

The amendments are adopted under Texas Civil Statutes, Article 4528c(h), §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514969 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date for §239.11 and §239.13: December 8, 1995

Effective date for §239.12: January 1, 1996

Proposal publication date: September 29, 1995

For further information, please call: (512) 835-2071

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## Hearings Process

### • 22 TAC §§239.29-239.33

The Board of Vocational Nurse Examiners adopts the repeals of §239.29, relating to continuance, §239.30, relating to Computation of Time, §239.31, relating to Probation, §239.32, relating to Records Retention Schedule, and §239.33, relating to Release of Information, without changes to the proposed text as published in the September 29, 1995, issue of the *Texas Register* (20 TexReg 7920).

These rules are being repealed to allow for the adoption of new rules in compliance with the Vocational Nurse Act as amended during the 74th Legislative Session and for renumbering purposes.

No comments were received regarding adoption of the repeals.

The repeals are adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514970 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 29, 1995

For further information, please call: (512) 835-2071

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### • 22 TAC §§239.29-239.36

The Board of Vocational Nurse Examiners adopts new §239.29, relating to Continuance, §239.30, relating to Entry of Appearance; Continuance, §239. 31, relating to Failure to Attend Hearing, §239.32, relating to Computation of Time, §239.33, relating to Probation, §239.34, relating to Records Retention Schedule, §239.35, relating to Release of Information, and §239. 36, relating to Temporary Suspensions, without changes to the proposed text as published in the September 29, 1995, issue of the *Texas Register* (20 TexReg 7920).

The new rules are adopted for clarity, for compliance with the Vocational Nurse Act, as amended during the 74th Legislative Session, and for renumbering of certain rules.

No comments were received regarding adoption of the new sections.

The new sections are adopted under Texas Civil Statutes, Article 4528c, §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514971 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: September 29, 1995

For further information, please call: (512) 835-2071

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## Reinstatement Process

### • 22 TAC §239.51, §239.53

The Board of Vocational Nurse Examiners adopts amendments to §239.51, relating to Application for Reinstatement of License and §239.53, relating to Procedure Upon Request for Reinstatement, without changes to the proposed text as published in the October 17, 1995, issue of the *Texas Register* (20 TexReg 8386).

Section 239.51 is being amended for consistency with other rules that have been amended. Section 239.53 is being amended to clarify information required in psychiatric, psychological or medical evaluations.

No comments were received regarding adoption of the amendments.

The amendments are adopted under Texas Civil Statutes, Article 4528c(h), §5(h), which provide the Board of Vocational Nurse Examiners with the authority to make such rules and regulations as may be necessary to carry in effect the purposes of the law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9514972 Marjorie A. Bronk
Executive Director
Board of Vocational Nurse Examiners

Effective date: December 8, 1995

Proposal publication date: October 17, 1995

For further information, please call: (512) 835-2071

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# Part XXX. Texas State Board of Examiners of Perfusionists

## Chapter 761. Perfusionists

### • 22 TAC §§761.2, 761.7, 61.9, 761.10, 761.13, 761.20

The Texas State Board of Examiners of Perfusionists (board) adopts amendments to §§761.2, 761.7, 761.9, 761.10, and 761.13 and new §761.20, concerning licensed perfusionists and provisional licensed perfusionists. Section 761.20 is adopted with changes to the proposed text as published in the September 15, 1995, issue of the *Texas Register* (20 TexReg 7259). Sections 761.2, 761.7, 761.9, 761.10, and 761.13 are adopted without changes to the proposed text as published in the September 15, 1995, issue of the *Texas Register* (20 TexReg 7258) and will not be republished.

Specifically, the amendments establish a fee for reinstatement of a license suspended for failure to pay child support; permit a licensed physician to supervise provisional licensed perfusionist with board approval; extend the grandfather period for application; establishes procedures for suspension of a license for failure to pay child support under the Family Code, Chapter 232 as added by Acts 1995, 74th Legislature, Chapter 751, §85 (HB433).

The amendments and new section assure that the regulation of perfusionists continues to identify competent practitioners.

No comments were received regarding the proposed amendments or the new section. However, a change was made to §761.20(h). The reference to subsection (g) was incorrect. The correct reference for the reinstatement fee is §761.2(s)(2)(F).

The amendments and new sections are adopted under the Licensed Perfusionists Act, Texas Civil Statutes, Article 4529e, §7, which provide the Texas State Board of Examiners of Perfusionists with the authority to adopt rules concerning the regulation and licensure of perfusionists.

*§761.20. Suspension of License for Failure to Pay Child Support.*

(a) On receipt of a final court or attorney general's order suspending a license due to failure to pay child support, the executive secretary shall immediately determine if the board has issued a license to the obligator named on the order. If a license has been issued, the executive secretary shall:

(1) record the suspension of the license in the board's records;

(2) report the suspension as appropriate; and

(3) demand surrender of the suspended license.

(b) The board shall implement the terms of a final court or attorney general's

order suspending a license without additional review or hearing. The board will provide notice as appropriate to the licensee or to others concerned with the license.

(c) The board may not modify, remand, reverse, vacate, or stay a court or attorney general's order suspending a license issued under the Family Code, Chapter 232 as added by Acts 1995, 74th Legislature Chapter 751, §85 (HB 433) and may not review, vacate, or reconsider the terms of an order.

(d) A licensee who is the subject of a final court or attorney general's order suspending his or her license is not entitled to a refund for any fee paid to the board.

(e) If a suspension overlaps a license renewal period, an individual with a license suspended under this section shall comply with the normal renewal procedures in the Act and this chapter; however, the license will not be renewed until subsections (g) and (h) of this section are met.

(f) An individual who continues to use the titles "licensed perfusionist" or "provisional licensed perfusionist" after the issuance of a court or attorney general's order suspending the license is liable for the same civil and criminal penalties provided for engaging in the prohibited activity without a license or while a license is suspended as any other license holder of the board.

(g) On receipt of a court or attorney general's order vacating or staying an order suspending a license, the executive secretary shall promptly issue the affected license to the individual if the individual is otherwise qualified for the license.

(h) The individual must pay a reinstatement fee set out at §761.2(S)(w)(F) of this title (relating to The Board's Operation) prior to issuance of the license.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 17, 1995.

TRD-9515029 Shannon E. Ballard
Chairman
Texas State Board of Examiners of Perfusionists

Effective date: December 11, 1995

Proposal publication date: September 15, 1995

For further information, please call: (512) 458-7236

# TITLE 25. HEALTH SERVICES

## Part I. Texas Department of Health

### Chapter 29. Purchased Health Services

On behalf of the State Medicaid Director, the Texas Department of Health (department) adopts amendments to §§29.601, 29.1104, 29.1126, and 29.1127, concerning purchased health services, without changes to the proposed text as published in the August 22, 1995, issue of the *Texas Register* (20 TexReg 6391).

The sections are amended to address cost-of-living adjustments applicable to reimbursements for hospital, in-home total parenteral hyperalimentation, in-home respiratory therapy services, and the Texas Medicaid reimbursement methodology which applies to physician and physician-related services. The sections specifically address cost-of-living adjustments during the 1996-1997 state biennium.

The sections specify in §29.601 that outpatient hospital services will be reimbursed at 83.65% of cost during fiscal year 1996 and 77.6% of cost during fiscal year 1997. Based on appropriated funding, outpatient hospital rates continue to be reduced by approximately 5.0% per year which results in the compounded percentages indicated above. The amendments to §§29.1104, 29.1126, and 29.1127 remove references to the governor's cost containment provisions which expire August 31, 1995. The existing language stipulates future cost-of-living adjustments (COLAs) and will be dependent on available funding.

A summary of the comments and the department's responses to the comments is as follows.

Comment: The commenter recognizes that the proposed rules are taken by the department in order to comply with the limitations of the 1996-1997 appropriations adopted by the 74th Legislature, however, the commenter has not been able to identify any legislative action or any appropriation rider approved by the legislature that mandates the department to extend the discount into the current biennium. Furthermore, the commenter suggests that the legislature has made it clear in the past that access to cost-effective preventive and primary care services should be maintained and enhanced to the greatest extent possible.

Response: The department agrees with the commenter that the 1996-1997 appropriations did not include a rider that mandates the department to extend the discount into the current biennium. However, the department is required to comply with the appropriations established for the next biennium, and these appropriations do not allow the department to maintain reimbursement rates at current levels.

Comment: In regard to §29.601(a)(2) regarding payments for outpatient hospital services, the commenter expressed concern with the amount of the discount calculated by the department. The commenter estimates that the actual discount factor for outpatient hospital services is more than 7.0% per year rather than the 5.0% estimated by the department. The commenter requested that the department provide a detailed description of how the discount factors were computed.

Response: The department states that the rates continue to be reduced by approximately 5.0% per year which results in the compounded percentages of 83. 65% for fiscal year 1996 and 77.6% for fiscal year 1997. It is the compounding effect of the discounting over the entire period that causes the discount applied in the final year to be slightly more than 7.0%. This estimate, while perhaps inappropriate on an individual hospital basis, is in keeping with the overall historical price behavior of this environment. The department will provide the commenter with the mathematical method of discounting to arrive at the stated percentages, however, no change will be made to the section as a result of the comment.

Comment: The commenter requests that the emergency rules published in the August 22, 1995, issue of the *Texas Register* be withdrawn and that the outpatient payment discount factor be eliminated for all outpatient services provided on or after September 1, 1995.

Response: As previously stated, the department must fund services based on the appropriations established by the legislature. In order to remain within these funding levels, the department must implement the reimbursement rates at the stated percentages. No change will be made as a result of the comment.

Comments were received from the Texas Hospital Association (THA) against the amendments.

### Subchapter G. Hospital Services

#### • 25 TAC §29.601

The amendment is adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to adopt rules to administer the state's medical assistance program and are submitted by the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the purchased health services program and authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514904 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 22, 1995

For further information, please call: (512) 458-7236

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## Subchapter L. General Administration

### • 25 TAC §§29.1104, 29.1126, 29.1127

The amendments are adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to adopt rules to administer the state's medical assistance program and are submitted by the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the purchased health services program and authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514905 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 22, 1995

For further information, please call: (512) 458-7236

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## Chapter 40. Medical Transportation

On behalf of the State Medicaid Director, the Texas Department of Health (department) adopts amendments to §§40.1, 40.101, 40.103, 40.202, and 40.401, concerning medical transportation services, without changes to the proposed text as published in the August 15, 1995, issue of the *Texas Register* (20 TexReg 6191).

Currently, medical transportation providers (MTP) are reimbursed for transporting Medicaid clients to and from allowable medical services at a rate of $.15 per mile, as established by the MTP program. The amendments will increase the mileage reimbursement rate for MTP providers to the rate established by the legislature for state employees; and authorize transportation of a client to and from a provider of services that meet the client's medical needs and who is located reasonably close to the client, whether the provider is located in the client's county of residence or elsewhere. The amendments also clarify that all Medicaid recipients up to age 21 and their attendants may be eligible for meals and lodging under the Early Periodic, Screening, Diagnosis, and Treatment Program (EPSDT).

These sections as amended will improve access to medical transportation services for Medicaid clients.

No comments were received during the public comment period.

## Program Overview

### • 25 TAC §40.1

The amendment is adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which authorize the Health and Human Services Commission to adopt rules to administer the state's medical assistance program, and are submitted to the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the medical transportation program as authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514900 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 15, 1995

For further information, please call: (512) 458-7236

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## Eligibility for Program Services

### • 25 TAC §40.101, §40.103

The amendments are adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which authorize the Health and Human Services Commission to adopt rules to administer the state's medical assistance program, and are submitted to the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the medical transportation program as authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514901 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 15, 1995

For further information, please call: (512) 458-7236

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## Program Services Limitations

### • 25 TAC §40.202

The amendment is adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which authorize the Health and Human Services Commission to adopt rules to administer the state's medical assistance program, and are submitted to the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the medical transportation program as authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514902 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 15, 1995

For further information, please call: (512) 458-7236

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## Payment Procedures and Recordkeeping

### • 25 TAC §40.401

The amendment is adopted under the Human Resources Code, §32.021 and Texas Civil Statutes, Article 4413(502), §16, which authorize the Health and Human Services Commission to adopt rules to administer the state's medical assistance program, and are submitted to the Texas Department of Health under its agreement with the Health and Human Services Commission to operate the medical transportation program as authorized under Chapter 15, §1.07, Acts of the 72nd Legislature, First Called Session (1991).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514903 Susan K. Steeg
General Counsel
Texas Department of Health

Effective date: December 7, 1995

Proposal publication date: August 15, 1995

For further information, please call: (512) 458-7236

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# TITLE 28. INSURANCE

## Part I. Texas Department of Insurance

## Chapter 3. Life, Accident and Health Insurance and Annuities

## Subchapter X. Preferred Provider Plans

### • 28 TAC §§3.3701-3.3705

The Texas Department of Insurance adopts amendments to §§3.3701-3.3705, concerning health insurance policies that incorporate preferred provider plans, with changes to the proposed text as published in the July 25, 1995 issue of the *Texas Register* (20 TexReg 5471).

These amendments address the Governor's directive that the Commissioner of Insurance enact rules to maintain quality of health care for all Texans at affordable prices and to establish procedures for fairness to health care providers. Protection of patients in the rapidly changing health care marketplace requires these updated regulations. These amendments are necessary to assist consumers in making informed choices among health care plans; to prohibit retaliation against insureds for filing complaints or appealing decisions, to provide for continuity of patient care; to provide for reimbursement for medically necessary emergency care services; to provide fairness to physicians and providers not designated as preferred providers or terminated from the preferred provider plan; and to assist the department in evaluating quality and costs of health care. The rules as adopted differ in some respects from the proposed rules as published based on further study generated by comments received. Specific changes and reasoned justification for the rule amendments and agency responses to comments are addressed in §4, Summary of Comments.

The amendments to this subchapter shall become effective December 6, 1995. Section 3.3701, as amended, states that these rules do not create a private cause of action, deletes provisions concerning physicians and practitioners and adds a severability provision. Section 3.3702 adds a definition of emergency care, changes the definition of health care provider and practitioner, adds a definition of prospective insured and changes the definition of utilization review. Section 3.3703 amends the existing requirement for a physician panel to review denial of a designation as a preferred provider by adding that the panel is to include, if available, one member in the same or similar specialty as the physician being reviewed and requiring that the panel's and insurer's determinations be provided to the affected physician upon request. The section also requires insurers to make application information available to prospective preferred providers. The section also adds a provision restricting financial incentives to providers which would act as an inducement to limit medically necessary services. Amendments to §3.3703 also clarify the ability of the department to obtain information from insurers to assess accessibility, affordability, quality and costs of health care. Amendments to §3.3704 enhance freedom of choice for the insured relating to continuity of care by requiring an insurer to provide reasonable advance notice and to make a current list of preferred providers available to an insured upon termination of a participating provider. The section provides for continuity of ongoing treatment for patients with special circumstances for up to 90 days after the effective date of termination of the treating physician or provider. Amendments to §3.3704 also require the insurer to reimburse at the preferred provider rate level of benefits for certain necessary emergency care services. Amended §3.3704 also enhances freedom of choice by assisting prospective insureds in making informed choices when selecting health care plans. The section requires insurers to disclose certain information about the plans to prospective group contract holders and prospective insureds. Section 3.3705, as amended, prohibits retaliation against an insured for filing complaints or appealing decisions or against a physician or provider complaining on behalf of an insured. Amended §3.3705 also requires an insurer to provide a list of written reasons to a physician or provider before terminating a contract with a physician or provider; provides that, upon request, the insurer shall provide an advisory panel to review the termination of a physician and requires the insurer to provide the panel's and insurer's determination to the affected physician upon request. The section, as amended, also requires any economic profiling data relied upon by the insurer to admit or terminate a particular physician or provider to be made available to that physician or provider upon request. New language added to §3.3705 provides that an insurer may contract with a preferred provider organization in order to meet the requirements of the subchapter, but specifies that it remains the insurer's responsibility to assure that the requirements are met.

General-Most commenters expressed general support for the proposed rule amendments and many offered comments or concerns on specific sections of the proposed amendments. Several commenters stated that the rules were a positive step in establishing meaningful standards for managed care and commended the agency for its efforts. A large number of commenters specifically supported the emergency care and disclosure provisions. One commenter expressed general support for the rules but cautioned that these issues call for legislative action and that the rules should not be viewed as a substitute for broad and comprehensive legislative action. Other commenters expressed generally negative comments about interference with private contractual relationships and conferring special rights on specific groups, particularly physicians and other providers of health care. Several commenters expressed concerns that the rules would drive up costs, including costs to small businesses, thus denying access to group health care for some Texas workers. Some commenters stated that the rules appeared to slant more toward fair treatment of providers rather than allowing the marketplace to set lower negotiated fees for medical care. One commenter stated that it is not clear whether fully insured plans provided by an employer would be exempt from the sections of this subchapter. A commenter stated that Medicare Supplement and Medicare Select policies should be exempt from these rules. Some commenters questioned the department's authority to promulgate specific benefits or regulate provider contracting. A commenter requested information about the applicability of the amended rules to policies that are already in force.

Agency Response: The agency received approximately 200 written comments on the rules as well as numerous oral comments at the public hearing. The agency appreciates the comments received and the information provided at the public hearing. The agency will carefully monitor the operation of these rules and consumer complaints it receives to determine if additional changes need to be made to the rules in the future. The commissioner recognizes that legislative action may also change department rules in the future but believes these amendments are necessary now to maintain quality of care and protect patient freedom of choice. The agency responds to objections that the department is interfering with private contractual relationships by stating that it is carrying out the intent of the legislature and the governor in enacting rules regarding the operation of managed health care plans to ensure affordable, quality health care for Texans. Through the Insurance Code, the legislature has recognized a public interest in the regulation of health insurance and has delegated to the Commissioner of Insurance the responsibility to ensure that health insurance plans contain certain minimum standards; thus the commissioner has the authority to impose requirements on otherwise private contractual arrangements. Fairness to the actual providers of the health care is necessary to the continued availability of quality care. Staff and the commissioner have made every effort to avoid imposing measures that would significantly increase the cost of health coverage. Although several commenters expressed concerns over cost, only one commenter submitted data projecting a premium cost increase of up to 8.7%. The prohibition on financial incentives accounted for 7.5% of this projected increase and was based on the commenter's incorrect assumption that the language would prohibit all financial incentives, including those for delivering appropriate, cost effective, high quality care. At the public hearing on these proposed amendments, the commenter conceded that the proposed staff modifications to the amended language in the three provisions cited as causing expected cost increases would significantly reduce costs. He was unable to give revised figures. The rules do not themselves mandate specific benefits but rather clarify how statutory mandates shall be carried out. Fully insured plans are not exempt from this subchapter because they are insurance policies regulated by the state. Entirely self-insured ERISA plans may be subject to federal preemption and the application of state law to those plans or to other policies subject to federal law would have to be determined on a case-by-case basis. The amendments to

the rules will become effective on January 1, 1996.

Several commenters stated that the language in the rules relating to HMOs and the language in the rules relating to PPOs should be identical where possible. One commenter requested a definition of the word "reasonable." Another commenter stated that the term "insured" should be clarified throughout the rules. This commenter stated that in the context of group health insurance, the term insured can refer to the group contract holder and that employees or members of a group are often considered "beneficiaries." The rules should clarify that references to "insured" include all plan beneficiaries. A commenter asked that "clinically appropriate" be substituted wherever "medically necessary" appears. A commenter recommended deletion of the words "nor do they sanction" from the scope §3.3701, which states that the rules do not apply to or sanction plans by any entity other than one authorized to engage in the business of health insurance in the state. Agency Response: The agency has made the HMO rules and the PPO rules consistent wherever possible. Differences occur, however, based upon the sometimes significant differences in the statutes that govern each type of managed care plan, in the way each type of plan functions and the structure of the existing rules concerning each type of managed care plan. The agency disagrees that a general definition of the word "reasonable" should be added to the rules. The use of this word must be considered in the context of a determination under or application of a particular rule and therefore does not lend itself to being defined generally and for all purposes. The agency disagrees that it is necessary to clarify the term "insured" throughout the rules. The agency agrees that the term may refer to the group contract holder in some sections and to the "beneficiary " in others. In some rules, the term refers to both. The agency believes that it is clear from the context of each section to whom the term "insured" applies. The rules used the term "insured" prior to these amendments and this has not resulted in any complaints to the agency or reported confusion regarding the intent of the rules. Nevertheless, the agency has added the words "group contract holder" to §3.3704(7) to ensure that complete information about the PPO plan is disclosed to both the prospective group contract holder and the prospective insured upon request so that each can make informed choices among health care plans. The commissioner has not adopted the suggestion that "clinically appropriate" be substituted for "medically necessary" wherever it appears in the rules, but has reviewed the rules carefully to ensure that the intended standard is stated. In some cases, the word "medically" was deleted. The agency will not remove the words "nor do they sanction" from §3.3701. The sentence in which this appears correctly states that the rules do not permit or allow the unauthorized business of insurance to be transacted in the state. This sentence was not proposed to be amended.

Several commenters requested that the rules be modified to account for agreements between insurers and third party preferred provider organizations under which the preferred provider organization contracts with individual providers and administers items such as quality assessment. A few commenters stated that the sole reference to this type of arrangement which appeared in §3.3705 was confusing.

Agency Response: The department recognizes the market place practice of contracting with a third party preferred provider organization for the purposes of offering a network of participating practitioners. In §3.3705 of the prior rules, the phrase "anyone contracting on the insurer's behalf" was used to designate a third party preferred provider network. These words have now been deleted from that section and, for clarification, new language has been added to paragraph (9), which acknowledges the ability of an insurer to contract with preferred provider organizations while confirming that the responsibility for compliance with the rules rests with the insurer.

One commenter requested the addition of "any willing provider" provisions. Another commenter recommended the inclusion of a provision permitting the use of a gatekeeper provision in a preferred provider plan so that a preferred provider plan would operate like an HMO: that is, for non-emergency care, patients would be directed to a primary care physician or provider who would provide initial and primary care to patients, maintain continuity of patient care and initiate any referrals to a specialist. Another commenter suggested the addition of a provision requiring the mandatory crediting of a calendar year deductible from one plan to another in instances of replacement in the middle of a calendar year.

Agency Response: The agency disagrees with these comments. It is the department's position that these provisions would need to be addressed through legislative change and would not currently be within the rulemaking authority of the department. Mandating the admission to a managed care plan network of any willing providers would fundamentally change the managed care system. Additionally, the suggested gatekeeper provisions would completely change the nature of health insurance policies containing PPO plans and would violate Insurance Code Articles 3.51-6, §§3; 3.70-3 and 21.52. Gatekeeper arrangements are appropriate for HMOs but not for PPO plans.

A commenter stated that the rules should include provisions requiring insurers to contract with Centers of Excellence because these facilities have higher medical outcomes and are more cost efficient in delivering specialty care.

Agency response: Access by insureds to Centers of Excellence is partially addressed in §3.3704(6) which provides that if services are not available through preferred providers, the insurer must reimburse for treatment by non-preferred providers at the preferred provider rate. This subsection was not proposed to be changed. The agency is considering whether further rulemaking would be appropriate concerning this issue, however.

One commenter requested the addition of a requirement that the department issue a Study and Report of Services on an annual basis to ensure that the public is properly served by PPOs. Another commenter suggested the addition of a provision requiring the Office of Public Insurance Counsel (OPIC) to issue an annual performance report to consumers which would be available to the public at a nominal cost and to allow OPIC access to department statistical information regarding utilization, quality assurance and complaints. One commenter asked that the rules specify that information provided to the department is an open record unless the department determines the information to be proprietary and recommended that the department work with the Texas Health Care Information Counsel to provide data to facilitate consumer decisions.

Agency response: The Office of Public Insurance Counsel (OPIC) is not part of the department but is a separate state agency. Although House Bill 2766 (the Patient Protection bill) contained a provision requiring an annual report by OPIC, the department cannot require actions by another state agency. The agency does intend to publish information regarding the performance of managed care plans and OPIC will have access to all information collected by the department except that which is exempt from disclosure under the Texas Open Records Act.

Section 3.3701 Private Cause of Action. Some commenters supported inclusion of language specifying that the rules do not create a private cause of action or create a standard of care. Other commenters objected strongly to this language, stating that the department has no authority to limit private causes of action or restrict a standard of care set forth in agency rules. Some commenters emphasized that the lack of a private right of action places all enforcement responsibility on the department and urged the department to create data categories to analyze complaints.

Agency Response: This language does not change any existing law but only emphasizes that these rules are administrative rules. Violation subjects the violator to administrative action by the commissioner but does not affect private causes of action. In other words, these rules cannot form the basis of a private lawsuit, nor can they diminish other rights of action or defenses. They do not create a standard of care upon which a private action can be based unless they are specifically incorporated by reference into a private contractual arrangement. Because of recent legislative action regarding private actions based on department rules, the commissioner believes it is important to emphasize the nature of these rules and rejects suggestions that the provision be deleted. The commissioner and staff recognize that it is the department's responsibility to collect data and enforce these rules.

Section 3.3702 Emergency Care. Several commenters stated that the definition of "emergency care" needs clarification because the definition does not specify in whose mind (the patient's, the treating physician's or the utilization review agent's) a medical condition could reasonably be expected to result in the adverse consequences set out in the defini-

tion. These commenters requested the express inclusion of a prudent layperson standard against which the reasonableness of the expectation could be judged.

A few commenters suggested that the words "sudden onset" be deleted from the definition of emergency care or that the definition be amended to include situations in which a condition can build gradually over time and steadily worsen to the point a patient seeks emergency treatment. Another commenter requested that the definition be broadened to expressly include dental emergencies. Other commenters recommended that the definition of emergency care be adopted as proposed.

Agency response: The definition of emergency care adopts by reference the definition contained in Insurance Code, Article 3.70-2. The agency believes that the existing definition includes the expectation of a prudent layperson. The definition also encompasses, in appropriate circumstances, dental emergencies and situations requiring treatment for an acute medical condition in the case where a condition began several days earlier but gradually worsens over time to the point at which a patient seeks emergency care.

Section 3.3702. Health Insurance Policy. A few commenters recommended deleting the words "or individual" from the definition of "health insurance policy." A commenter believed that the real purpose of the rules is to regulate group policies rather than individual policies.

Agency response: Individual policies have been included within the scope of the definition of "health insurance policy" since the inception of the PPO rules. These rules apply to any policy containing a preferred provider benefit plan, regardless of whether or not the plan is offered through a group or to an individual. The agency does not believe any change to this definition is necessary.

Section 3.3702 Practitioner, Health Care Provider, Institutional Provider. Numerous comments were received relating to the definition of "practitioner" as used in the rules. Many of these commenters believed that the sections concerning fairness to providers should not be confined to only those practitioners within the scope of Articles 3.70-2(B) and 21.52, Texas Insurance Code. Many commenters requested that the definition of "practitioner" be expanded to include all licensed or certified health care providers. Some commenters recommended the inclusion of specific providers by name. Others requested that the term "health care provider" be defined as in the HMO rules. Some commenters recommended expanding the definition of "practitioner" but limiting the applicability of procedures to appeal denials of admissions to or terminations from a network to physicians only as a cost containment measure. Several commenters expressed concerns about potentially broadening the scope of the practitioners with whom insurers or PPOs would be required to contract. A commenter recommended including "home and community support services agency" within the definition of "institutional provider". Agency response: The agency intends to extend certain protections and requirements concerning physicians and practitioners to all health care providers with which an insurer or third party entity may contract. Accordingly, changes have been made to the definition of "health care provider" to include any other licensed provider that furnishes health care services. Also, the word "medicine" has been deleted from the definition of "practitioner" as unnecessary in light of the definition of "physician." In addition, changes have been made to §§3.3701, 3.3703, 3.3704, and 3.3705 to clarify the applicability of each provision to physicians, practitioners, institutional providers, and other health care providers. Some provisions remain unchanged, however. The kinds of providers with whom insurers or PPOs are required to contract is governed by Articles 3.70-2 and 21.52, Texas Insurance Code. It is not the agency's intent to broaden or expand these statutory provisions. Therefore, changes have not been made to any rules that are, by their nature, limited by the statutory provisions.

Section 3.3702 Prospective Insured. Several commenters requested a definition of "prospective insured" in order to clarify persons to whom information about the PPO plans must be disclosed. Several of these commenters suggested the term be defined to include only persons "eligible" for coverage.

Agency Response: The agency has added a definition of "prospective insured" in response to the comments. This definition is intended to be expansive so that the information will be available to all persons who meet the basic requirements for coverage under the plan. The agency does not intend for insurers to limit the application of this definition to persons who are eligible for coverage after underwriting standards are applied.

Section 3.3703 Composition of Advisory Review Panel. Numerous comments were received with respect to the members of the advisory review panel. Many commenters recommended that the panel consist of at least three physicians. Several commenters felt that the panel should not be comprised solely of physicians who contract with the insurer. Other commenters stated that the affected physician should be permitted to select at least one member of the panel. A few commenters objected to the requirement that the panel include one member who is a physician in the same or similar specialty, if available. Several commenters recommended that the advisory review panel process be made available to all health care providers and not limited to physicians. Conversely, several commenters expressed concerns that any expansion of the panel to include other health care providers would unnecessarily increase costs which would ultimately be passed along to insureds.

Agency response: The existence of a three-member review panel consisting of physicians who contract with the insured was in the previous non-amended section and should not be changed The agency believes that expanding the availability of the advisory review panel to review admission and termination decisions with regard to all health care providers would be time consuming and costly. All health care providers are entitled to written reasons for denial or termination under the section, however. Adding the requirement that the panel include a specialist, if available, however, is not burdensome and will make the panel's recommendation more meaningful in cases in which a specialist appeals an adverse decision.

Section 3.3703 Admission of Preferred Providers. One commenter objected to the provision in the rules requiring annual publication of a provider application period. The commenter believed this to be an unnecessary administrative expense when plans have sufficient providers. A few commenters generally objected to any requirements for disclosure to providers of admission and qualification criteria on the basis that it interferes with market based contracting practices. A commenter stated that it is bad public policy to require an insurer to disclose proprietary information regarding specific economic data used in management practices. Several commenters recommended that insurers or PPOs be required to respond to requests for information concerning the application process within a designated time frame. Suggested time frames ranged from within ten days of request to within 60 days of request

One commenter stated that the section should only require insurers to give written responses for denial of an "initial" application. A few commenters recommended prescribing the time frame within which written reasons for denial of an application must be given Suggested time frames range from within ten days of denial of application to within 90 days of receipt of application.

A few commenters objected to the provision allowing denial of an application on the basis that the plan has sufficient participating providers and requested that insurers be required to prove to the rejected provider that the network does, in fact, have sufficient providers. One commenter stated that the use of this reason for denial of an application should not be allowed if more than 20% of the plan's participating providers are no longer accepting new patients. A commenter requested that the rule prohibit rejecting the application of a physician or provider solely because of the anticipated characteristics of the patients of that applicant. Another commenter suggested deletion of the reference to §21.52B, Insurance Code as being confusing.

Several commenters recommended that in the case of an appeal to the advisory review panel by a physician whose application is rejected, the panel's recommendation should be disclosed to the affected physician, along with an explanation if the insurer rejects the panel's recommendation. Others recommended that this information should only be made available upon request.

A commenter recommended requiring the insurer or PPO to accept certification of hospitals, home health, or hospice providers by the Medicare program as an alternative to accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) during any credentialing process conducted since a similar requirement is currently applicable to HMOs. Agency response: The agency disagrees that application procedures and qualification requirements should be withheld from disclosure to providers. In

order to maintain a fair and reasonable contracting environment, it is necessary for providers to be informed of the application and qualifications requirements. This subsection does not require the release of proprietary information; it simply requires the disclosure of information concerning the application and qualification requirements upon request. Annual notification to physicians and practitioners is not a new requirement and the agency believes it should be retained to provide fair and reasonable opportunities to contract.

The agency has not added specific response times for providing application materials or denying applications believing that the existing requirements are adequate to produce timely responses; the department will monitor complaints to determine if insurers are failing to respond timely to applicants. In response to comments the agency has retained the requirement for written reasons for denial to be provided on "initial" application.

The agency believes that insurers must be allowed to limit the participation of preferred providers when they have sufficient preferred providers of a particular type to have an economically viable managed care network. The department believes that requiring the insurer to prove to the rejected provider that the network has sufficient providers would be costly and burdensome to insurers. The department has not articulated any prohibited bases for excluding a physician or provider from a PPO network but will monitor complaints to determine if such prohibition may be advisable in future legislation or rulemaking.

The agency agrees that the recommendations of the advisory review panel and any decision of the insurer if contrary to the panel's recommendation should be provided to the affected physician upon request in order to ensure a more meaningful appeals process The section has been modified accordingly. The agency disagrees that the reference to Insurance Code, §21.52B is confusing. This statute has established a procedure different from that set out in the rule and the agency believes the reference to this statute in the subsection is helpful.

The acceptance of either Medicare or JCAHO certification during any credentialing process for HMOs is a recent legislative mandate Whether a similar process should be applied to insurance policies containing preferred provider benefit plans is outside of the scope of this rulemaking. Additional research and evaluation will be necessary to determine whether it is appropriate to address this in a separate rulemaking effort, or whether this is more appropriate for legislative action.

Section §3 3703(3) Requirements-Financial Incentives. Many commenters supported restrictions on the use of financial incentives that would limit availability of medically necessary care. Some commenters preferred the language contained in the PPO rules to that contained in the HMO rules. A few commenters requested the addition of the language "or clinically appropriate" in addition to "medically necessary." Suggestions were made to more clearly define unacceptable financial arrangements because certain financial incentives may be an appropriate aspect of cost containment. Specifically, many commenters wanted it clearly stated that the rule does not prohibit rewards to providers who reduce the cost of unnecessary care and provide appropriate medical care.

Agency response: The agency agrees that restrictions are needed on the use of financial incentives that would limit the provision of medically necessary care. The agency does not intend to prohibit reasonable cost containment and managed care features of a PPO plan that do not adversely affect the provision of medically necessary services. The agency agrees that some clarification is needed, however, and the subsection has been changed accordingly. The language as modified is intended to broaden the scope of the financial incentives that may be considered unacceptable and to include both positive and negative incentives. Although the agency has eliminated the more specific prohibitions contained in the subsection prior to these amendments, those activities would still be unacceptable under the language of the amended subsection.

Section 3.3703(5)-Data Collection. Some commenters stated that the data to be made available to the department under this section is inadequate. Other commenters stated that the section's ambiguous reporting requirements would result in increased administrative expense and inefficiency.

Agency response: The agency disagrees with the comments concerning data collection. The amended rule merely clarifies language in the prior rule, substitutes Texas Department of Insurance for Board, and maintains the same categories of data already subject to department request. In making a request for data, the agency will identify the information to be provided and the manner in which it is to be provided to eliminate concerns relating to ambiguous reporting requirements or duplicative efforts.

Section 3.3704(3)-Continuity of Treatment. Many commenters strongly supported the provision requiring continuity of care for patients with special circumstances whose physicians or providers are terminated from the preferred provider network. Several commenters who generally supported the provision also suggested that the subsection require advance notice to the patient; some suggested a specific period for advance notice such as 90 days. Other commenters stated that the requirement in the proposed subsection for "immediate notice" to the insured is unworkable.

Several commenters objected to the 90-day limit for continuing care by the terminating provider, arguing that continuity requires reference to clinical standards rather than an arbitrary deadline; these commenters suggested that the physician or provider continue to be compensated by the plan until the conclusion of the "episode of care" or an "episode of acute care".

Some commenters stated that the insurer should reimburse the terminated provider at the contract amount unless it is based on a discounted fee, in which case reimbursement should be based on reasonable and customary charges and that the provider should be required to accept the plan's payment as payment in full and not seek additional compensation from the patient.

A few commenters requested that "special circumstances" include women at or beyond the 24th week of pregnancy or the second trimester rather than "in the third trimester". Many commenters requested that the subsection specify that a plan need not continue payment to a physician or provider removed for quality of care reasons. Some commenters requested that the continuity of care provision be available to all patients, not just those with special circumstances.

An opponent of the provision commented that the contract terms, not "medical prudence" should govern continuity of care provisions and they should apply to all insureds.

Many commenters requested that the rule clarify that a provider removed for quality of care reasons need not be compensated for continuing to see a patient. Several commenters stated that the language should be clarified, specifying such things as who will make final decision as to when continuity of care is required, who will monitor the process, and further defining special circumstances. Some commenters supported including the term "disability"; others suggested it be deleted as being vague. A few commenters suggested that the subsection require that continuity of care be requested by the treating physician or health care provider. Some commenters stated that the insurer should not be responsible for payment after a provider voluntarily drops from a network.

A few commenters recommended that the words "plan termination" be deleted from the subsection because those words are used in a situation in which a group contract holder terminates the contract rather than the situation in which a preferred provider or provider network is terminated by the insurer. Agency response: There is general agreement that some provision for continuity of treatment is desirable. The agency disagrees that contract terms rather than medical prudence should govern continuity of care; contract provisions must not undermine the exercise of medical prudence.

The agency agrees that the subsection should require pre-termination notice to the patients so that patients may begin to make arrangements with other providers or request continuity of treatment through their current providers. The agency agrees that immediate notice is unworkable but has rejected the comments that an advance notice period, such as 90 days, should be specified in the subsection because this is too inflexible. The subsection has been changed to require reasonable advance notice to the insured of an impending termination of a provider currently treating the insured. The department will monitor complaints to determine if more specific requirement of advance notice is necessary.

In response to comments, the commissioner has adopted language clarifying that the provisions do not apply to a physician or provider removed for quality of care reasons and clarifying the meaning of "special circumstance."

For clarification, the commissioner has changed "third trimester" to "24th week" of pregnancy. "Second trimester" has not been added because this would require continued reimbursement at the preferred provider rate long beyond that required for other conditions and the agency believes that the requirement for reimbursement at the preferred provider rate after the 24th week of pregnancy along with the reasonable advance notice that must be given to the insured will give the insured sufficient time to find a qualified preferred provider. The subsection has been changed to specify that the physician or provider must identify a patient's special circumstances to the plan and request that the patient continue under his or her care, and to prohibit the physician or provider from seeking compensation from the patient beyond what the patient would have been responsible for under the plan. These changes have been made in response to comments to clarify the procedures by which the continuity of care requirements will be applied.

The agency disagrees with comments suggesting that compensation should be at a rate different than the physician or provider received under the plan (preferred provider rate) because that would impose additional costs on the plan and it is reasonable for the physician or provider to continue to accept compensation at the preferred provider rate for the limited time required to complete the patient's care or arrange for the patient's safe transfer to another treating physician or provider. The 90-day limit on continued reimbursement to the terminated provider is the maximum time required by the subsection but plans and physicians or providers may extend this time period by contract or by agreement on a case-by-case basis as needed. Based on information received by the department, the commissioner believes that many managed care plans currently negotiate continuity of treatment based on the needs of the patient and hopes that arrangements beyond those mandated by the rules based on the needs of individual patients will continue.

The agency disagrees with the suggestion that continuity of care be required to continue until the conclusion of an episode of care because this could be such a long period of time that this provision would undermine the managed care plan's control of its preferred provider network. The agency believes, based upon the definition of acute care provided by the commenter, that an "episode of acute care" would be covered by the 90-day period in the proposed language. The agency believes that the subsection should apply for the benefit of the patient, whether the plan or the health care provider initiates the termination and therefore rejects the suggestion that the provisions should not apply if a physician or provider voluntarily terminates from the network.

"Plan termination" will be deleted from the subsection. References to termination of preferred providers includes termination by the insurer or either an individual provider or a network of preferred providers. The provision is not intended to apply to a situation where the group or individual contract holder terminates the contract with the insurer because the insurer would not be receiving any premium payments.

Section 3.3704(4) (changed to §3.3704(5))- Emergency care services Many commenters expressed strong support for the rules relating to emergency care services. This issue, stated many commenters, is a crucial one to consumers of managed care plans. According to these commenters, the subsection will prevent unnecessary delays in providing emergency care service, avoid inappropriate denials of coverage and improve the overall health care provided by managed care plans.

Some commenters expressed their concern that the emergency care provisions will impose costly burdens upon managed care plans to pay for non-emergency care rendered in a hospital emergency department. As an illustration, one commenter stated that if a patient presents at the emergency department with an ordinary cold, potentially costly emergency medical screening examinations and treatment would be required to be covered.

A few commenters stated that the subsection should not impose any requirement for coverage for emergency care services stating that this would undermine the insurer's plan of benefits and the preferred provider organization's contracting arrangements. Several commenters stated that the agency should not enact any rules concerning emergency care because the Governor's veto message did not specifically mention emergency care.

Several commenters recommended that the subsection clarify that coverage for emergency care services must be provided without regard to whether the provider is a preferred provider.

Several commenters stated that the term "emergency department" used in the subsection should be changed to "emergency room" to make it clear that only emergency medical conditions are intended to be covered. One commenter suggested that use of the term "emergency department" is too restrictive and that the reimbursement obligation should be imposed regardless of where patients receive emergency care.

Some commenters stated that in general emergency care requirements could increase costs to managed care plans if services are unnecessarily utilized for non-emergency situations.

A few commenters suggested that reimbursement for emergency care services should be determined retrospectively in light of whether an emergency medical condition actually existed or, for the emergency medical screening examination, whether a prudent layperson would have reasonably believed a medical screening examination was necessary. Another commenter stated that reimbursement should be withheld unless the treating provider certifies that an actual emergency medical condition existed.

Many of the commenters addressed the portion of the subsection prohibiting denial of reimbursement for medical screening examinations to determine whether an emergency medical condition exists. Some commenters recommended deletion of the word "initial" used to describe the medical screening examination to determine whether an emergency medical condition exists. These commenters stated that the word "initial" is not used in either federal or state regulations concerning emergency services. Other commenters requested the insertion of the word "necessary" before the phrase "to determine whether an emergency medical condition exists" in order to clarify that only screening tests that are necessary to the determination of whether an emergency medical condition exists must be covered by insurer. Other commenters requested that the term "appropriate" be inserted to modify medical screening examinations because that term is used in federal law which mandates the provision of emergency services by hospitals.

Several commenters recommended that the subsection require coverage of not only a screening examination but also diagnostic tests and other procedures to determine whether an emergency condition exists. Several commenters requested that the subsection provide for medical screening examinations to be conducted only by or at the direction of a physician.

Several commenters requested that the term "medically necessary" be removed from the portion of the subsection prohibiting denial of reimbursement for treatment and stabilization of an emergency medical condition. These commenters stated that the definition of emergency care in §3.3702 already establishes medical necessity making the use of the term here redundant.

With regard to post-stabilization care, some commenters requested that a requirement be imposed on insurers to respond to inquires of a treating provider concerning post-stabilization care within a defined time period like that required under the proposed department rules concerning HMOs. One commenter stated that language in the existing subsection requiring reimbursement for post-stabilization care at the preferred provider rate if the insured "cannot reasonably reach a preferred provider" is vague.

Several commenters recommended that the words "for an emergency condition" be inserted after "or services originating in a hospital emergency department following treatment and stabilization" in order to clarify that the required reimbursement is for post-stabilization of an emergency condition. One commenter recommended insertion of the words "the insured" before "cannot reasonably reach" in the post-stabilization care provision while another commenter suggested that the words "the treating physician" should be inserted here. Some commenters recommended substitution of the words "emergency care services" or "care for an emergency medical condition" for the words "under emergency conditions" in the post-stabilization care provision. These commenters stated that the words "under emergency conditions " were ill-defined and that this provision should be consistent with the provision requiring reimbursement for treatment and stabilization of an emergency medical condition.

A few commenters stated that the subsection should require post-stabilization care to be reimbursed at the treating provider's rate rather than at the preferred provider rate. Agency response:

The agency agrees that the subsection will help clarify coverage for emergency care services and should provide greater assurances to consumers of managed care products. The subsection will also address some of the questions that have arisen in this area and provide greater direction to insurers. The emergency care provisions are consistent with the Governor's proclamation which addressed the need to provide patient protection and quality assurance and to expand patient freedom of choice.

The subsection is not intended to mandate coverage for situations which are clearly non-emergencies. The agency believes that definition of "emergency care" in §3.3702, together with other language in this subsection, should avoid payment for inappropriate uses of emergency care services. Moreover, managed care plans already do and should continue to educate their members concerning the appropriate use of emergency care services. Also, the disclosure provisions in §3.3704(7) require the insurer to give information to prospective insureds about access to after-hours care. The availability of, and information about after-hours care should also help direct patients away from emergency departments for non-emergency situations. As suggested by one commenter, if a patient comes to the emergency department with a cold, a screening examination necessary to determine whether an emergency medical condition exists should not be costly, if needed at all under such circumstances. Once it is determined that the patient has a cold, emergency care services would not be considered necessary and would not be covered. No coverage would be required for treatment after stabilization because no emergency condition existed to which this treatment would relate.

The agency disagrees that these requirements disrupt an insurer's plan of benefits and a preferred provider organization's contracting arrangements. Emergency care services are already required to be provided in health insurance policies and the subsection is intended to clarify what services must be reimbursed and under what circumstances.

The subsection has been reorganized and renumbered to clarify that the emergency services specified must be covered at the preferred provider level of benefits without regard to whether the provider furnishing the services has contractual or other arrangement with the insurer or preferred provider plan. The subsection as reorganized more closely resembles the HMO rules on this subject while maintaining differences which reflect the distinctions between HMO and PPO plans.

The agency disagrees that the term "emergency room" should be substituted for "emergency department" because it believes the term "emergency room" is too restrictive. On the other hand, the agency does not believe the term "emergency department" is unduly restrictive. These rules are intended for general application and the agency believes they are adequate because most patients present to the emergency department of a hospital in a medical emergency situation. The agency expects that for rare circumstances when a true emergency is handled outside a hospital, reimbursement will be determined on a case-by-case basis. The subsection is not intended to prohibit or limit reimbursement for emergency care services rendered outside the emergency department of a hospital.

The commissioner disagrees that reimbursement for emergency care services should be determined retrospectively by the insurer or based on certification by the treating provider. This can create a chilling effect on patients which can cause delays in patients seeking needed emergency care. The agency disagrees that a prudent layperson standard should be applied to a decision concerning the necessity for an emergency screening examination. This kind of determination is best made by a practitioner under the circumstances of each medical emergency.

The agency agrees that the term "initial" should be deleted from the subsection because it is not a term used in either federal or state regulation and may be interpreted to inappropriately restrict reimbursement. The agency further agrees that the term "necessary" should be inserted to modify "to determine whether the emergency condition exists." The agency believes that the addition of this term will clarify that the screening examination must be related to a determination of whether an emergency medical condition exists. The agency disagrees with adding the term "appropriate" or that the subsection must specify coverage of diagnostic testing in order to be consistent with federal law. The subsection provides that a health care plan must cover any medical screening examination or "other evaluation required by state or federal law" which is necessary to determine whether a medical emergency condition exists. This would include an examination as described by the Emergency Medical Treatment and Active Labor Act, 42 United States Code, §1395dd.

The agency disagrees that the subsection should limit persons who can conduct emergency screening examinations to physicians. Such a provision would be unduly restrictive and, under some circumstances, it may be more appropriate for another type of health care provider to conduct a screening examination.

The agency agrees that the term "medically" used to modify necessary emergency care is redundant and its use could be confusing because the term "medically necessary" may be defined differently in different health policies. The word has been deleted. The subsection will retain the word "necessary," however.

The agency disagrees with the comments that a time limit similar to that found in the HMO rules needs to be imposed on the insurer or PPO plan within which either of those entities must respond to inquires from a treating provider concerning post-stabilization care. The subsection requires payment at the preferred provider rate if the insured "cannot reasonably reach a preferred provider." Under circumstances in which an insured can reasonably reach a preferred provider, an insurer must still pay reimbursement for the services but reimbursement would be at the non-preferred provider rate. The phrase "cannot reasonably reach a preferred provider" was in the subsection prior to the proposed amendments and the agency has not received any complaints or information that this language has caused problems or been misunderstood.

The subsection already provides for payment to the treating provider for post-stabilization care under circumstances in which the insured cannot reasonably reach a preferred provider or reasonably be expected to transfer to a preferred provider at the treating provider's rate rather than at a discounted rate by requiring reimbursement to the insured at the preferred provider level of benefits; no change to the subsection is necessary. In response to comments the agency will add "of an emergency medical condition" after the words "treatment and stabilization" to clarify that reimbursement at the preferred provider level of benefits applies to post-stabilization care related to an emergency condition. The subsection as reorganized has deleted "under emergency conditions" and inserted "the insured" before the phrase "cannot reasonably reach," as requested by the commenters.

Section 3.3704(5) (changes to §3.3704(7))-Disclosure Requirements. Many commenters strongly supported the disclosure of information concerning PPO plan terms and conditions in a uniform and consistent manner to enable consumers to make informed decisions when choosing among plans. Some commenters made suggested language changes to this subsection while others supported the subsection as proposed. Some commenters did not support the inclusion of this subsection. A commenter stated that the information required to be disclosed would be of no interest to the public. Another commenter stated that the requirement would duplicate what is required under ERISA.

Several commenters requested that the disclosure form also be provided to the employer or other group contract holder contracting for the insurance not just to "prospective insureds." Another commenter stated that for group coverage, the subsection should require the insurer to provide an employer or other prospective group contract holder with sufficient copies of the disclosure information for distribution to all employees or members.

Many commenters requested that the information be required to be in a particular "format" rather than in a "form prescribed by the department" because, these commenters stated, use of a form prescribed by the department would be costly and businesses should not be required to follow government prescribed forms. A few commenters disagreed that the information should be required to be provided in a particular "form" or "format" and recommended that the subsection only state the information to be disclosed and allow the insurer to determine the format. Some commenters stated that the types of information required to be disclosed by the subsection are already currently available upon request from some insurers and thus the subsection is unnecessary. A few commenters suggested that the department allow insurers to make available a certificate of insurance or an outline of coverage in lieu of the disclosure information.

Several commenters suggested that the words "shall make available" be changed to "shall provide." Others recommended that the form be provided "upon request." Other commenters requested that "upon request" not be added.

Several commenters stated that the subsection should require all marketing materials to contain the required disclosure information. One commenter suggested that the subsection require the disclosure information to be mailed within two working days of a request for it.

A commenter suggested that the disclosures be required to be available in a variety of language formats including in the primary language of 10% or more the of the residents of the service area, in Braille and on audio tape. A commenter stated that the subsection would impose greater readability requirements on PPOs than on other kinds of health policies.

Many commenters suggested changes to the list of items required to be disclosed by the subsection. A few commenters recommended that the list be reordered to provide consumers with the more important information first. Several commenters stated that the insurer's phone number required to be included in the disclosure information for insureds to obtain additional information should be a toll-free number. A commenter recommended that the disclosure form also specify what other types of information are available as well as giving a toll-free number. A commenter suggested the disclosure include an explanation of the difference between a PPO and an HMO and a statement in 12 point type that the disclosures are required to be in a standard format for comparison.

A commenter requested that the item requiring disclosure of emergency care benefits specify that the disclosure include language that emergency care will be covered no matter where it is delivered. Another commenter requested that the disclosure include information on obtaining after-hours care.

Numerous commenters stated that the requirement for disclosure of the drug formulary as proposed was too broad and would require insurers to produce long lists of drugs that would be constantly changing and would not be meaningful to consumers. Several of these commenters recommended that the words "existence of" be added to modify "drug formulary" to clarify that the entire drug formulary need not be reproduced in the disclosure forms. Several commenters requested specific language to clarify that preexisting condition limitations must be disclosed. One of these commenters also requested disclosure of the number of years of medical history that will be considered in determining preexisting conditions.

A commenter requested deletion of the words "plan termination" from the requirement to disclose continuity of treatment provisions for the same reasons the commenter requested the words be deleted from §3.3703(3). A commenter recommended that the provision concerning continuation of coverage in the event of discontinuance or replacement of the policy should be deleted. Some commenters requested that complaint and grievance procedures be required to be disclosed including information concerning the prohibition against retaliation and the names and numbers of individuals responsible for processing complaints.

Several commenters requested that the names of providers not accepting new patients should be disclosed along with the names of providers contracting with more than one plan and the total number of patients treated by each provider. A commenter suggested that the requirement for disclosure of the service area should include a statement that if the insured has to drive more than 20 minutes to obtain preferred provider benefits, the plan would be required to reimburse a non-preferred provider closer to the insured at the preferred provider rate. Several commenters requested mandated disclosure of preferred provider-to-insured ratios and information related to hold-harmless requirements.

Agency response: The agency agrees that requiring the disclosure of information about PPO plans to be made available in an uniform and consistent manner will assist consumers in making informed choices when choosing among plans and enhance their freedom of choice. The agency disagrees that the information will be of no interest to the public. The agency recognizes that some of the information required to be disclosed may duplicate disclosure requirements contained in federal law but not all of the information required by this subsection is disclosed under federal law. All prospective group contract holders and prospective insureds should be able to receive the same information, not just those covered by plans subject to federal law.

The agency agrees that an employer should be provided with the disclosure information upon request. The words "group contract holder" have been added to the subsection to clarify the commissioner's intent that an insurer must also provide the disclosure information to an employer or other group contract holder. The agency does not agree, however, that the subsection should expressly mandate insurers to provide employers or other prospective group contract holders with sufficient numbers of disclosure statements to distribute to all of their employees or members due to the costs this would impose; however, the agency encourages insurers to cooperate with prospective group contract holders when they make such a request. The insurer must respond, however, to requests for information from prospective insureds.

The agency agrees that the required disclosures need not be "in a form prescribed by the department." The term "format" has been substituted. The agency believes that requiring the information to be disclosed in a set format will help consumers make comparisons from plan to plan. The agency disagrees with the suggestions that an insurer should be able to substitute a certificate of insurance or outline of coverage for the required information. The layout and format of certificates of insurance are not prescribed and providing these to consumers would not facilitate plan comparison. Outlines of coverage may not provide all of the information required to be included by this subsection again defeating the purpose of facilitating ease of comparison.

The agency agrees that "shall make available" should be changed to "shall provide" for clarification. The agency also agrees that "upon request" should be added to be consistent with the HMO rules and to reduce costs by requiring the information to be provided only to persons interested in the coverage.

The agency believes that the requirement to include the disclosure statement in all marketing materials would be too costly and would duplicate some of the information already made available by the insurer. The suggestion that the disclosure form be mailed within two working days of the request has not been adopted; however, the department will monitor complaints in this regard, if any, to determine if further amendment of the subsection may be appropriate.

To keep costs at a minimum, the subsection will not require that disclosures be provided in different languages, in Braille or on audio tape; however, the department encourages insurers to make the disclosure information accessible and otherwise to provide assistance to those who request it. The subsection does not put any greater readability requirements on insurance contracts with preferred provider provisions than are required for any other health benefit plans that must comply with the department's rules.

In response to comments the agency has revised the list of items required to be disclosed to prospective group contract holders and prospective insureds and has reordered the items. Although the agency believes disclosure of all of these items is important to consumers, the agency believes it has put the items of more general interest first. The agency agrees that a toll-free number should be provided. Although certain insurers who transact only a small amount of business in the state are exempted by statute (Insurance Code Article 21.71) and rule (28 Texas Administration Code, §1.601) from the requirement of maintaining a toll-free number, the department believes that most of these insurers currently provide a toll-free number. The department encourages all insurers otherwise exempt from this requirement to maintain a toll-free number for prospective as well as existing insureds to obtain information about their PPO plans.

The agency disagrees that the disclosure should contain an explanation of the difference between HMOs and PPOs and a statement that the disclosures are required to be in standard format. Information concerning HMOs in a PPO disclosure form might be confusing to consumers. Instead, the agency has added a requirement that the insurer disclose that the coverage is provided by an insurance company, the name of the insurance company and that the insurance contract contains preferred provider benefits. The requested 12 point type statement is unnecessary because the format requirement in this subsection will allow consumers to make comparisons.

The agency disagrees that the disclosure needs to explicitly state that emergency care

benefits will be provided no matter where delivered. This is implicit in requiring a disclosure of these benefits. The agency agrees that information about after-hours care should be disclosed. Disclosure of this information can help direct insureds away from emergency departments for non-emergency conditions.

The agency does not intend to require disclosure of an entire drug formulary because it would be costly to do so and the formulary would need to be updated constantly. The subsection has been reworded to require disclosure of the existence of any drug formulary limitations. The agency has added language clarifying that any preexisting condition limitation must be disclosed. It is unnecessary to specify that this information must include the number of years of medical history used to determine preexisting conditions because full disclosure will require the inclusion of this information.

"Plan termination" has been deleted from the subsection to be consistent with the deletion to these words in §3.3703(3). The agency agrees that disclosure concerning continuation of coverage in the event of discontinuance or replacement of a policy should be deleted because such provisions would be lengthy, complicated and of interest to only a small number of prospective insureds. Also, statutes and other agency rules fully address these requirements. The agency has modified the subsection to require disclosure of complaint and grievance procedures as requested by the commenters.

The agency agrees that information concerning which providers are not accepting new patients is important to consumers and should be disclosed. The subsection has been modified accordingly. The agency disagrees, however, that providers contracting with more than one plan and the total number of patients treated should be disclosed as this information would constantly change, would be too costly to implement and would be only of limited use to the consumer. The agency disagrees with the comment that the service area disclosure should include a requirement for reimbursement at the preferred provider rate if an insured has to drive more than 20 minutes to reach a preferred provider. This would be a substantive requirement rather than a disclosure requirement. The agency has not received complaints concerning this issue; nevertheless the agency will continue to monitor complaints to determine whether future rulemaking may be necessary concerning this issue. The agency disagrees that disclosure of preferred provider-to-insured ratios should be required because this information alone could be misleading to consumers. The department will monitor complaints that sufficient preferred providers are not available to insureds. The requested disclosure of hold-harmless requirements has raised a new substantive issue. This comment was related to one requesting a new provision in the subchapter concerning hold-harmless clauses in provider contracts in which the provider would agree to look only to the insurer for payment and not to the insured. The department will study this issue to determine whether it may be appropriate for future rulemaking.

Section 3.3704(6) (changed to §3.3704(8))- Filing Requirements A commenter questioned the authority to require information which must be disclosed to prospective group contract holders and insureds to be filed with the department. A commenter asked whether insurers would be required to file all advertising for their PPO plans. A commenter requested the agency to delete this subsection. Another commenter requested the agency to add a date on which the list of providers must be filed annually with the department. Agency response: The subsection does not mandate the filing of all advertising with the department but requires an insurer to file the information provided to prospective group contract holders and insureds and to file annually their provider lists and service areas. The agency is considering the appropriateness of rules requiring the filing of all advertising for managed care plans, however. In the meantime, the agency will retain this subsection because it is necessary for the agency to monitor compliance with the disclosure requirements. The subsection has been amended to include a date by which insurers must file their annual list of providers.

Section 3.3704(7) (changed to §3.3704(9))- Provider directory to be sent to insureds quarterly. Several commenters stated that the requirement for a current provider directory to be sent to insureds quarterly would drive up costs significantly and is not necessary because the subsection also requires a toll-free number for insureds to obtain that information. A commenter stated that because networks provide toll-free numbers, insurers should not have to provide one. Another commenter stated an that exception from the quarterly provider list and toll-free number should be made for small employer carriers.

Agency response: The agency agrees that a complete provider list sent quarterly to all enrollees would be more costly than it would be useful. In order to reduce costs, the agency has rewritten the subsection to require this list to be sent annually. Supplying insureds with an updated provider list annually plus providing a toll-free number for insureds to call to obtain a current provider list should suffice. Insurers may use the same toll-free number as that used to provide insureds with other information, for example by §3.3704(5). The agency does not agree that small employer carriers should be exempt from the subsection as revised. Insureds need access to current information about available providers to be able to make informed choices.

Section 3.3704(8) (changed to §3.3704(10))- Prohibition on Misleading Information. A commenter stated that this subsection, which appeared to be derived from various statutes prohibiting the dissemination of false or misleading consumer information, was unnecessary in light of the existing statutory provisions and would create confusion over whether the intent was to create a new type of cause of action. The commenter recommended deletion of the subsection.

Agency Response: The agency agrees that the language in this subsection should be simplified but does not agree that the subsection should be deleted. The language has been changed accordingly and is substantially the same as that in the HMO rules. The intent in adding this subsection was not to create a new or different cause of action but to emphasize that consumers must be given thorough and accurate information about PPO plans and the failure to do so may result in agency enforcement.

Section 3.3705(2) (changed to §3.3705(3))- Retaliation. Most commenters support this proposed subsection. Several commenters suggested that the subsection should extend protection against retaliatory actions to physicians and providers who complain or appeal a decision on behalf of their patients, especially in utilization review situations. Other commenters suggested that complaints and appeals should be uniformly recorded and monitored by the department and that the proposed rule should be aggressively enforced. A commenter stressed that this rule is very important for persons with disabilities since, based upon information from other states, disabled persons expect to experience more barriers to quality services than other individuals.

Some commenters argued that insertion of the word "solely" before the words "before the insured" clarifies that there are other acceptable reasons for termination of coverage and avoids a situation where an insured or employer might complain in anticipation of termination of coverage to prevent it. Agency response: The department agrees that the proposed section should be expanded to prohibit retaliatory actions against physicians and providers who, on behalf of their patients, complain or appeal a decision of an insurer. The department strongly believes that a physician or provider should feel free to act as an advocate on behalf of a patient who the physician or provider reasonably believes has been or will be denied medically necessary and appropriate health care services covered by an insurer. For this reason, the department has amended this section to clarify an insurer may not retaliate against a physician, provider or insured for complaining or appealing a decision of the insurer on behalf of the insured. The department agrees that complaints against insurers should be uniformly recorded and monitored.

The department disagrees that the word "solely" should be inserted before the words "because the insured." The department believes insertion of the word "solely" would make the provision unenforceable by the department because an insurer could easily establish more than one reason for taking the retaliatory action other than a complaint or appeal of a decision. The department disagrees that the provision as worded would effectively prevent an insurer from terminating a provider who had complained on behalf of an insured in anticipation of the provider's termination from the plan in order to prevent termination. There can be many legitimate reasons to terminate a provider, but retaliation for a complaint on behalf of a patient is not one of them.

Section 3.3705(2) (changed to §3.3705(4))- Provider Termination. Several commenters supported the requirement that written reasons be given prior to termination of a con-

tract with a preferred provider. Some commenters, however, objected to this requirement as costly. These commenters stated that the contract should be terminated in accordance with contractual provisions and that any additional requirements would create a special employment class for physicians and health care providers. A few commenters recommended prescribing the time frame in which written reasons must be provided. One commenter suggested that the PPO or insurer be required to provide written reasons for termination within ten days of notification of termination.

Many commenters supported the idea of an advisory review panel to review termination decisions but stated that the advisory review panels should be available to all providers, not just to physicians. Several commenters requested language requiring the insurer to disclose the advisory review panel's recommendation to the affected physician, along with an explanation by the insurer if the insurer rejected the panel's recommendation. Other comments suggested that an explanation should only be required to be made available upon request by the affected physician.

Some commenters expressed concern that the requirement for a pretermination advisory panel review would prohibit an insurer from terminating a physician where continued practice constitutes imminent threat of harm to patients or against whom license action is pending and suggested that the rule allow summary suspension for patient safety reasons. A commenter objected to the requirement of the advisory review panel process in the event of termination due to economic considerations. One commenter stated that the rule should set out the proper reasons for termination.

Agency response: The agency agrees that the requirement to provide written reasons for termination of a physician or provider should be retained and will not add significant administrative cost because the insurer is simply required to inform the terminated physician or provider of the reasons for its decision. This requirement is consistent with the goal of maintaining availability of quality care and coverage. The department has not added specific response times for providing written reasons for termination believing that the existing requirements are adequate to produce timely responses; the department will monitor complaints to determine if insurers are failing to respond timely to terminated physicians or providers.

The subsection is designed to provide a review process for a physician before termination without imposing additional cost on the insurer by requiring the advisory review panel only if requested by the affected physician. The agency agrees that the recommendations of the panel and any decision of the insurer if contrary to the panel's recommendation should be provided to the affected physician upon request, and the subsection has been changed accordingly.

Provisions have been included which would permit immediate action in the event of imminent threat of harm to patients. The commissioner rejects the suggestion that review panels not be used when a termination is for economic reasons because a meaningful review mechanism must apply equally to all terminations. If the review panel were required only when a physician is terminated for non-economic (quality of care) reasons review would rarely be afforded because most insurers would simply state that the termination is for economic reasons thus the insurer could avoid detailing a quality of care reason for termination and review. There may be many appropriate reasons for termination of a physician or provider's participation in a PPO plan and the department does not believe it is necessary or advisable to attempt to list them in an agency rule.

Section 3.3705(4) (changed to §3.3705(5))-Economic Profiling. Many commenters supported the disclosure of economic profiling information to physicians and providers. Supporters of disclosure also opposed the "market strategies" exception as unclear or as a loophole which would defeat the purpose of the subsection and requested additional language requiring that economic profiling be adjusted for case mix and other factors which may affect higher or lower costs. Other commenters opposed the section as vague, burdensome and costly, requiring the disclosure of private business information and benefiting providers rather than patients. Several commenters suggested that the entire section be deleted. Some commenters who objected to the disclosure of economic profiling stated that the types of risk adjustment mechanisms used by insurers are crude, uncertainty about their effectiveness of practicality exists and that the meaning of economic profiling is unclear. One commenter suggested that if economic profiling information is shared with physicians, it should also be made available to purchasers. Some commenters requested that if the section is retained, it should be narrowed to be provided only upon written request to require only that an insurer provide written criteria to a terminated provider if economic profiling is part of the reason for termination.

Agency Response: Commenters have explained that the term "economic profiling" is a term of art used to describe the evaluation of a particular physician or provider based on comparisons of money expended by that physician or provider in relation to other physicians or providers in the network. The department accepts that definition for the term as used in this subsection. The department accepts the objection that mandated disclosure of detailed economic measurements of individual performance by all preferred physicians or providers to any requesting physician or provider could be burdensome to the insurer. However, if such evaluations are used, an affected physician or provider should have access to the criteria by which the physician or provider is measured and to the physician's or provider's own economic profile. The language of the subsection has been amended to limit required disclosure accordingly. Narrowing the information available to that pertinent only to a requesting physician or provider obviates the need for the "market strategies" exception, which has been deleted.

Section 3.3705(6)-Deleted Section Deeming Compliance. One commenter supported the deletion of the subsection deeming insurers to be in compliance with the requirements of the subchapter upon approval of policy forms. One commenter opposed the deletion of this subsection.

Agency Response: The agency agrees that the provision should be deleted. The agency believes that this provision as written was not binding on the agency and was unnecessary. Also, several amended and new sections of the subchapter create ongoing obligations which cannot be met merely upon review and approval of a policy form.

Section 3.3705(6) (changed to §3.3705)-Utilization Review. One commenter opposed the language referencing the provisions of Article 21.58A on the basis that it removes opportunities for the participating community practitioner to have input into the insurer's utilization review process.

Agency response: The agency believes that changes should be made to the prior subsection concerning utilization review. Actions taken related to utilization review are governed by the provisions of Article 21.58A, Texas Insurance Code and Subchapter R of Chapter 19 of Texas Administrative Code. The original adoption of this subsection predates those laws. The changes to this subsection are necessary to avoid discrepancies or duplication in the requirements related to utilization review. Upon review of this comment, however, the agency believes that as defined in §3.3702, the term "utilization review" is inconsistent with the definition contained in Article 21.58A and should be revised to be consistent with that article. The agency has revised this definition accordingly The agency believes the commenter may have misunderstood the agency's intent in revising this subsection. The agency does not intend for the revised subsection to diminish the treating physician's role in the utilization review process and does not believe the revised subsection will have that effect.

Section 3.3705(7) (changed to §3.3705(8))-Hold-harmless provision. A few commenters requested that the hold-harmless provision be expanded to include a provision similar to that in the HMO rules 28 Texas Administrative Code, §11. 1102 in which a provider would agree to look only to the insurer for payment and not to the insured.

Agency response: Expanding the hold-harmless provision as requested is a new issue that is beyond the scope of this rulemaking. The agency will study this issue to determine whether it may be appropriate for future rulemaking.

Because of the number of proposed amendments to these rules and the complexity of the issues raised, it is difficult to categorize the comments as either "for" or "against" adoption of the rules. Most commenters expressed some level of support for the amendments and offered some criticisms or suggested changes; those commenters are listed as "for with changes". A few commenters offered no positive comments and objected to certain provisions in the rules; those commenters are listed as "against". No commenter suggested that the proposed amendments be withdrawn.

For with changes: Advocacy, Inc., Alliance for Managed Care-Aetna, American Medical Security, American National Insurance Company, Baylor University Medical Center, The Beacon, Blue Cross and Blue Shield of Texas, Brinker International, Center for Public Policy Priorities, City of Houston, Clark, Thomas & Winters, Clear Lake Rehabilitation Association, Consortium of Texas Certified Nurse-Midwives, Consumers Union, Coronado Hospital, Disability Policy Consortium, Doctors Hospital, DuPont Human Resources, EmCare, Group Health Association of America, Harris County Medical Society, Haynes & Boone, Health Insurance Association of America, Holy Family Services, individual advanced practice nurses, individual certified nurse-midwives, individual consumers, individual emergency physicians, Jenkens & Gilchrist, John Hancock Mutual Life Insurance Company, Kaiser Foundation Health Plan of Texas, M. D. Anderson Cancer Center, Mental Health Association in Texas, Metroplex Emergency Physician Association, National Association of Dental Plans, Office of Public Insurance Counsel, Parkland School of Nurse-Midwifery, Pharmaceutical Research, Scott & White Hospital, Society of Oral and Maxillofacial Surgeons, Texas Academy of Family Physicians, Texas Association of Home Care, Texas Association of Insurance Officials, Texas Association of Nurse Anesthetists, Inc., Texas Association of Retail Optometry, Texas Business Group on Health, Texas Citizens for a Sound Economy, Texas College of Emergency Physicians, Texas Dental Association, Texas Disability Consortium, Texas HMO Association, Texas Hospital Association, Texas Legal Reserve Officials Association, Texas Life Insurance Association, Texas Medical Association, Texas Nurses Association, Texas Occupational Therapy Association, Texas Osteopathic Medical Association, Texas Planning Council for Developmental Disabilities, Texas Psychological Association, Texas Society of Pathologists, Texas Speech-Language-Hearing Association, Third Coast Emergency Physicians, United Cerebral Palsy of Texas, Inc.

Against: Boon-Chapman, Golden Rule Insurance Co., Texas Association of Business & Chambers of Commerce, United Healthcare Dental, Inc., USA Health Network, Wadley Regional Clinic.

The amendments are adopted under the Insurance Code, Articles 1.03A, 3.42(i) and (p) (as amended by Senate Bill 1637 enacted by the 74th Legislature; 3. 51-6, §3 and §5; 3.70-2(B); 3.70-3(A)(9); 21.21, §3, §4(1) and (2) and §13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 21.21-8, §2 (as added by House Bill 668 enacted by the 74th Legislature); 21.52; 21.58A, §13; 26 08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature) and the Government Code §2001.004 et seq. (Administrative Procedure Act). Article 3.42(i) authorizes the Commissioner of Insurance to disapprove any policy form which is unjust or which does not comply with the Insurance Code. Article 3.42(p) authorizes the commissioner to adopt reasonable rules to implement and accomplish the purposes of Article 3. 42, concerning review and approval of policy forms. Article 3.51-6, §3 provides that a group accident and health policy may not require that a service be rendered by a particular hospital or person. Article 3.51-6 §5 authorizes the commissioner to issue rules to carry out the provisions of Article 3.51-6, concerning group accident and health insurance. Article 3. 70-3(A)(9) provides that payment of claims other than indemnity for loss of life or accrued indemnities remaining unpaid at the death of the insured shall be payable to the insured. Articles 21.21 §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance. Article 21.21-8, §2 prohibits the making or permitting of any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of the contract, or in any other manner whatever. Articles 3.70-2(B) and 21.52 require freedom of choice for the insured in selecting a practitioner under health and accident insurance policies. Article 21.58A, §13 authorizes the commissioner to adopt rules to implement the provisions of that article, concerning utilization review to determine the medical necessity and appropriateness of health care services. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan, including different benefits applicable to providers that participate or do not participated in restricted network arrangements, and provides that utilization review must comply with Article 21. 58A. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 26.75 authorizes the commissioner to adopt rules providing for the fair marketing and broad availability of small employer health benefit plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance. The Government Code, §2001.004 et seq. authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following statues are affected by these sections: Articles 3.42, 3.51-6; 3.70-2; 3.70-3; 21.21; 21.21-6; 21.21-8; 21.52; 21.58A; 26.08; 26.71 and 26. 75.

*§3.3701. Scope.* The sections of this subchapter apply to a preferred provider plan in which an insurer, as defined in §3.3702 of this title (relating to Definitions) provides through its health insurance policy for the payment of a level of coverage which is different from the basic level of coverage provided by the health insurance policy, if the insured uses a preferred provider. The sections of this subchapter do not apply to nor do they sanction any plan arranged or provided for by any provider, employer, union, third-party entity, or any person or entity other than an insurer authorized to engage in the business of health insurance in this state. The sections of this subchapter do not apply to provisions for dental care benefits in any health insurance policy. This subchapter is not an interpretation of and has no application to any law requiring licensure to act as a principal or agent in the insurance or related businesses including, but not limited to, health maintenance organizations. The provisions of this subchapter shall be subject to the Insurance Code, Articles 3.70-2(B) and 21. 52, as they relate to insurers and the practitioners named therein. These sections do not create a private cause of action for damages or create a standard of care, obligation or duty that provides a basis for a private cause of action. These sections do not abrogate a statutory or common law cause of action, administrative remedy or defense otherwise available. If any terms, sections or subsections of this subchapter are determined by a court of competent jurisdiction to be inconsistent with the Texas Insurance Code or invalid for any reason, the remaining terms, sections or subsections of this subchapter will continue in effect.

*§3.3702. Definitions.* The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

Emergency care-As defined in Insurance Code Article 3. 70-2(I).

Health care provider or provider-Any practitioner (other than a physician), institutional provider, or any other person or organization that furnishes health care services, and that is licensed or otherwise authorized to practice in this state.

Health insurance policy-A group or individual insurance policy or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness, which is approved under the Insurance Code, Article 3.42.

Hospital-A licensed public or private institution as defined by the Texas Hospital Licensing Law, Texas Civil Statutes, Article 4437f, or by the Texas Mental Health Code, §88, Texas Civil Statutes, Article 5547-88.

Institutional provider-A hospital, nursing home, or any other medical or health-related service facility caring for the sick or injured or providing care for other coverage which may be provided in a health insurance policy.

Insurer-Any life, health, and accident; health and accident; or health insur-

ance company or company operating pursuant to the Insurance Code, Chapters 3, 10, 20, 22 and 26, as amended, authorized to issue, deliver, or issue for delivery in this state health insurance policies approved under the Insurance Code, Article 3.42.

Medical care–Furnishing those services defined as the practice of medicine in the Medical Practice Act of Texas, Texas Civil Statutes, Article 4495b.

Physician–Anyone licensed to practice medicine in the State of Texas.

Practitioner–One who practices a healing art and is specified in the Insurance Code, Article 3.70-2(B) or 21.52.

Preferred provider–A physician, practitioner, hospital, institutional provider, or health care provider, or an organization of physicians or health care providers who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy as authorized by law and this subchapter.

Prospective insured–For group coverage, an individual, including dependents, eligible for coverage under a health insurance policy issued to the group. For individual coverage, an individual, including dependents, eligible for coverage who has expressed an interest in purchasing an individual health insurance policy.

Quality assessment–A mechanism which is in place or put into place and utilized by an insurer for the purposes of evaluating, monitoring, or improving the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to insure that such care delivered is consistent with that delivered by an ordinary, reasonable, prudent physician or health care provider under the same or similar circumstances.

Service area–A geographic area or areas set forth in the health insurance policy or preferred provider contract.

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.

*§3.3703. Requirements.* A health insurance policy that includes different benefits from the basic level of coverage for use of preferred providers shall not be considered unjust under the Insurance Code, Article 3.42, or unfair discrimination under the Insurance Code, Articles 21. 21-6 or 21.21-8, or to violate Article 3.70-2(B) or 21.52 of the Insurance Code, if.

(1) physicians, practitioners, institutional providers and health care providers other than physicians, practitioners and institutional providers, if such other health care providers are included by the insurer as preferred providers, licensed to treat injuries or illnesses or to provide services covered by the health insurance policy that comply with the terms and conditions established by the insurer for designation as preferred providers may apply for and shall be afforded a fair, reasonable, and equivalent opportunity to become preferred providers. Such designation shall not be unreasonably withheld. If such designation is withheld relating to a physician, the insurer shall provide a reasonable review mechanism that incorporates an advisory role only by a physician panel. Any recommendation of the physician panel shall be provided upon request to the affected physician. In the event of an insurer determination which is contrary to any recommendation of the physician panel, a written explanation of the insurer's determination shall also be provided upon request to the affected physician. The panel shall be composed of not less than three physicians selected by the insurer from a list of those physicians contracting with the insurer, and shall include one member who is a physician in the same or similar specialty, if available. The list of physicians is to be provided to the insurer by those physicians contracting with the insurer in the applicable service area. The insurer must give a physician or health care provider not designated upon initial application written reasons for denial of the designation; however, unless otherwise limited by Insurance Code, Article 21.52B, this subsection does not prohibit an insurer from rejecting an application from a physician or health care provider based on the determination that the preferred provider plan has sufficient qualified providers. Any insurer, when sponsoring a preferred provider plan, shall notify immediately all physicians and practitioners in the geographic area covered by the plan of its intent to offer such a plan by publication, or in writing to each physician and practitioner of the opportunities to participate. Such notice and opportunities to noncontracting physicians and practitioners as described above shall be provided on a yearly basis thereafter. The insurer shall, upon request, make available information concerning the application process and qualification requirements for participation as a provider in the plan to any physician or health care provider;

(2) the terms and conditions of the contract between the insurer and the preferred providers shall be reasonable, shall not violate any law or any section of this subchapter, shall be based solely on economic, quality, and accessibility considerations, and shall be applied in accordance with reasonable business judgment. Exclusive preferred provider contracts under which a physician or health care provider is prevented from contracting with others to provide similar services shall not be permitted under this subchapter. Any term or condition limiting participation on the basis of quality shall be consistent with established standards of care for the profession. In the case of physicians or practitioners with hospital or institutional privileges who provide a significant portion of care in a hospital or institutional setting, terms and conditions may include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the lack of hospital or institutional privileges shall not be a basis for denial of participation to such practitioners of that class. No insurer may contract with a hospital or institutional provider which, as a condition of staff membership or privileges, requires a practitioner to enter into a preferred provider contract. The preferred provider may agree with an insurer to not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the plan shall not require the preferred provider to pay hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary;

(3) under the preferred provider plan, the insured shall be provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the health insurance policy. There shall be no requirement that the insured be referred by a physician or practitioner of another class or by a subspecialty within the same class, except that a plan may provide for a different level of coverage for use of a nonpreferred provider if a referral is made by a preferred provider. The referring physician or practitioner may not be required to bear the expenses of referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate. An insurer shall not use any financial incentive or make payment to a physician or health care provider which acts directly or indirectly as an inducement to limit medically necessary services.

(4) in addition to all other contract rights, violations of these rules shall be treated for purposes of complaint and action in accordance with the Insurance Code, Article 21.21-2, and the provisions of that article shall be utilized insofar as practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties;

(5) the insurer offering preferred provider plans shall, upon request, file with the Texas Department of Insurance all data and information on activities of preferred provider plans in order to assess the impact of these plans on:

(A) quality of care;

(B) access to care;

(C) cost of care;

(D) the availability and affordability of accident and health insurance; and

(E) the provision of care of the uninsurable or medically indigent

*§3.3704. Freedom of Choice.* Pursuant to the Insurance Code, Article 3.51-6, §3, and Article 3.70-3(A)(9), no health insurance policy may require that a service be rendered by a particular physician or health care provider. A health insurance policy that includes different benefits from the basic level of coverage for use of preferred providers shall not be considered to unlawfully restrict freedom of choice in the selection of physicians or health care providers by insureds provided:

(1) (No change.)

(2) the rights of an insured to exercise full freedom of choice in the selection of physician, hospital or practitioner are not restricted by the insurer, and physicians and health care providers shall be free to join one or more insurance plans or other preferred provider plans or HMOs whether or not sponsored by an insurance carrier or HMO;

(3) the insurer shall establish reasonable procedures for assuring a transition of insureds to physicians or health care providers and for continuity of treatment, including providing reasonable advance notice to the insured of the impending termination from the plan of a physician or health care provider who is currently treating the insured and making available to the insured a current listing of preferred providers, in the event of termination of a preferred provider's participation in the plan. Each contract between an insurer and a physician or health care provider must provide that the termination of a preferred provider's participation in the plan, except for reason of medical competence or professional behavior, shall not release the physician or health care provider from the generally recognized obligation to treat the insured and cooperate in arranging for appropriate referrals or release the obligation of the insurer to reimburse the physician or health care provider or, if applicable, the insured at the same preferred provider rate if, at the time of preferred provider termination, the insured has special circumstances such as a disability, acute condition, or life threatening illness or is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence. Special circumstances mean a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider who must request that the insured be permitted to continue treatment under the physician or provider's care and agree not to seek payment from the patient of any amounts for which the insured would not be responsible if the physician or health care provider were still a preferred provider. Contracts between an insurer and physicians and health care providers shall include procedures for resolving disputes regarding the necessity for continued treatment by the physician or health care provider. This section does not extend the obligation of the insurer to reimburse, at the preferred provider rate, the terminated physician or health care provider or, if applicable, the insured for ongoing treatment of an insured beyond 90 days from the effective date of the termination;

(4) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, then the basic level of coverage must be reasonably consistent with such other health insurance policies offered by the insurer which do not provide for a different level of coverage for use of a preferred provider.

(5) an insurer shall provide reimbursement for the following emergency care services at the preferred provider level of benefits if the insured cannot reasonably reach a preferred provider and until the insured can reasonably be expected to transfer to a preferred provider:

(A) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency department of a hospital which is necessary to determine whether a medical emergency condition exists;

(B) necessary emergency care services including the treatment and stabilization of an emergency medical condition; and

(C) services originating in a hospital emergency department following treatment or stabilization of an emergency medical condition.

(6) Physicians or health care providers may refer an insured to other than preferred providers, provided that the insured is advised that a different indemnity payment may apply. If services are not available through preferred providers, nonpreferred providers shall be reimbursed at the same rate as the preferred providers would have been reimbursed had the insured been treated by them;

(7) all health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders shall be written in plain language, must be in a readable and understandable format and must comply with Texas Department of Insurance rules found in 28 Texas Administrative Code, Chapter 3, Subchapter G. The insurer shall provide to a prospective group contract holder and prospective insured upon request an accurate written description of the terms and conditions of the policy to allow the prospective group contract holder or prospective insured to make comparisons and informed decisions before selecting among health care plans. The written description must be in a readable and understandable format, by category, and must include a clear, complete and accurate description of these items in the following order:

(A) a statement that the entity providing the coverage is an insurance company, the name of the insurance company, and that the insurance contract contains preferred provider benefits;

(B) a toll free number, unless exempted by statute or rule, and address for the prospective group contract holder or prospective insured to obtain additional information;

(C) an explanation of the distinction between preferred and nonpreferred providers;

(D) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(E) emergency care services and benefits and information on access to after-hours care;

(F) out of area services and benefits;

(G) an explanation of the insured's financial responsibility for payment for premiums, deductibles, coinsurance or any other out-of-pocket expenses for noncovered or nonpreferred services;

(H) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(I) any prior authorizations, including preauthorization review, concurrent review, post-service review, and postpayment review and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(J) provision for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(K) summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or other person has filed a complaint on behalf of the insured and against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(L) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients;

(M) service area;

(8) A copy of the written description of the terms and conditions of the policy to be made available to prospective group contract holders and prospective insureds as required in paragraph (5) of this subsection shall be filed with the department. A current list of preferred providers and the insurer's service area shall be filed with the department annually by June 1;

(9) the health insurance policy and all promotional, solicitation, and advertising material concerning the health insurance policy shall clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits. A list of preferred providers shall be distributed to all prospective insureds. Any change in the list of preferred providers shall be provided to all insureds no less than annually to all insureds. Unless exempted by statute or rule, the insurer shall provide to each insured a toll free number to be maintained 40 hours per week during regular business hours that the insured can call to obtain a current up-to-date list of preferred providers;

(10) no insurer, or agent or representative thereof, may cause or permit the use or distribution of prospective insured information which is untrue or misleading;

(11) both preferred provider benefits and basic level benefits must be reasonably available to all insureds within a designated service area;

(12) payment by the insurer shall be made for services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider;

(13) the insurer will make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the plan's service area to afford all persons insured under such plan freedom of choice in the selection of institutional providers at which they will receive care, unless such a mix proves to be not feasible due to geographic, economic, or other operational factors. In addition, special consideration shall be given to contracting with teaching hospitals and hospitals providing indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

*§3.3705. Procedure to Assure Adequate Treatment.* Insurers which market a preferred provider plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner assuring both availability and accessibility of adequate personnel, specialty care, and facilities.

(1) Each insured patient shall have the right to treatment and diagnostic techniques as prescribed by the physician, or other health care provider included in the plan.

(2) Every contract by an insurer with a physician or physician group shall have a mechanism for the resolution of complaints initiated by the insured, physicians, or physician organization. Such mechanism shall provide for reasonable due process which includes and advisory role only by a physician panel selected in the manner provided in §3.3703(1) of this title (relating to Requirements).

(3) No insurer shall engage in any retaliatory action against an insured, including cancellation or refusal to renew a policy, because the insured, or person acting on behalf of the insured, has filed a complaint against the insurer or against a preferred provider or has appealed a decision of the insurer. No insurer shall engage in any retaliatory action against a physician or provider, including termination or refusal to renew a contract, because the physician or provider has, on behalf of an insured, reasonably filed a complaint against the insurer or has appealed a decision of the insurer.

(4) Before terminating a contract with a preferred provider, the insurer shall provide written reasons for termination. Prior to termination of a physician, the insurer shall, upon request, provide a reasonable review mechanism that incorporates an advisory role only by a panel selected in the manner provided in §3.3703(1) of this title (relating to Requirements), except in cases in which there is imminent harm to patient health or an action by a state medical or other physician licensing board or other government agency that effectively impairs the physician's ability to practice medicine or in cases of fraud or malfeasance. Any recommendation of the physician panel shall be provided to the affected physician. In the event of an insurer determination which is contrary to any recommendation of the physician panel, a written explanation of the insurer's determination shall also be provided upon request to the affected physician.

(5) An insurer that conducts, uses or relies upon economic profiling to admit or terminate physicians or health care providers shall make available to a physician or health care provider upon request, the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

(6) No insurer shall engage in quality assessment, as defined herein, unless the insurer does so through a physician panel of not less than three physicians selected by the insurer from among a list of physicians contracting with the insurer, which list is to be provided by those physicians contracting with the insurer in the applicable service area.

(7) Actions taken by an insurer engaged in utilization review, as defined in §3.3702 of this title (relating to Definitions), shall be taken pursuant to Insurance Code, Article 21.58A, and Subchapter R of Chapter 19 of this title.

(8) A preferred provider contract may not require any health care provider, physician or physician group to execute hold-harmless clauses in order to shift the insurer's tort liability to the preferred provider.

(9) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that the notice and other insurer requirements of this subchapter may be complied with by either the insurer or the preferred provider organization on behalf of the insurer. If an insurer enters into an agreement with a preferred provider under this section, it is the insurer's responsibility to meet the requirements of this subchapter or to assure that the requirements are met. All preferred provider insurance benefit plans offered in this state shall comply with the requirements of this subchapter.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514859 Alicia M. Fechtel
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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## Chapter 11. HMO's

The Texas Department of Insurance adopts amendments to Chapter 11, §§11. 1, 11.2, 11.204, 11.301 and new §§11.1103, 11.1500, 11.1501, and 11.1600-11. 1603, concerning health maintenance organizations, with changes to the proposed text as published in the July 25, 1995 issue of the *Texas Register* (20 TexReg 5475).

These amendments address the Governor's directive that the Commissioner of Insurance enact rules to maintain quality of health care for all Texans at affordable prices and to establish procedures for fairness to health care providers. Protection of patients in the rapidly changing health care marketplace requires these updated regulations. These amendments are necessary to assist consumers in making informed choices among health maintenance organization (HMO) health care plans; to prohibit retaliation against enrollees and group contract holders (employers) for filing complaints or appealing decisions of an HMO; to provide for continuity of patient care; to provide for reimbursement of necessary emergency care services; to provide fairness to physicians and providers not designated as HMO plan providers or terminated from the HMO plan and to assist the department in evaluating quality and costs of health care. The amendments as adopted differ in some respect from the proposed published amendments based on further study generated by comments received. Specific changes and reasoned justification for the amendments and agency responses to comments are addressed in Section 4, Summary of Comments.

The amendments to this chapter shall become effective on December 6, 1995. Section 11.1, as amended, provides that Subchapter C, §11.204(17)-(20) (relating to Contents); Subchapter D, §11.301(4)(L) and (5)(I), (J) and (K) (relating to Filing Requirements); Subchapter L, §11.1103 (relating to Continuity of Treatment); Subchapter P, §11.1500 (relating to Retaliation) and §11.1501 (relating to Prohibited Payments); and Subchapter Q, §§11. 1600 (relating to Information to Prospective Group Contract Holders and Enrollees), 11.1601 (relating to Admissions and Terminations of Physicians and Providers), 11.1602 (relating to Primary Care Selection) and 11.1603 (relating to Capitation) do not create a private cause of action. Section 11.2(b), as amended, defines "dentist" and "emergency care", and changes the definition of "capitation". These terms are necessary to clarify the meaning of these amendments. New §11.2(b)(14) changes the definition of "primary care physician" to include physicians and providers. In addition, new §11.2(b)(15) defines "prospective enrollee" to clarify the meaning of this term used in new §11.1600 (relating to Information to Prospective Group Contract Holders and Enrollees), 11.11.204(17) (relating to Contents) and §11.301(5)(I) (relating to Filing Requirements). Proposed new §11.2(b)(19), a definition of "single health care service plan", was deleted and will be published for proposal in the future in conjunction with additional rules which will address additional issues raised in comments related to this proposed definition.

Section 11.204, as amended, adds paragraphs (17) through (20) to require that the contents of the application for a certificate of authority include a written description of health care plan terms and conditions to be provided prospective enrollees, provider network configuration information, written disclosure of types of compensation arrangements, and documentation demonstrating the health care plan contains certain prescribed procedures and provisions for coverage of emergency care services.

Section 11.301, as amended, adds a sentence to paragraph (4) to require an HMO, after receiving its certificate of authority, to file information required by any amendment to §11.204 (relating to Contents) which has not been previously filed with and approved by the commissioner. Section 11.301, as amended, adds paragraph (4)(L) to require an HMO, after receiving its certificate of authority, to file with the commissioner for approval any material change in the plan's emergency care procedures. Section 11.301, as amended, adds paragraphs (5)(I), (J) and (K) to require an HMO, after receiving its certificate of authority, to file with the commissioner for information any modifications to the written description of health care plan terms and conditions for prospective group contract holders and enrollees, any types of compensation arrangements made to physicians and providers, and any material change in network configuration.

New §11.1103 requires each contract between an HMO and a physician or provider of health care services to provide for reasonable advance notice to an enrollee of the impending termination of a treating physician or provider from the network and, upon request by the treating physician or provider, for continuity of ongoing treatment for enrollees with special circumstances for up to 90 days after the effective date of termination of the treating physician or provider.

New §11.1500(a) provides an HMO may not take retaliatory action against a group contract holder or an enrollee because the group contract holder or enrollee has complained about the HMO. New §11.1500(b) provides an HMO may not take retaliatory action against a physician or provider who has reasonably complained on behalf of an enrollee.

New §11.1501 provides that an HMO may not use any financial incentive or make payment to a physician or provider which acts as an inducement to limit medically necessary services.

Proposed new §11.1502 was deleted based on comments that the section is unnecessary and redundant.

New §11.1600 requires an HMO to provide to any group contract holder or enrollee upon request a written disclosure of certain information about the HMO health care plan. This section enhances the ability of consumers and their employers to make informed choices among HMO plans.

New §11.1601 requires an HMO to make application information available to interested providers, offer written reasons for denial or termination of providers, and make available to physicians and providers economic profiling information used by the HMO.

New §11.1602 requires an HMO to include a space on each plan application form for an enrollee to make a selection of a primary care physician or provider. New §11.1602 further provides an HMO must offer enrollees the opportunity to select or change a primary care physician or provider within the HMO network of available primary care physicians and providers, and provides for a limitation of an enrollee's request to change a primary care physician or provider to four changes in any 12-month period.

New §11.1603(1) provides that capitation payments to a primary care physician or provider must begin within 90 days of selection or assignment, calculated from the date of enrollment, or if selection does not occur, the HMO must reserve the capitation payable until a selection or assignment is made. New §11.1603(2) provides that if an enrollee does not select a primary care physician or provider, the HMO must assign an enrollee to a primary care physician or provider who is located in a zip code nearest to the enrollee's residence or place of employment. Assignments must be in a manner that result in a fair and equal distribution of enrollees among

primary physicians or providers. New §11.1603(3) provides an HMO may propose to the department an alternative capitation plan that provides for immediate availability and accessibility to a primary care physician or provider and adequately compensates the primary care physician or provider for risk assumed.

Most commenters expressed general support for the proposed rule amendments and offered comments or concerns on specific sections of the proposed amendments. Several commenters stated that the rules were a positive step in establishing meaningful standards for managed care; a large number of commenters specifically supported the emergency care and disclosure provisions. Several commenters asked that language in the PPO and HMO rules be made as consistent as possible. Some commenters asked that the department work closely with the Texas Department of Health to clarify the roles of each agency in the regulation of HMOs and one commenter asked that the written agreement between the two agencies be made public so that people would know which agency has responsibility for which issue.

One commenter asked that "clinically appropriate" be substituted wherever "medically necessary" appears. One commenter expressed general support for the rules but cautioned that these issues really call for legislative action and that the rules should not be viewed as a substitute for broad and comprehensive legislative action. Other commenters expressed generally negative comments about interference with private contractual relationships and conferring special rights on specific groups, particularly physicians and other providers of health care. Several commenters expressed concerns that the rules would drive up costs, including costs to small businesses, thus denying access to group health care for some Texas workers. Some commenters stated that the rules appeared to slant more toward fair treatment of providers rather than allowing the marketplace to set lower negotiated fees for medical care. Some commenters questioned the department's authority to promulgate specific benefits or regulate HMO provider contracting.

Agency response: The agency received approximately 200 written comments on the rules as well as numerous oral comments at the public hearing. The agency appreciates the comments received and the information provided at the public hearing. The agency will carefully monitor the operation of these rules and consumer complaints it receives to determine if additional changes need to be made to the rules in the future. The commissioner recognizes that legislative action may also change department rules in the future but believes these amendments are necessary now to maintain quality of care and protect patient freedom of choice.

The department has attempted to make the rule requirements consistent for both PPOs and HMOs. However, because there were already rules in place for one type of plan or the other and because of the differences in how the different types of plans operate, it was not always possible to use identical language. If existing rule language in the Chapter 3 (PPO) rules, for example, had not generated problems, staff's goal was not to disturb those provisions even if the corresponding new provisions in the HMO rules were somewhat different. The department and the Texas Department of Health have already worked to ensure the compatibility of the two agencies' rules and will continue to coordinate compliance efforts. The memorandum of understanding between the two agencies will be a public document.

The commissioner has not adopted the suggestion that "clinically appropriate" be substituted for "medically necessary" wherever it appears in the rules, but has reviewed the rules carefully to ensure that the intended standard is stated. In many cases, the word "medically" was deleted. The agency responds to objections that the department is interfering with private contractual relationships by stating that it is carrying out the intent of the legislature and the governor that the department enact rules regarding the operation of managed health care plans to ensure affordable, quality health care for Texans. Through the Insurance Code, the legislature has recognized a public interest in the regulation of health insurance and has delegated to the commissioner the responsibility to ensure managed care plans contain minimum standards; thus the commissioner has the authority to impose requirements on otherwise private contractual arrangements. Fairness to the actual providers of the health care is necessary to the continued availability of quality care. Staff and the commissioner have made every effort to avoid imposing measures that would significantly increase the cost of health coverage. Although several commenters expressed concerns over cost, only one commenter submitted data projecting a premium cost increase of up to 17.2%. The prohibition on financial incentives accounted for 15% of this projected increase and was based on the commenter's incorrect assumption that the language would prohibit all financial incentives, including those for delivering appropriate, cost effective, high quality care. At the public hearing on these proposed amendments, the commenter conceded that the proposed staff modifications to the amended language in the three provisions cited as causing expected cost increases would significantly reduce costs. He was unable to give revised figures. The rules do not themselves mandate specific benefits but rather clarify how statutory mandates shall be carried out.

Additional provisions requested. Several commenters suggested that the rules require the Office of Public Insurance Counsel (OPIC) to issue an annual HMO performance report which would be available to the public at a nominal cost and to allow OPIC access to the department and Texas Department of Health statistical information regarding utilization, quality assurance and complaints. One commenter requested that the department issue an annual report on the performance of HMOs in Texas.

One commenter asked for special attention to elderly enrollees including specific rules governing Medicare HMOs. Another commenter recommended that the agency promulgate rules to require HMOs that serve Medicare enrollees, who are residents of a nursing facility or retirement community to choose from among any skilled nursing care provider in an HMO's network that can best meet the enrollees' needs, including the need to remain within the enrollees' own retirement communities. This commenter also recommended that residents of Continuing Care Retirement Communities (CCRCs) be allowed to use the skilled nursing care they receive in their residential facility regardless of whether or not the CCRC is a network provider.

Some commenters asked that "any willing provider" or "point of service" provisions be included in the rules. One commenter asked that the rules specify that information provided to the department is an open record unless the department determines the information to be proprietary and recommended that the department work with the Texas Health Care Information Counsel to provide data to facilitate consumer decisions. One commenter asked that a section be added prohibiting "hold-harmless" clauses shifting any of the HMO's tort liability to the provider. Several commenters suggested that the term "dentist" be included in these amendments, including use of the term "dentist" in addition to, or in lieu of, the term "provider". Some commenters have requested that providers offering certain specialized services be required on all HMO networks. A commenter stated that access numbers for emergency numbers (on patient cards) and information provided to hospitals should be required.

Agency response: House Bill 2766 (The Patient Protection Act) contained a provision requiring an annual report by OPIC, but department rules cannot require actions by another state agency. The department does intend to publish information regarding the performance of HMOs and OPIC will have access to all information collected by the department and the Texas Department of Health except that which is exempt from disclosure under the Texas Open Records Act.

These rules are for general application; the department shares the commenter's concern over HMOs offering coverage to Medicare beneficiaries and will be monitoring activities and complaints to determine if additional rulemaking is necessary.

The department will examine the issue of tort liability shifting by HMOs for possible future rulemaking. The agency believes that use of the term "dentist" in these sections in addition to the term "provider" is not necessary unless the agency intends to refer to "a dentist" or "dentists" specifically. The definition of "provider" in the HMO Act includes dentists. The Texas Department of Health examines the sufficiency of network providers for certain specialized covered services, but this department is considering for future rules provisions that HMO enrollees have access to appropriate physicians and providers for all covered services. The agency believes that certain information should be required to be on enrollee cards and such recommendation will be considered for future revisions to the HMO rules.

Section 11.1(4)-Cause of action. Some commenters supported inclusion of language

specifying that rules do not create a private cause of action or create a standard of care. Other commenters objected strongly to this language, stating that the department has no authority to limit private causes of action or restrict a standard of care set forth in agency rules. Some commenters emphasized that the lack of a private right of action places all enforcement responsibility on the department and urged the department to create data categories to analyze complaints and to coordinate with the Texas Department of Health to compile information, investigate complaints and take enforcement action.

Agency response: This language does not change any existing law but only emphasizes that these rules are administrative rules. Violation subjects the violator to administrative action by the commissioner but does not affect private causes of action. In other words, these rules cannot form the basis of a private lawsuit, nor can they diminish other rights of action or defenses. They do not create a standard of care upon which a private action can be based unless they are specifically incorporated by reference into a private contractual arrangement. Because of recent legislative action regarding private actions based on department rules, the commissioner believes it is important to emphasize the nature of these rules and rejects suggestions that the provision be deleted. The commissioner and staff recognize that the burden of collecting data and enforcing these rules is with this agency and the Texas Department of Health and both agencies have committed to working together to ensure compliance with the laws and rules governing managed care plans.

Section 11.2(B)(5)-Definitions-Capitation. While no commenters opposed the new definition of capitation, some commenters criticized deleting the prior definition of capitation (average amount of money required per enrollee to administer health plan and provide services for specified time period), stating that it is also an accurate definition of capitation. The amended definition, (method of compensation-per member/per month) is only one way capitation is used and commenters argue that both definitions should be retained. Several commenters state that the phrase "and guaranteeing payment of " should be deleted because it is confusing. Other commenters suggested that specifying "per month" is too restrictive and that the definition should be broadened to "specified time period".

Agency response: Capitation payments are key to the operation of HMOs and must be defined; while the old definition is also "capitation", the new definition defines how "capitation" is used in these rules. The "guarantee" phrase was inserted to clarify that payment was for agreement to provide services and providing them as needed regardless of whether the services were actually used. The phrase is not necessary to the definition and has been deleted as suggested by commenters. The commissioner agrees with commenters that "per month" should be changed to "specified period of time" to allow flexibility.

Section 11.2(B)(9)-Definitions-Emergency care. Several commenters stated that the definition of "emergency care" needs clarification because the definition does not specify in whose mind (the patient's, the treating physician's or the utilization review agent's) a medical condition could reasonably be expected to result in the adverse consequences set out in the definition. These commenters requested the inclusion of a prudent layperson standard against which the reasonableness of the expectation could be judged.

A few commenters suggested that the words "sudden onset" be deleted from the definition or defined to include situations in which a condition can build gradually over time and steadily worsen to the point a patient seeks emergency treatment. Another commenter requested that the definition be broadened to expressly include dental emergencies. Other commenters recommended that the definition be adopted as proposed.

Agency response: The definition of emergency care in the rules is taken from the HMO Act, Insurance Code, Article 20A.02(t). The agency does not believe it is necessary to clarify this statutory definition. The agency believes that the existing definition includes the expectation of a prudent layperson. The definition also encompasses, in appropriate circumstances, dental emergencies and situations requiring treatment for an acute medical condition in the case where a condition began several days earlier but gradually worsened over time to the point at which a patient seeks emergency care.

Section 11.2(B)(14)-Definitions-Primary care physician. A commenter argued that a definition of "primary care provider" is necessary because practitioners other than physicians may provide primary care to patients, maintain continuity of care and initiate referrals for care.

Agency response: The agency agrees with the commenter and will add "provider" to the definition of "primary care physician". The agency recognizes that practitioners other than physicians may contract to provide primary care to patients, maintain continuity of patient care, and initiate referrals for care. For example, a dentist may provide primary care in a dental HMO.

Section 11.2(B)(15)-Definitions-Prospective enrollee. One commenter suggested adding a definition of "prospective enrollee" to clarify the meaning of the term used throughout the rules and include individuals not in a group. Agency response: The agency agrees that adding a definition of "prospective enrollee" will clarify the meaning of the term used throughout the rules. Accordingly, the agency has amended §11.2 (relating to Definitions) to include a definition of "prospective enrollee".

Section 11.2(B)(19)-Definitions-Single health care service plan. A few commenters do not support mental health and chemical dependency single health care service HMOs. The commenters stated that it may stigmatize the users and segregate services for persons with disabilities. One commenter strongly supports mental health and chemical dependency single health care service HMOs. One commenter wants further clarification concerning contracting issues. A few commenters raised significant issues concerning contracting and minimum benefit standards that have not been addressed by the published definition of "single health care service plan" or other rules.

Agency response: The department believes that, under current law, an entity which provides both mental health and chemical dependency services may obtain a certificate of authority to operate as a single health care service HMO rather than being required to obtain two separate certificates of authority, one for mental health and the other for chemical dependency. An additional sentence was added to the statutory definition of "single health care service plan" to clarify the agency's interpretation. However, the agency agrees that additional clarification is necessary concerning contracting minimum benefit standards and possibly other issues. For this reason, the agency recommends removing the definition of single health care service plan from the rules. The agency intends to study the additional by commenters and to propose additional rules in the future.

Section 11.204-Filing requirements in general. One commenter questioned whether the additional items to be included with the application for certificate of authority means that a currently licensed HMO must amend its certificate of authority, and if so, when?

Agency response: The agency agrees that the rules as proposed do not clarify additional filing requirements for HMOs currently licensed. A sentence has been added to paragraph (4) of §11.301 of this title (relating to Filing Requirements) to clarify that after the issuance of a certificate of authority, each HMO shall file for approval any information required by any amendment to §11.204 of this title (relating to Contents). The agency intends for all currently licensed HMOs to file for approval with the department the written description of health care plan terms and conditions, network configuration information, written disclosure of types of compensation arrangements, and documentation demonstrating that the health care plan contains certain provisions and procedures for coverage of emergency care services. Thereafter, any changes to this information must be filed for information pursuant to paragraph (5) of §11.301 (relating to Filing Requirements), except for any material change to the plan's emergency care procedures, which must be filed for approval pursuant to paragraph (4) of §11.301 (relating to Filing Requirements). The agency believes it is necessary that these rules apply equally and fairly to all HMOs operating in this state in order to provide a "level playing field" for all HMOs, to maintain quality of health care for all Texans at affordable prices, and to establish procedures for fairness to providers.

Section 11.204(17)-Contents-Disclosure requirements. Many commenters support the required submission of written descriptions of health care plan terms and conditions required pursuant to §11.1600 of this title (relating to Information to Prospective Group Contract Holders and Enrollees ). Many commenters requested that not only the information required in §11.1600 (relating to Infor-

mation to Prospective Group Contract Holders and Enrollees) be submitted as part of the application process but all advertising and promotional materials be submitted as part of the application process. Several commenters requested that the disclosure form be approved, not just filed with the department, while other commenters stated that providing the disclosure statement to the department will increase cost.

Agency response: The agency agrees that advertising material should be submitted as part of the application process; however, this requirement could delay the issuance of the certificate of authority because the advertising material must be reviewed in conjunction with the evidence of coverage and cannot be reviewed until the evidence of coverage is in an approvable form. The agency is concerned with HMO advertising and is considering the appropriateness of rules requiring the filing of all advertising for managed care plans in the future.

The agency disagrees that the required filing of the disclosure statement will increase costs significantly because HMOs are already required to file numerous other items as part of the application process.

Section 11.204(18)-Contents-Provider network, accessibility or referral information. Many commenters strongly support the requirement of filing with the department maximum provider-to-enrollee ratios for both primary care and specialty care providers. Some commenters stated that the definition of "network configuration" should be changed to clarify the intent of the rules to determine the adequacy of the provider network and to mandate disclosure of information by zip code. A commenter stated the network configuration information in the HMO application should specify provider identification by zip code and delete the identification by specialty and other providers. Another commenter stated that network configuration information should include all providers and geographic areas the providers serve. A commenter stated that the proposed regulation does not clarify that dental services are not required to be offered or covered by an HMO.

Agency response: The agency agrees that the intent of the subsection should be clarified to require an explanation of the adequacy of the physician and other provider network configuration. The proposed subsection, which required an "explanation of the contracted or targeted physician, dentist, and as appropriate, other provider network configuration" was unclear and unnecessary. However, the department needs to know network configuration information, including the location of network primary care physicians, specialists and other providers, so that the agency and the Texas Department of Health can monitor the availability and accessibility of health care services offered by an HMO.

The department has modified this subsection to more clearly specify the information necessary for the department to determine the adequacy of the physician and other provider network configuration.

The department may determine provider to enrollee ratios from the network configuration information filed and current enrollment statistics filed with the department.

Section 11.204(19)-Contents-types of compensation arrangements. Some commenters objected to this provision as an intrusion into private contractual arrangements of independent businesses. Others requested that the application require only types of risk-sharing compensation arrangements and not individual provider compensation arrangements. These commenters stated that disclosure of individual compensation arrangements would be onerous and require disclosure of proprietary information. Several commenters suggested limiting the disclosure to require only "general" types of compensation arrangements and changing "any financial incentives" to "types of risk-sharing arrangements, if any."

Agency response: This new subsection does not require disclosure of individual provider compensation arrangements. The agency believes the subsection clearly requires "types of compensation arrangements." The commissioner disagrees with the suggestion to change "any financial incentives" to "types of risk-sharing arrangements" because the intent of this subsection is to require broad disclosure of types of financial incentive arrangements, both to examine financial viability and to ensure that no financial incentives prohibited by §11.1501 of this title (related to Financial Incentive Programs) are used by an HMO.

The phrase, "and the guaranty of the provision of", has been deleted because it may cause confusion, the same reason this phrase was deleted from the definition of capitation in §11.2 of this title (relating to Definitions) .

Section 11.204(20)-Contents-emergency care services. Many commenters expressed strong support for the paragraph relating to emergency care services. This issue, stated many commenters, is a crucial one to consumers of managed care plans. According to these commenters, the paragraph will prevent unnecessary delays in providing emergency care services, avoid inappropriate denials of coverage and improve the overall health care provided by managed care plans.

Several commenters stated that the agency should not enact rules concerning emergency care because the Governor's veto message did not specifically mention this area.

Some commenters expressed their concern that the emergency care provisions will impose costly burdens upon managed care plans to pay for non-emergency care rendered in a hospital emergency department. As an illustration, one commenter stated that if a patient presents at the emergency department with an ordinary cold, potentially costly emergency medical screening examination and treatment would be required to be covered.

Several commenters recommended that the paragraph clarify that coverage for emergency care services must be provided without regard to whether the emergency care services provider has a contractual or other arrangements with the HMO.

Several commenters stated that the term "emergency department" used in the paragraph should be changed to "emergency room" to make it clear that only emergency medical conditions are intended to be covered.

Some commenters stated that in general emergency care requirements could increase costs to managed care plans if such services are unnecessarily utilized for non-emergency situations.

Several commenters stated that coverage for emergency care services should be determined restrospectively by the HMO in light of whether an emergency medical condition actually existed and, for an emergency medical screening examination, whether a prudent layperson would have reasonably believed medical screening was necessary.

Agency response: The agency agrees that the paragraph will help clarify coverage for emergency care services and should provide greater assurances to consumers of managed care products. A significant number of complaints received by the agency concerning managed care plans have been related to coverage for emergency care services. The paragraph is intended to address some of the problems that have arisen in this area and to provide greater direction to the HMOs. The emergency care provisions are consistent with the Governor's proclamation which addressed the need to provide patient protection and quality assurance and to expand patient freedom of choice.

The paragraph is not intended to mandate coverage for situations which are clearly non-emergencies. The agency believes that the definition of "emergency care," together with other language in the paragraph, should not require payment for inappropriate use of emergency care services. Moreover, managed care plans already do and should continue to educate their members concerning the appropriate use of emergency care services. Also, the disclosure provision in subsection (b)(4) of §11.1600 of this title (related to Information to Prospective Group Contract Holders and Enrollees) require the HMO to give information to prospective enrollees about access to after hours care. HMOs require a copayment for emergency services of $50 or more from many of their enrollees. This higher copayment also helps to avoid presentations at the emergency department for non-emergency services. If a patient, as suggested by one commenter, comes to the emergency department with a cold, a screening examination necessary to determine whether an emergency medical condition exists should not be costly. Once it is determined that the patient has a cold, emergency care services would not be considered necessary and would not be covered. No coverage would be required for treatment after stabilization because no medical emergency condition existed to which this treatment would relate.

The paragraph has been modified to clarify that the emergency services specified must be covered without regard to whether the provider furnishing the services has contractual or other arrangements with the HMO. Although language to this effect appeared in

one part of the paragraph concerning emergency care services, the agency intended for it to apply to all of the emergency care provisions.

The agency disagrees that the term "emergency room" should be substituted for "emergency department" because it believes the term "emergency room" is too restrictive. The agency does not believe the term "emergency department" is unduly restrictive. This paragraph is intended for general application because most patients present to the emergency department of a hospital in a medical emergency situation.

The commissioner disagrees that coverage for emergency care services should be determined restrospectively by the HMO. Such practices can create a "chilling effect" on patients which can cause delays in patients seeking needed emergency care. The agency will consider it to be an unacceptable practice subject to enforcement action for an HMO to approve the provision of emergency care services during the patient's visit and then retroactively refuse to pay for the services. When contacted by the emergency department or treating provider the HMO must either approve or deny payment.

Section 11.204(20)(A)-Contents-medical screening examinations. Many of the commenters addressed the requirements concerning emergency medical screening examinations. Some commenters recommended deletion of the word "initial" used to describe the medical screening examination to determine whether an emergency medical condition exists. These commenters stated that the word "initial" is not used in either federal or state regulations concerning emergency services.

Other commenters requested the insertion of the word "necessary" before the phrase "to determine whether an emergency medical condition exists" in order to clarify that only screening examinations that are necessary to the determination of whether an emergency medical condition exists must be covered by the HMO. Other commenters requested the term "appropriate" be inserted to modify medical screening examinations because that term is used in federal law which mandates the provision of emergency services by hospitals.

Several commenters recommended that the subparagraph require coverage of not only an examination and but also diagnostic tests and other procedures to determine whether an emergency condition exists. Several commenters requested that the subparagraph provide for medical screening examinations to be conducted only by or at the direction of a physician.

One commenter suggested limiting HMO liability for payment for an emergency medical screening exam to $50, including the patient's copayment, and only to services performed in the emergency department of a licensed hospital. This commenter further suggested that the medical screening examination should be billed separately.

Agency response: The agency agrees that the term "initial" should be deleted from the rule because it is not a term used in either federal or state regulation. The agency further agrees that the term "necessary" should be inserted to modify "to determine whether the emergency condition exists." The agency believes that the addition of this term will clarify that the screening examination must be related to a determination of whether an emergency medical condition exists. The agency disagrees with adding the term "appropriate" to the rule or that the rule must specifically require coverage of diagnostic testing or other procedures in order to be consistent with federal law. The rule provides that a health care plan must cover any medical screening examination or "other evaluation required by state or federal law." This would include an examination as described by the Emergency Medical Treatment and Active Labor Act, 42 United States Code, §1395dd.

The agency believes that a $50 limit on payments for medical screening examinations would be unreasonably low.

The agency disagrees that the rule should limit persons who can conduct emergency screening examinations to physicians. Such a provision would be unduly restrictive and, under some circumstances, it may be appropriate for another type of health care provider to conduct screening.

Section 11.204(20)(B)-Contents-emergency care services. Many commenters requested that the term "medically necessary" be removed from this subparagraph requiring that an HMO plan contain a provision for emergency care to be provided to covered enrollees. These commenters stated that the definition of emergency care in the rules already establishes medical necessity making the use of the term in this subparagraph redundant.

Agency response: The agency agrees that the term "medically" used to modify necessary emergency care is redundant and may create confusion in light of the definition of emergency care. The term "medically necessary" may also be defined differently in different health care plans. This word will be removed. The subparagraph will retain the word "necessary."

Section 11.204(20)(C)-Contents-post-stabilization care. Many commenters addressed the requirements concerning care following treatment or stabilization of an emergency medical condition. Many of the commenters support the requirement that the HMO be responsible for answering calls for assistance in a timely fashion stating that this will prevent unnecessary delays of post-stabilization care. A large number of the commenters, however, disagreed with the three hour time limit provided for in this subparagraph. A large number of these commenters requested that a shorter response time be imposed (for example, either thirty minutes or one hour), while a few commenters suggested a longer response time (for example, two days).

One commenter stated that the subsection should require the primary care provider to respond rather than the HMO.

Several commenters stated that the post-stabilization care should be deemed to be covered if the HMO does not respond within the time limit. These commenters state that addition of this provision would make the subparagraph self-enforcing and that without it, the subparagraph will not be as meaningful.

Agency response: The subparagraph concerning coverage for post-stabilization care is intended to apply only to care rendered after the patient is stabilized and to the services related to the emergency condition. Under this subparagraph, the HMO must respond to inquiries from the treating provider within the time appropriate to the circumstances and no later than an outside time limit. The commissioner agrees that the maximum time for an HMO to respond should be shortened to one hour. This request will avoid unnecessary delays in treatment and can also avoid costs associated with holding patients in an emergency department rather than transferring them to post-stabilization care facilities within the hospital.

The department disagrees that the rule should require a primary care provider to respond rather than the HMO. The HMO should determine how to best provide responses to inquiries from treating providers. A response from the patient's primary care provider would satisfy the rule but is not mandated by it. Situations may arise, however, in which no primary care provider has been selected by or assigned to the enrollee or the primary care provider is unavailable. In those situations, the HMO must make other arrangements for a response to an inquiry regarding post-stabilization care.

The department disagrees that the rule should provide that if the HMO fails to respond by the maximum time, the HMO will deem coverage for post-stabilization care approved. The commissioner intends to handle HMO non-compliance with this subsection through enforcement action.

Section 11.301-Filing Requirements.

Section 11.301(4)L)-Filing requirements-changes in network configuration A few commenters expressed support for requiring commissioner approval before implementing changes in network configuration.

Several commenters stated that changes in network configuration should not require prior approval for a variety of reasons, including reasons that unreasonable burdens would be imposed on an HMO's ability to develop its networks and to contract with providers; filing every change for approval would be cost prohibitive and burdensome; and initial network configuration is approved with the application for a certificate of authority. Some commenters suggested that modifications to network configuration information should be moved to paragraph (5) of §11.301 (relating to Filing Requirements) to require filing with the department for information only. Some commenters suggested a requirement that "substantial modifications" be filed for information only and one commenter suggested that network configuration information be filed for information only "at least annually". A commenter requested a separate sentence

be added to the proposed paragraph to clarify that HMOs are not required to offer dental services.

Agency response: The agency agrees that filing all changes to network configuration information may impose an unreasonable burden on HMOs, especially a requirement that all changes be filed for approval before effectuation of changes. For this reason, the agency has deleted the requirement that modifications to network configuration information be filed for prior approval. A new paragraph (5)(K) has been added to §11.301 (relating to Filing Requirements) to require that any material change in network configuration be filed with the department for information only. The type of material changes to network configuration information required by new §11.301(5)(K) will include the type of information required to be filed pursuant to new paragraph (17) of §11.204 (relating to Contents). Regular examinations will determine if HMOs have made material changes without notifying the department, and material changes that are filed can be examined to ensure that provision of services to enrollees is not impaired. The reference to "dentist" in the network configuration information required to be filed has been deleted, and, therefore, the agency does not believe it is necessary to add a sentence to clarify that HMOs are not required to offer dental services.

Section 11.301(4)(M) Filing requirements-emergency care services Several commenters stated that restating the language from amended §11. 204(20) of the rules was unnecessarily repetitive. The commenters recommended that instead of restating the emergency care provisions,. the agency should require that HMOs file for approval any material change in the plan's emergency care provisions.

One commenter suggested that changes to the HMO's emergency care services plan should be filed for information only rather than for approval by the commissioner.

Agency response: The agency agrees that it is unnecessary to repeat the provisions of amended paragraph (20) of §11.204 of this title (relating to Contents) in this paragraph. The agency intends for changes relating to the plan's emergency care services to be filed for approval and will change the language of the proposed paragraph to require an HMO to submit material changes in the plan's emergency care procedures.

The agency disagrees that material changes to the plan's emergency care services provisions should be filed for information only because of the importance of these provisions to the enrollee. The agency believes that commissioner approval is necessary to ensure that material changes in a plan's emergency care provisions comply with the rules.

Section 11.301(5)(I) Filing requirements-disclosure requirements A commenter suggested that the language in paragraph (5)(I) of §11.301 (relating to Filing Requirements) be changed from "any written description..." to "the written description..." Several commenters requested a requirement that amendments to the disclosure statement be filed for approval.

Numerous commenters suggested that all advertising and promotional materials be submitted after issuance of the certificate of authority.

Agency response: The agency agrees with the commenter and has changed §11. 301(5)(I) to read "the written description". The agency also agrees that promotional and advertising material should be filed for information with the department. Having the advertising material on file with the department will enable department staff to have immediate access to the advertising and stop deceptive advertising quickly. The staff will consider rules in the future to require HMOs to file all promotional and advertising material with the department.

The agency does not agree with the recommendation that amendments to the disclosure statement should be filed for approval. The agency intends to monitor the amendments to disclosure statements that are filed for information only.

Section 11.1103-Continuity of Treatment Agreements. Many commenters strongly supported the provision requiring continuity of care for patients with special circumstances whose physicians or providers are terminated from the HMO. Several commenters who generally supported the provision also suggested that the rule should require advance notice to the patient; some suggested a specific period for advance notice such as 90 days.

Several commenters objected to the 90-day limit for continuing care by the terminating physician or provider, arguing that continuity requires reference to clinical standards rather than an arbitrary deadline; these commenters suggested that the physician or provider continue to be compensated by the HMO until the conclusion of the "episode of care" or an "episode of acute care".

Some commenters stated that the HMO should pay the terminated provider at the contract amount unless it is based on capitation or a discounted fee, in which care reimbursement should be based on reasonable and customary charges and that the provider should be required to accept the HMO's payment as payment in full and not seek additional compensation from the patient. One commenter requested that the HMO be required to assist the patient in finding a new participating physician and to assure orderly transfer of records.

A few commenters requested that "special circumstances" include women at or beyond the 24th week of pregnancy, or "the second trimester" rather than "in the third trimester". Many commenters requested that the rules specify that an HMO need not continue payment to a physician or provider removed for quality of care reasons. Some commenters requested that the continuity of care provision be available to all patients, not just those with special circumstances.

An opponent of the provision commented that the contract terms, not "medical prudence" should govern continuity of care provisions and they should apply to all enrollees.

Many commenters requested that the rule clarify that a provider removed for quality of care reasons need not be compensated for continuing to see a patient. Several commenters stated that the language should be clarified, specifying such things as who will make final decision as to when continuity of care is required, who will monitor the process, and defining special circumstances. Some commenters supported including the term "disability"; others suggested it be deleted as vague. A few commenters suggested that the rule require that continuity of care be requested by the treating physician, dentist or provider. One commenter suggested that the enrollee, with the concurrence of the treating physician or provider could identify the special circumstance to the HMO. Some commenters stated that the HMO should not be responsible for payment after a provider voluntarily drops from a network. Agency response: The agency disagrees that contract terms rather than medical prudence should govern continuity of care; contract provisions must not undermine the exercise of medical prudence. The final rule adopts the suggestion of many commenters that the rule require pre-termination notice to the patients so that patients may begin to make arrangements with other providers or request continuity of treatment through their current providers. Reasonable advance notice is required by the PPO rules as published, and similar language has been added to the HMO rule. The commissioner has rejected the comment that an advance notice period, such as 60 or 90 days, be specified in the rule as too inflexible. The department will monitor complaints to determine if more specific requirement of advance notice is necessary. In response to comments, the commissioner has adopted language clarifying that the provisions do not apply to a physician or provider removed for quality of care reasons, clarifying the meaning of "special circumstance." For clarification the commissioner has changed "third trimester" to "24th week" of pregnancy. "Second trimester" has not been added because this would require continued reimbursement long beyond that required for other conditions and the agency believes that the requirement for reimbursement after the 24th week of pregnancy along with the reasonable advance notice that must be given to the enrollee will give the enrollee sufficient time to find a qualified physician or provider. The section has been changed to specify that the physician or provider must identify a patient's special circumstances to the HMO and request that the patient continue under his or her care, and to prohibit the physician or provider from seeking compensation from the patient beyond what the patient would have been responsible for under the plan. The changes have been made in response to comments to clarify the procedures by which the continuity of care requirements will be applied. The commissioner has not adopted the comment that the enrollee, with the concurrence of the treating physician or provider identify the special circumstance to the HMO because the determination of special circumstance involves both the medical judgment and the agreement to continue treatment of the treating physician or provider. Therefore, it is appropriate to require the treating physician or provider to request the continuing care.

The commissioner has not adopted comments suggesting that compensation should be at a rate different than the physician or provider received from the HMO because that would impose additional cost on the HMO and it seems reasonable for the physician or provider to continue to accept compensation at the plan rate for the limited time required to complete the patient's care or arrange for the patient's safe transfer to another treating physician or provider. The 90-day limit on continued reimbursement to the terminated provider is the maximum time required by the rules but plans and physicians or providers may extend this time period by contract or by agreement on a case-by-case basis as needed. Based on information received by the department, the agency believes that many managed care plans currently negotiate continuity of treatment based on the needs of the patient and hopes that arrangements beyond those mandated by the rules based on the needs of individual patients will continue.

The commissioner has not adopted the suggestion that continuity be required until the conclusion of an episode of care because this could be such a long period of time that such a provision would undermine the HMO's control of its provider network; the agency believes that an "episode of acute care" would be covered by the 90-day period in the proposed language. The agency believes that the provisions should apply for the benefit of the patient, whether the plan or the physician or provider initiates the termination and therefore rejects the suggestion that the provisions should not apply if a physician or provider voluntarily terminates from the network.

Section 11.1500-Retaliation. Most commenters support this proposed section. Several commenters suggested that the proposed rule should extend protection against retaliatory actions to physicians and providers who complain or appeal a decision on behalf of their patients, especially in utilization review situations. Other commenters suggested that complaints and appeals should be uniformly recorded and monitored by both the department and the Texas Department of Health and that the proposed rule should be aggressively enforced.

Some commenters argued that insertion of the word "solely" after the word "enrollee" clarifies there are other acceptable reasons for termination of coverage and avoids a situation where an enrollee or employer might complain in anticipation of termination of coverage to prevent it.

Agency response: The department agrees that the proposed section should be expanded to prohibit retaliatory actions against physicians and providers who, on behalf of their patients, complain or appeal a decision of an HMO. The department strongly believes that a physician or provider should feel free to act as an advocate on behalf of a patient who the physician or provider reasonably believes has been or will be denied medically necessary and appropriate health care services covered by an HMO. For this reason, the department has amended this section to clarify an HMO may not retaliate against a physician, provider, group contract holder or individual enrollee for complaining or appealing a decision of the HMO relating to the group or individual enrollee.

The department agrees that the department and Texas Department of Health should coordinate to assure complaints against HMOs are uniformly recorded and monitored. The department is working with the Texas Department of Health to achieve this objective.

The department disagrees that the word "solely" should be inserted after the word "enrollee." The department believes insertion of the word "solely" would make the provision unenforceable by the department because an HMO could easily establish more than one reason for taking the retaliatory action other than a complaint or appeal of a decision. The department disagrees that the provision as worded would effectively prevent an HMO from terminating a physician or provider who had complained on behalf of an enrollee in anticipation of the physician's and provider's termination from the plan in order to prevent termination. There can be many legitimate reasons to terminate a physician or provider, but retaliation for a complaint on behalf of a patient is not one of them.

Section 11.1501-Prohibited Payments. Numerous commenters supported restrictions on the use of financial incentives that would restrict availability of medically necessary care. Many commenters preferred the language contained in the PPO rules to that contained in the HMO rules. A few commenters requested the addition of the language "or clinically appropriate" in addition to medically necessary. In addition, numerous commenters objected to the language as too vague. Suggestions were made to more clearly define unacceptable financial arrangements, since certain financial incentives may be an appropriate aspect of cost containment. Specifically, many commenters wanted it clearly stated that the rule does not prohibit rewards to providers who reduce cost of unnecessary care and provide appropriate medical care. Agency response: The agency agrees that restrictions are needed on the use of financial incentives that would limit the provision of medically necessary care. The agency does not intend to prohibit reasonable cost containment and managed care features of an HMO plan that do not adversely affect the provision of medically necessary services. The agency agrees that some clarification is needed, however, and the section has been changed accordingly. The language as modified is intended to broaden the scope of the financial incentives that may be considered unacceptable and to include both positive and negative incentives.

Section 11.1502-Emergency Care. One commenter stated that proposed §11. 1502 (relating to Emergency Care) which requires an HMO to respond to inquiries from a treating physician or provider concerning services following treatment and stabilization of an emergency medical condition in compliance with its plan is redundant and unnecessary. This commenter states that it is obviously prohibited conduct to violate the terms of the contract and plan and recommends that the provision be deleted.

Agency response: The agency agrees with the comment recommending deletion of §11.1502. It is clear from §11.204 (relating to Contents) that an HMO plan must provide for emergency care services for its enrollees. If an HMO fails to comply with these provisions of its plan, the agency may take enforcement action. Section 11.1502 neither adds to nor takes anything away from the agency's ability to take enforcement action and it is therefore unnecessary. The section will be deleted.

Section 11.1600-Information to prospective enrollees.

Section 11.1600(a). Many commenters supported the disclosure of information concerning HMO plan terms and conditions in a uniform and consistent manner to enable consumers to make informed decisions when choosing among plans. Some commenters did not support the inclusion of this subsection. Several commenters made suggested language changes to this subsection while others supported the language as proposed. Suggested changes include (a) "shall make available" be changed to "shall provide"; (b) "upon request" be deleted so that all consumers will receive the same information; and (c) "to allow groups and individuals eligible for enrollment" be changed to "to allow prospective enrollees."

A comment was made that the rules should require two disclosures; one which would be made available to everyone and one to only those who request information. Several suggestions were made that all marketing materials should include the disclosure information or at least a listing of the information available and how to receive it. A commenter suggested that the subsection require the disclosure information to be required to be mailed within two working days of the request for it.

A commenter suggested that the disclosures be required to be available in a variety of language formats including the language which is the primary language of 10% or more the of the residents of the service area, in Braille and on audio tape.

A comment was made that for group coverage, the HMO should be required to provide the prospective group contract holder with sufficient copies of the disclosure information for distribution to all employees or members of the group. Another commenter suggested adding a provision that an HMO marketing to an employer group may satisfy this subsection by supplying the disclosures directly to the employer.

Agency response: The agency agrees that requiring the disclosure of information about HMO plans to be made available in a uniform and consistent manner will assist consumers in making informed choices when choosing among plans and will enhance their freedom of choice. The agency agrees that the language "shall make available" should be changed to "shall provide" because this clarifies that the HMO is to provide the information, not just make it available. The subsection has been modified accordingly. The agency does not agree that the language "upon request" should be deleted. To require disclosure to consumers who are not applying for or even interested in the coverage would increase costs. Additionally, the agency does not agree that the language "to allow groups

and individuals eligible for enrollment" should be deleted.

The agency believes that requiring two disclosure forms and inclusion of all marketing materials would be too costly and would duplicate some of the information already made available by HMOs; therefore, no change in the subsection has been made requiring this. The suggestion that marketing materials include a statement that other information is available and how to receive it has not been incorporated in these rules but will be considered in future amendments to HMO advertising regulations. The suggestion that the disclosure form be mailed within two working days of the request has not been incorporated; however, if the department receives complaints that HMOs are not promptly providing the required disclosures, consideration will be given to amending the subsection to establish a timeline for compliance.

To keep costs at a minimum, the agency does not agree that the rules should mandate the disclosures to be provided in different languages, Braille or on audio tape; however, HMOs are encouraged to make the disclosure information accessible and otherwise to provide assistance to those who request it.

The agency does not agree that the subsection should expressly mandate HMOs to provide prospective group contract holders with sufficient disclosure statements to distribute to all employees or members due to the costs this would impose; however, the agency encourages HMOs to cooperate with prospective group contract holders when they make such a request. Additionally, the agency does not agree with the suggestion that an HMO marketing to a group may satisfy the subsection by supplying the disclosures directly to the group. HMOs may provide the disclosures to the group; however, this action will not release the HMO from supplying the disclosure to a prospective enrollee who requests the information.

Section 11.1600(b). Many commenters stated that the requirement that the disclosures be in a form prescribed by the department was costly and that businesses should not be required to follow government prescribed forms or even a set order. A commenter stated that the rule should require the basic information to be provided and allow the HMO to determine the method and the format for distribution. Other commenters recommended that the rules require disclosure statements to be uniform and consistent to promote effective comparison. Additionally, comments were made that the disclosures required by this subsection and similar provisions of the PPO rules should be as uniform as possible.

A commenter stated that the information required to be disclosed would be of no interest to the public. Another commenter stated that the requirements would duplicate what is required under ERISA.

Several commenters stated that the information required to be disclosed is already available but not in the order required by the subsection and that most of the items contained in the disclosure form are already contained in brochures.

Many commenters suggested changes to the list of items required to be disclosed by the subsection. A few commenters recommended that the list be reordered to provide consumers with the more important information first. Several commenters stated that the HMO's phone number required to be included in the disclosure information for prospective enrollees to obtain additional information should be a toll-free number. A commenter recommended that the disclosure also specify what other types of information are available as well as giving a toll-free number.

A commenter suggested the disclosure include an explanation of the difference between an HMO and a PPO and a statement in 12 point type that the disclosures are required to be in a standard format for comparison. A commenter requested a provision requiring the identification of the plan as an HMO.

A commenter requested that the item requiring disclosure of emergency care benefits include disclosure of out-of-area emergency care. Another commenter requested that the disclosure include information on obtaining after-hours care.

Numerous commenters stated that the requirement for disclosure of the drug formulary as proposed was too broad and would require insurers to produce long lists of drugs that would be constantly changing and would not be meaningful to consumers. Several of these commenters recommended that the words "existence of" be added to modify "drug formulary" to clarify that the entire drug formulary need not be reproduced in the disclosure forms.

Some commenters requested that complaint and grievance procedures be required to be disclosed including information concerning the prohibition against retaliation and the names and numbers of individuals responsible for processing complaints. Several commenters requested that the names of providers not accepting new patients should be disclosed along with the names of providers contracting with more than one plan and the total number of patients treated by each provider.

Several commenters requested disclosure of provider-to-enrollee ratios for both primary care providers and by specialty, including maximum provider-to-enrollee ratios. It was also recommended that this information be required to be disclosed in the application for a certificate of authority and that the agency should monitor these ratios and compare them with data on consumer complaints regarding access to providers. These commenters also requested mandated disclosure of information related to hold-harmless requirements.

Additional disclosure requirements requested by several commenters included information about network configuration; compensation arrangements; percentage of premiums allocated for medical or dental care, administrative costs and profits; the information in a paragraph entitled YOUR RIGHTS UNDER TEXAS LAW from the vetoed Patient Protection bill and mental health benefits and limitations.

Agency response: The agency agrees that the required disclosures need not be in a form prescribed by the department; however, to facilitate comparison and consumer understanding, the agency believes the order in which the disclosures are to be made should be uniform. Additionally, the agency agrees that the disclosures required in this subsection and in similar provisions of the PPO rules should be as uniform as possible and the required disclosures have been reorganized accordingly.

The agency disagrees the information will be of no interest to the public. The agency recognizes that some information required to be disclosed may duplicate disclosure requirements contained in federal law, but not all of the information required by this section is disclosed under federal law. All prospective group contract holders and prospective enrollees should be able to receive the same information, not just those covered by plans subject to federal law.

Although some HMOs may currently make the disclosure information available to prospective enrollees, not all of them may do so. The subsection will ensure that this information is available to all prospective group contract holders and prospective enrollees to facilitate consumer choices among plans.

In response to comments the agency has revised the list of items required to be disclosed to prospective group contract holders and prospective enrollees and has reordered the items. Although the agency believes disclosure of all of these items is important to consumers, the agency believes it has put the items of more general interest first. The agency agrees that a toll-free number should be provided. Although certain HMOs who transact only a small amount of business in the state are exempted by statute (Insurance Code, Article 21.71) and rule (28 Texas Administrative Code §1.601) from the requirement of maintaining a toll-free number, the department believes that most of these HMOs currently provide a toll-free number. The department encourages all HMOs otherwise exempt from this requirement to maintain a toll-free number for prospective as well as existing enrollees to obtain information.

The agency disagrees that the disclosure should contain an explanation of the difference between HMOs and PPOs and a statement that the disclosures are required to be in standard format. Information concerning PPOs in an HMO disclosure might be confusing to consumers. Instead, the agency has added a requirement that the HMO disclose that the entity providing coverage is a Health Maintenance Organization. The requested 12 point type statement is unnecessary because the format requirement in this subsection will allow consumers to make comparisons.

The agency agrees that this subsection needs to be amended to clarify that the disclosure of emergency care services and benefits is to include out-of-area emergency care. The language of the rule has been amended accordingly. The agency agrees that information about after-hours care should be disclosed. Disclosure of this information can help direct enrollees away from emergency departments for non-emergency conditions.

The agency does not intend to require disclosure of an entire drug formulary because it would be costly to do so and the formulary would need to be updated constantly. The subsection has been reworded to require disclosure of the existence of any drug formulary limitations.

The agency has modified the subsection to require disclosure of complaint and grievance procedures as requested by the commenters. The agency agrees that information concerning which physicians or providers are not accepting new patients is important to consumers and should be disclosed. The subsection has been modified accordingly. The agency disagrees, however, that providers contracting with more than one plan and the total number of patients treated should be disclosed as this information would constantly change, would be too costly to implement and would be only of limited use to the consumer.

The agency disagrees that disclosure of provider-to-enrollee ratios should be required because this information alone could be misleading to consumers. The department will monitor complaints that sufficient physicians and providers are not available to enrollees. The requested disclosure of hold harmless requirements has raised a new substantive issue. This comment was related to one requesting a new provision in the subchapter concerning hold harmless clauses in physician and provider contracts. The department will study this issue for possible future rulemaking

The agency disagrees with the recommended disclosure of percentage of premiums allocated for medical or dental care, administrative costs, and profits because this information constantly changes and can be obtained by calling the HMO. The suggested change to mandate disclosure of mental health benefits and limitations was not added as this information is already required to be disclosed by provisions addressing disclosure of the HMO plan's benefits, limitations and exclusions

Section 11.1601 Admissions and Terminations of Physicians and Providers. Some commenters supported the standards for admission and termination of providers.

A commenter objected to this section as offering special protections and procedures to one class of workers which interfere unreasonably with a market based contracting system and impose burdensome and restrictive regulatory controls. One commenter stated, in regard to this section, that it is bad public policy to require a company to disclose proprietary information regarding specific economic data used in management practices.

Agency response: This section is designed to provide basic guidelines for the admission and termination of physicians and providers to help assure a stable and adequate provider network of providers available to the enrollee. This subsection does not require the release of proprietary information; it simply requires a response to an application from a physician or provider and that the HMO provide reasons for denying an application or terminating a physician or provider.

Section 11.1601(a)-Admissions. A commenter requested the addition of "any willing provider" provisions; another specifically commented that there should be no such provision. Other commenters suggested the deletion of the reference to Article 21.52B as confusing. Several commenters recommended that HMOs be required to respond to requests for applications within a designated time frame; suggested time frames ranged from within 10 days of request to within 60 days of request. Other commenters suggested that applications should be available at any time. A few commenters recommended prescribing a time frame within which the HMO must provide written reasons for denying an application; suggested time frames ranged from within 10 days of denial of an application to within 90 days of receipt of an application. Some commenters objected to allowing denial of an application based on sufficiency of providers and requested that HMOs be required to prove to the rejected provider that the network does in fact have sufficient providers. A commenter requested that the rule prohibit excluding a physician or provider solely because of the anticipated characteristics of the patients of that applicant and suggested that unsuccessful applicants be afforded an appeals process as they are under the rules governing PPOs.

Agency response: Mandating the admission to a managed care network of any willing provider would fundamentally change the character of the managed care system established by Chapter 20A; such a change requires legislative action. Through Article 21.52B, the legislature has established a procedure different from that set out in the section and the agency believes the specific reference to the statute in this subsection is helpful. The department has not added specific response times for providing application materials or denying applications believing that the existing requirements are adequate to produce timely responses; the department will monitor complaints to determine if HMOs are failing to respond timely to applicants. HMOs must be allowed to limit the participation of providers when they have sufficient providers of a particular type to have an economically viable managed care network. The department believes that requiring the HMO to prove to the rejected provider that the network has sufficient providers is unnecessary because complaints from rejected providers that an HMO is using sufficiency of providers as a pretext to deny admission could be reviewed by the state. The department has not articulated any prohibited bases for excluding a physician or provider from an HMO network but will monitor complaints to determine if such prohibition may be advisable in future legislation or rulemaking. The department has rejected the suggestion that unsuccessful applicants be provided an appeals process as too costly.

Section 11.1601(b)-Terminations. Several commenters supported requiring that the HMO provide written reasons for terminating a physician or provider; others objected to the requirement as costly. A few commenters recommended prescribing the time frame for providing written reasons for termination. One commenter recommended that physicians terminating their contracts be required to notify the HMO and affected patients with written reasons for termination.

Many commenters supported the idea of advisory review panels but stated that the advisory review panels should be available to all providers, not just to physicians and dentists. Other commenters objected to the provision of advisory review panels or to any expansion of the applicability of the panel as an unnecessary cost driver. Many commenters had specific suggestions for the composition of the advisory review panel, such as including a member chosen by the affected physician or dentist, off-network members, retired physicians or educators, or all network specialists. Several commenters requested language requiring the HMO to disclose the advisory review panel's recommendation to the affected physician and dentist, along with an explanation if the HMO rejected the panel's recommendation. Other comments recommended that an explanation should only be required to be made available upon request.

Some commenters expressed concern that the requirement of a before termination advisory review would prohibit an HMO from terminating a physician where continued practice constitutes imminent threat of harm to patients or against whom license action is pending and suggested that the rule allow summary suspension for patient safety reasons. One commenter objected to the requirement of the advisory review panel process in the event of termination due to economic considerations. A commenter requested the addition of a requirement that procedural standards in the federal Health Care Quality Improvement Act of 1986 be followed in any action of a type that must be reported to the National Practitioner Data Bank. One commenter stated that the rule should set out the proper reasons for termination.

Agency response: The department believes that requiring an HMO to provide written reasons for terminating a physician or provider will not add significant administrative cost because the HMO is simply required to inform the terminated physician or provider of the reasons for its decision. The department has not added specific response times for providing written reasons for termination believing that the existing requirements are adequate to produce timely responses; the department will monitor complaints to determine if HMOs are failing to respond timely to terminated physicians or providers. The proposed rules are designed to provide a review process for a physician or dentist before termination without imposing additional cost on the HMO by requiring the panel only if requested by the affected physician or dentist and by allowing the HMO to use a standing committee as its advisory review panel. The commissioner agrees with commenters that the recommendations of the panel should be available to the affected physician or dentist upon request and the subsection has been amended accordingly. Provisions are specifically included which would permit immediate action in the event of imminent threat of harm. The commissioner rejects the suggestion that review panels not be used when a termination is for

economic reasons because a meaningful review mechanism must apply equally to all terminations. If the review panel is required only when a physician or dentist is terminated for non-economic (quality of care) reasons, review would rarely be afforded because most HMOs would simply state that the termination is for economic reasons thus the HMO could avoid detailing a quality of care reason for termination and a review. The procedures in the federal act cited by the commenter are standards the use of which insulates participants in a professional review process from liability based on their professional review activities. These standards are far more detailed than the advisory review panel required by this subsection and would not be appropriate for non-quality of care terminations. There may be many appropriate reasons for termination of a physician or provider's participation in an HMO network and the department does not believe it is necessary or advisable to attempt to list them in an agency rule.

Section 11.1601(c)-Economic profiling. Many commenters supported the disclosure of economic profiling information to physicians and providers. Supporters of disclosure also opposed the "market strategies" exception as unclear or as a loophole which would defeat the purpose of the subsection and requested additional language requiring that economic profiling be adjusted for case mix and other factors which may affect higher or lower costs. Other commenters opposed the section as vague, burdensome and costly, requiring the disclosure of private business information and benefiting providers rather than patients. Several commenters suggested that the entire section be deleted. Some commenters who objected to the disclosure of economic profiling stated that the types of risk adjustment mechanisms used by HMOs are crude, and uncertainty about their effectiveness of practicality exists and that the meaning of economic profiling is unclear. One commenter suggested that if economic profiling information is shared with physicians, it should also be made available to purchasers of the HMO plan. Some commenters requested that if the section is retained, it should be narrowed to be provided only upon written request or to require only that an HMO provide written criteria to a terminated provider if economic profiling is part of the reason for termination.

Agency response: Commenters have explained that the term "economic profiling" is a term of art used to describe the evaluation of a particular physician or provider based on comparisons of money expended by that physician or provider in relation to other physicians or providers in the network. The department accepts that definition for the term as used in this subsection. The department accepts the objection that mandated disclosure of detailed economic measurements of individual performance by all HMO physicians or providers to any requesting physician or provider could be burdensome to the HMO. However, if such evaluations are used, an affected physician or provider should have access to the criteria by which that physician or provider is measured and to the physician or provider's own economic profile; the language of the rule has been amended to limit required disclosure accordingly. Narrowing the information available to that pertinent only to a requesting physician or provider obviates the need for the "market strategies" exception, which has been deleted.

Section 11.1602-Primary care selection. Some commenters expressed strong support for protecting the enrollees right to choose providers and to change providers at any time. Other commenters criticized the section as increasing costs and suggested that the provision be stricken or that enrollees should be allowed to select or change providers only during the open enrollment period. Others suggested that the right to change be limited to no more than once a year other than the enrollment period or four times a year and once a month. One commenter suggested that the right to change providers up to four times per year might conflict with the continuity of treatment provisions extending treatment by a terminated provider for up to 90 days. Several commenters asked that the rule specify that the right to select is from network providers only. One commenter requested that the phrase "upon reasonable notice to the HMO" be added to the section and another asked that the rule specify that the effective date of a change may occur within a reasonable time frame, for example, the first day of the month following the month in which the change request was received. Some commenters suggested that this section be combined with the section on capitation.

Agency response: The rule specifies that an enrollee has a right to select and change a primary care physician from within the HMO network, but, as suggested by several commenters, has been amended to allow the HMO to limit the changes to no more than four times per year to alleviate potential administrative burden and cost. The commissioner does not believe that this provision conflicts with the 90-day continuity of treatment requirement because in one case the enrollee seeks to change and in the other the enrollee seeks to continue treatment by the same provider, so it is difficult to imagine the two provisions colliding. The commissioner believes that the suggested reasonable notice and change date provisions are implied in the language of the rule. While staff initially recommended combining §11.1602 and §11.1603 as suggested, upon further study, staff recommended and the commissioner agreed that the rule provisions are clearer if the two sections remain separated.

Section 11.1603-Capitation. Some commenters expressed general support for the section, stating that it would remedy current abuses by some HMOs. Some commenters who expressed general support for the section requested that the provisions extend to all providers, not just physicians and dentists. Many commenters requested that HMOs be required to notify enrollees of any assignment made by the HMO. Some commenters stated that the section be deleted, arguing that it is an inappropriate and harmful intrusion into private contractual relationships or that the commissioner has no statutory authority to require assignment of enrollees or dictate terms of payment of providers. Many commenters objected to requiring assignment of a primary care provider because such a requirement interferes with an enrollee's freedom to choose, arguing that an enrollee may wish to delay selection until care is needed, and that it would drive up costs. Several commenters objected to the requirement that assignments be on a rotational basis and suggested that there should be only a requirement that an assigned primary care provider be within a reasonable travel distance of the enrollee's residence or work. A few commenters objected to the requirement that capitation payments be made retroactively with one commenter arguing that retroactive capitation payments deprive the HMO of revenue used to pay specialists, stipends to dentists in underserved areas and emergency dental reimbursements for out of area service. That commenter estimated that retroactive capitation payments would increase premium costs by 7.5%. Another HMO argued that the rule as proposed would defeat its arrangement of paying reduced capitation fees to a group practice which provides primary care services to all enrollees who have not selected a primary care physician. Several commenters stated that requiring that capitation payments begin within 30 days is too short; some suggested a 90-day time period.

Agency response: The amended rule is necessary to ensure that primary care providers are immediately available and accessible to HMO enrollees and to ensure that premium payments are used as necessary to compensate primary care physicians and providers who assume the risk of providing health care services to the plan's enrollees. When enrollees do not have a selected or assigned primary care provider, they may find themselves in need of immediate care with nowhere to turn but expensive emergency care. Likewise, when an HMO is allowed to retain premium payments until the enrollee actually visits a primary care provider, providers may not receive adequate compensation to provide the services they have contracted to provide. The commissioner therefore rejects the comments which propose deleting this section.

In response to commenters, the adopted rule reflects some changes to the rule as proposed. The amended rule lengthens the maximum time period for beginning capitation payments from 30 to 90 days, eliminates the mandatory assignment provision, requires notice of assignment to the enrollee and allows an HMO to seek approval of an alternative plan for capitation payments.

The commissioner has retained the requirement that capitation payments be made retroactively because he believes this to be the most sound way to ensure that providers are receiving compensation in proportion to their risk. The department staff believe that only a small number of HMOs currently retain premium payments of unassigned enrollees, thus the overall increase in premium, if any, should be negligible. Also, the provision for seeking approval of an alternative capitation payment plan gives HMOs the opportunity to satisfy the department that the HMO has a structure other than the one set out in the section for providing immediate access to a primary care physician or provider and ade-

quate compensation to the physicians and providers.

The department's statutory authority to regulate the payment of capitation is the general authority granted in Article 20A.22 along with the department's specific responsibility to ensure that an HMO has a financially sound plan to provide health care services as set forth in Article 20A.05(a)(2)(A) and (b)(B) , (C).

The department has used nearest zip code rather than "reasonable travel distance" to define the location of any assigned primary care physician or provider because the department believes it to be more advantageous to the enrollee to have the closest possible provider assigned. The department has not extended the capitation provisions to other physicians and providers as requested by one commenter because the availability and accessibility of a primary care physician or provider is of critical importance to the enrollee and the department does not believe that more comprehensive language is necessary at this time.

Because of the number of proposed amendments to these rules and the complexity of the issues raised, it is difficult to categorize the comments as either "for" or "against" adoption of the rules. Most commenters expressed some level of support for the amendments and offered some criticisms or suggested changes; those commenters are listed as "for with changes". A few commenters offered no positive comments and objected to certain provisions in the rules; those commenters are listed as "against". No commenter suggested that the proposed amendments be withdrawn.

For with changes: Advocacy, Inc., Alliance for Managed Care-Aetna, American Medical Security, Baylor University Medical Center, The Beacon, Blue Cross and Blue Shield of Texas, Brinker International, CIGNA, Center for Public Policy Priorities, City of Houston, Clear Lake Rehabilitation Association, Consumers Union, Coronado Hospital, DeLeon & Boggins, Disability Policy Consortium, Doctors Hospital, DuPont Human Resources, EmCare, Group Health Association of America, Group Plan Clinic, doing business as Benesys, Harris County Medical Society, Harris Methodist Health System, Haynes & Boone, Health Insurance Association of America, Holy Family Services, individual advanced practice nurses, individual certified nurses, individual certified nurse midwives, individual consumers, individual emergency physicians, Jenkens & Gilchrist, John Hancock Mutual Life Insurance Company, Kaiser Foundation Health Plan of Texas, Kaiser Permanante, Third Coast Emergency, M. D. Anderson Cancer Center, Medco Behavioral Care Corporation, Mental Health Association in Texas, Metroplex Emergency Physician Association, National Association of Dental Plans, New York Life SANUS, Office of Public Insurance Counsel, Parkland School of Nurse-Midwifery, Pharmaceutical Research, Prudential and Metra Health, Rio Grande HMO, Inc., Scott & White Hospital, Honorable John Smithee, Society of Oral and Maxillofacial Surgeons, Texas Academy of Family Physicians, Texas Association of Homes and Services for the Aging, Texas Association of Home Care, Texas Association of Nurse Anesthetists, Inc., Texas Association of Retail Optometry, Texas Business Group on Health, Texas Chapter of the National Association of Social Workers, Texas Citizens for a Sound Economy, Texas College of Emergency Physicians, Texas Counseling Association, Texas Dental Association, Texas Dermatologic Society, Texas HMO Association, Texas Hospital Association, Texas Life Insurance Association, Texas Medical Association, Texas Nurses Association, Texas Optometric Association, Texas Planning Counsel for Development Disabilities, Texas Psychological Association, Texas Society of Pathologists, Texas Speech-Language-Hearing Association, Third Coast Emergency Physicians, United Cerebral Palsy of Texas, Inc., United Dental Care of Texas.

Against: PCA Health Plans, Texas Association of Business & Chambers of Commerce, United Dental Care, United Healthcare Dental, Inc., Wadley Regional Clinic.

## Subchapter A. General Provisions

### • 28 TAC §11.1, §11.2

The amendments are adopted under the Insurance Code, Articles 20A.22, 20A. 04(a)(13) and (b); 20A.05(b) and (d); 20A.14(a), (b) and (c); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code, §§2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.04(a)(13) provides that in addition to items to be accompanied with each applicant for an HMO certificate of authority as set forth in Article 20A.04(a)(1)-(12), the commissioner may require other information to make determinations required by the HMO Act. Article 20A.04(b) provides the State Board of Insurance may promulgate such reasonable rules and regulations as it deems necessary to the proper administration of the HMO Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents submitted upon application for a certificate of authority to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to both the Texas Board of Health and the Commissioner of Insurance at the time of the next site visit or examination. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be cancelled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected, 20A.22; 20A.04; 20A.05; 20A.14; 21.21; 21-21-6, 26.08; 26.71, 26.75 and 1.03A

*§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 2, 1975, as amended, codified as the Texas Insurance Code, Chapter 20A.

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

(4) Cause of action. Subchapter C, §11.204(17)-(20) of this title (relating to Contents); Subchapter D, §11.301(4)(L) and (M) and (5)(I) and (J) of this title (relating to Filing Requirements); Subchapter L, §11.1103 of this title (relating to Continuity of Treatment Agreements); Subchapter P, §11.1500 of this title (relating to Retalia-

tion), and Subchapter Q, §11. 1600 of this title (relating to Information to Prospective Group Contract Holders and Enrollees), §11.1601 of this title (relating to Admission and Termination of Physicians and Providers), §11.1602 of this title (relating to Primary Care Selection) and §11.1603 of this title (relating to Capitation) do not create a private cause of action for damages or create a standard of care, obligation or duty that provides a basis for a private cause of action. Nor do these sections or subchapters abrogate a statutory or common law cause of action, administrative remedy or defense otherwise available.

*§11.2. Definitions.*

(a) (No change.)

(b) 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 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, Chapter 20A.

(2) Admitted assets-All assets as defined by generally accepted accounting principles, as permitted and valued in accordance with §11.803 of this title (relating to Investments, Loans, and Other Assets).

(3) Affiliate-a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(4) Agent-A health maintenance organization agent as defined in the Insurance Code, Articles 20A.15 and 20A.15A, unless the context of the rule clearly indicates applicability to any agents licensed under one specific article.

(5) Capitation-A method of compensation to a physician or provider based on a predetermined payment per enrollee for a specified period of time for certain enrollees in exchange for arranging for or providing a defined set of covered health care services to such enrollees for a specified period of time, regardless of the amount of services actually provided.

(6) Code-The Texas Insurance Code, 1951, as amended.

(7) Copayment-An additional charge to an enrollee for a service which is not fully prepaid.

(8) Dentist-A person licensed to practice dentistry by the Texas State Board of Dental Examiners.

(9) Emergency Care-As defined in the Insurance Code, Article 20A.02(t) . Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(10) Excess surplus-The surplus that is in excess of the minimum surplus required by the Insurance Code, Article 20A.13, excluding from surplus those assets a health maintenance organization finds necessary for its operations as set forth in §11.803(5) of this title (relating to Investments, Loans and Other Assets).

(11) HMO-A health maintenance organization which has been issued a certificate of authority under the Act.

(12) Out of area benefits-The benefits that the HMO covers when its members are outside the geographical limits of the HMO service area.

(13) Premium-The prospectively determined rate, based on the capitation, that is paid by or on behalf of a subscriber for specified health services.

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

(15) Prospective Enrollee-In the case of a member of a group, an HMO, an individual eligible for enrollment in an HMO purchased through that individual's group. In the case of an individual who is not a member of a group or whose group has not purchased or does not intend to purchase an HMO plan, "prospective enrollee" means an individual who has expressed an interest in purchasing individual HMO coverage and who is eligible for coverage by the HMO.

(16) Qualified HMO-An entity which has been federally approved under Title XIII of the Public Health Service Act, Public Law 93-222, as amended.

(17) Rules-All sections under this chapter.

(18) Schedule of charges-The specific rates or premiums to be charged for a single enrollee, a two-member family, three-member family, etc.

(19) Service area-The geographical area within which direct service benefits are available and accessible to HMO enrollees.

(20) Subscriber-If nongroup coverage, the person who is the policyholder and is responsible for payment of premiums to the HMO; or if group coverage, the person who is the certificate holder and whose employment or other status, except for family dependency, is the basis for eligibility for membership in the HMO.

(21) Surplus-The admitted assets minus uncovered liabilities.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 15, 1995.

TRD-9514860

Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

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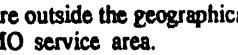
For further information, please call: (512) 463-6327



## Subchapter C. Application for Certificate of Authority

### • 28 TAC §11.204

The amendment is adopted under the Insurance Code, Articles 20A.22, 20A. 04(a)(13) and (b); 20A.05(b) and (d); 20A.14(a), (b) and (c); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code §§2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.04(a)(13) provides that in addition to items to be accompanied with each applicant for an HMO certificate of authority as set forth in Article 20A.04(a)(1)-(12), the commissioner may require other information to make determinations required by the HMO Act. Article

20A.04(b) provides the State Board of Insurance may promulgate such reasonable rules and regulations as it deems necessary to the proper administration of the HMO Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents submitted upon application for a certificate of authority to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to both the Texas Board of Health and the Commissioner of Insurance at the time of the next site visit or examination. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be cancelled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected, 20A.22; 20A.04; 20A.05; 20A.14; 21.21; 21-21-6, 26.08; 26.71, 26.75 and 1.03A.

*§11.204. Contents.* Contents of the application must include the following items in the order as listed:

(1)-(16) (No change.)

(17) the written description of health care plan terms and conditions made available for any prospective group contract holder and prospective enrollee of the HMO pursuant to the requirements of §11.1600 of Subchapter Q of this title (relating to Information to Prospective Group Contract Holders and Enrollees);

(18) network configuration information, including an explanation of the adequacy of the physician and other provider network configuration. The information provided must include the names of physicians, specialty physicians 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) written disclosure of types of compensation arrangements, such as compensation based on a fee-for-service arrangement, a risk-sharing arrangement, or a capitated risk arrangement, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; and

(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 the following provisions and procedures for coverage of emergency care services 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 covered individuals:

(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 covered enrollees in the emergency department of a hospital;

(B) necessary emergency care services will be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition;

(C) services originating in a hospital emergency department following treatment or stabilization of an emergency medical condition as approved by the HMO. This provision must require the HMO to approve 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. The HMO must respond to inquiries from the treating physician or provider in compliance with this provision in the HMO's plan.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-9514861 Alicia M. Fechtel
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 D. Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority

### • 28 TAC §11.301

The amendment is adopted under the Insurance Code, Articles 20A.22, 20A. 04(a)(13) and (b); 20A.05(b) and (d); 20A.14(a), (b) and (c); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code, §§2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.04(a)(13) provides that in addition to items to be accompanied with each applicant for an HMO certificate of authority as set forth in Article 20A.04(a)(1)-(12), the commissioner may require other information to make determinations required by the HMO Act. Article 20A.04(b) provides the State Board of Insurance may promulgate such reasonable rules and regulations as it deems necessary to the proper administration of the HMO Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents submitted upon application for a certificate of authority to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to both the Texas

Board of Health and the Commissioner of Insurance at the time of the next site visit or examination. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be cancelled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected, 20A.22; 20A.04; 20A.05; 20A.14; 21.21; 21-21-6, 26.08; 26.71, 26.75 and 1.03A.

*§11.301. Filing Requirements.* Subsequent to the issuance of a certificate of authority, each health maintenance organization (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 Expansion Requests). These requirements include filing of any changes necessitated by federal or state law or regulation.

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

(4) Filings requiring approval. Subsequent to the issuance of a certificate of authority, each HMO shall file for approval with the commissioner all information required by any amendment to §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)-(K) (No change.)

(L) any material change in the plan's emergency care procedures.

(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 Form #7 - Certification of Compliance, referred to in §11.1001(8) of this title (relating to Forms Adopted by Reference) 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)-(H) (No change.)

(I) the written description of health care plan terms and conditions made available for any prospective group contract holder and prospective enrollee of the HMO pursuant to the requirements of §11.1600 of Subchapter Q of this title (relating to Information to Prospective Group Contract Holders and Enrollees); and

(J) modifications to any types of compensation arrangements, such as compensation based on a fee-for-service arrangement, a risk-sharing arrangement, or a capitated risk arrangement, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; and

(K) Any material change in network configuration.

(6) (No change.)

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-9514862 Alicia M. Fechtel
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 L. Standard Language for Mandatory and other Provisions

### • 28 TAC §11.1103

The new section is adopted under the Insurance Code, Articles 20A.22, 20A. 04(a)(13) and (b); 20A.05(b) and (d); 20A.14(a), (b) and (c); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code, §§2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.04(a)(13) provides that in addition to items to be accompanied with each applicant for an HMO certificate of authority as set forth in Article 20A.04(a)(1)-(12), the commissioner may require other information to make determinations required by the HMO Act. Article 20A.04(b) provides the State Board of Insurance may promulgate such reasonable rules and regulations as it deems necessary to the proper administration of the HMO Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents submitted upon application for a certificate of authority to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to both the Texas Board of Health and the Commissioner of Insurance at the time of the next site visit or examination. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate

holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be cancelled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected, 20A.22; 20A.04; 20A.05; 20A.14; 21.21; 21-21-6, 26.08; 26.71, 26.75 and 1.03A.

*§11.1103. Continuity of Treatment Agreements.* Each contract between an HMO and a physician or provider of health care services must provide that reasonable advance notice be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee. Each contract must also provide that the termination of the physician or provider contract, except for reason of medical competence or professional behavior, does not release the obligation of the HMO to reimburse the physician or provider who is treating an enrollee of special circumstance, such as a person who has a disability, acute condition, life-threatening illness, or is past the twenty fourth week of pregnancy, at no less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence. Special circumstance means a condition such that the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient. Special circumstance shall be identified by the treating physician or provider who must request that the enrollee be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still on the HMO network. Contracts between an HMO and physicians and providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by the physician or provider. This section does not extend the obligation of the HMO to reimburse the terminated physician or provider for ongoing treatment of an enrollee beyond 90 days from the effective date of the termination.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-9514863 Alicia M. Fechtel
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, §11.1501

The new sections are adopted under the Insurance Code, Articles 20A.22, 20A.04(a)(13) and (b); 20A.05(b) and (d); 20A.14(a), (b) and (c); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code, §§2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.04(a)(13) provides that in addition to items to be accompanied with each applicant for an HMO certificate of authority as set forth in Article 20A.04(a)(1)-(12), the commissioner may require other information to make determinations required by the HMO Act. Article 20A.04(b) provides the State Board of Insurance may promulgate such reasonable rules and regulations as it deems necessary to the proper administration of the HMO Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents submitted upon application for a certificate of authority to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to both the Texas Board of Health and the Commissioner of Insurance at the time of the next site visit or examination. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be cancelled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §§2001.004 et seq authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected, 20A.22; 20A.04; 20A.05; 20A.14; 21.21; 21-21-6, 26.08; 26.71, 26.75 and 1.03A.

*§11.1500. Retaliation.*

(a) No HMO shall engage in any retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the

group, enrollee or person acting on behalf of the group or enrollee, has filed a complaint against the HMO or appealed a decision of the HMO.

(b) No HMO shall engage in any retaliatory action, including terminating or refusal to renew a contract, against a physician or provider, because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or has appealed a decision of the HMO.

*§11.1501. Prohibited Payments.* An HMO may not use any financial incentive or make payment to a physician or provider which acts directly or indirectly as an inducement to limit medically necessary services.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## Subchapter Q. Other Requirements

### • 28 TAC §§11.1600-11.1603

The amendments to the Administrative Code, Chapter 11, are proposed under the Insurance Code, Articles 20A.22; 20A.05(b) and (d); 20A.14(a), (b), (c), (d); 21.21, §3, §4(1) and (2) and 13; 21.21-6, §1 and §3 (as added by House Bill 1367 enacted by the 74th Legislature); 26.08; 26.71 (as amended by House Bill 369 enacted by the 74th Legislature); 26.75 (as amended by House Bill 369 enacted by the 74th Legislature); 1.03A and the Government Code §2001.004 et seq (Administrative Procedure Act). The Insurance Code, Article 20A.22 provides that the State Board of Insurance may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of the Texas HMO Act. Article 1.01A provides that except as otherwise provided by law, all references in the Insurance Code to the State Board of Insurance mean the department or the commissioner as consistent with the respective duties of the commissioner or the department under the Insurance Code and other laws relating to the business of insurance in this state. Article 20A.05(b) sets forth the determinations the commissioner and the Texas Board of Health must make prior to granting a certificate of authority to an HMO. Article 20A.05(d) provides a certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of the HMO Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. Article 20A.14(a) provides that no HMO, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Article 20A.14(b) provides that Article 21.21 applies to HMOs. Article 21.21, §3 and §4(1) and (2) prohibit untrue, deceptive or misleading statements with respect to the business of insurance. Article 21.21, §13 authorizes the commissioner to promulgate rules as necessary to accomplish the purposes of Article 21.21, concerning unfair practices. Article 20A.14(c) provides that an enrollee may not be canceled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner. Article 21.21-6, §1 and §3 define and prohibit unfair discrimination in the business of insurance, including HMOs. Article 26.08 provides that small employer health benefit plan carriers may use cost containment and managed care features in a small employer health benefit plan. Article 26.71 requires the fair marketing of small employer health benefit plans and authorizes the department to require submission of data concerning those plans. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute. The Government Code, §2001.004 et seq. authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirement of available procedures and prescribes the procedures for adoption of rules by a state administrative agency.

The following articles are affected by this proposal: Insurance Code, Articles 20A.22, 20A.04; 20A.05, 20A.14; 21.21; 21-21-6,26.08; 26.71, 6.75, and 1.03A.

*§11.1600. Information to Prospective Group Contract Holders and Enrollees.*

(a) An HMO shall provide upon request an accurate written description of health care plan terms and conditions, as referenced in §11.204(17) of Subchapter C of this title (relating to Contents) and §11.301(5)(I) of Subchapter D of this title (relating to Filing Requirements), to allow any prospective group contract holder and prospective enrollee eligible for enrollment in a health care plan to make comparisons and informed decisions before selecting among health care plans.

(b) The written plan description must be in a readable and understandable format, by category, and must include a clear, complete and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is a Health Maintenance Organization (HMO);

(2) a toll-free number, unless exempted by statute or rule, and address for the prospective group contract holder or prospective enrollee to obtain additional information including provider information;

(3) all covered services and benefits, including a description of the options (if any) for prescription drug coverage, both generic and brand name;

(4) emergency care services and benefits, including coverage for out of area emergency care services and information on access to after-hours care;

(5) out of area services and benefits (if any);

(6) an explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out of pocket expenses for noncovered or out-of plan services;

(7) any limitations and exclusions including the existence of any drug formulary limitations;

(8) any prior authorization, including limitations or restrictions on, and a summary of procedures to obtain approval for, referrals to providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review and the consequences resulting from the failure to obtain any required authorizations;

(9) provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(10) a summary of the complaint resolution procedures of the HMO, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(11) a current list of physicians and providers updated on at least a quarterly basis, including names and locations of physicians and providers, a statement of limitations of accessibility and referrals to specialist, and a disclosure of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees; and

(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.

*§11.1601. Admissions and Terminations of Physicians and Providers.*

(a) Application by physicians and providers to participate in an HMO plan. An HMO upon request shall make available and disclose to physicians and providers written application procedures and qualification requirements for contracting with the HMO. Each physician and provider who initially applies to contract with an HMO for the provision of health care services on behalf of the HMO and who is denied a contract with the HMO must be provided written notice of the reasons the initial application was denied. Unless otherwise limited by Insurance Code, Article 21.52B, this subsection does not prohibit an HMO plan from rejecting an application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

(b) Termination of physicians and providers. Before terminating a contract with a physician or provider, the HMO shall provide a written explanation to the physician or provider of the reasons for termination. Upon request and before the effective date of the termination, a physician or dentist shall be entitled to a review of the HMO's proposed termination by physicians and dentists, including at least one representative in the physician's or dentist's same or similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of the HMO established pursuant to 25 TAC §119.11 (Texas Department of Health Regulations relating to Quality Assurance), except in cases in which there is imminent harm to patient health or an action by a state medical, dental, or other physician or dentist licensing board or other government agency that effectively impairs the physician's or dentist's ability to practice medicine or dentistry or in cases of fraud or malfeasance. The decision of the advisory panel must be considered but is not binding on the HMO. The HMO shall provide to the affected physician or dentist upon request, a copy of the recommendation of the advisory review panel and the HMO's determination.

(c) Economic profiling information. An HMO that conducts or uses economic profiling of physicians or providers within the HMO shall make available to a network physician or provider upon request, the economic profile of that physician or provider, including the standards by which the physician of provider is measured. The use of an economic profile must recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs.

*§11.1602. Primary Care Selection.* Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall make a selection of a primary care physician or primary care provider. An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the HMO network of available primary care physicians and primary care providers. However, an HMO may limit an enrollee's request to change physicians or providers to no more than 4 changes in any 12 month period.

*§11.1603. Capitation.* The following applies to any HMO that to any extent uses capitation as a method of compensation:

(1) The HMO shall begin payment of the contracted for capitation amounts to the enrollee's primary care physician or primary care provider, calculated from the date of enrollment, no later than 90 days following the date an enrollee has selected or has been assigned a primary care physician or primary care provider. If selection or assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected primary care physician or primary care provider had a selection been made shall be reserved as a capitation payable until such time as an enrollee makes a selection or the plan assigns a primary care physician or primary care provider.

(2) If an enrollee does not select a primary care physician or primary care provider at the time of application or enrollment, an HMO may assign an enrollee to a primary care physician or primary care provider. If an HMO elects to assign an enrollee to a primary care physician or primary care provider, the assignment shall be made to a primary care physician or primary care provider located within the zip code nearest the enrollee's residence or place of employment and, to the extent practicable given the zip code limitation, shall be done in a manner that results in a fair and equal distribution of enrollees among the plan's primary care physicians or primary care providers. An enrollee shall have the right at any time to reject the physician or provider assigned and to select another physician or provider from the list of primary care physicians or primary care providers on the HMO's network. An election by an enrollee to reject an assigned physician or provider shall not be counted as a change in providers for purposes of the limitation described in §11.1602 of this title (relating to Primary Care Selection).

(3) As an alternative to the above provisions, an HMO may seek approval from the department of a different capitation payment scheme that assures:

(A) immediate availability and accessibility of a primary care physician or primary care provider; and

(B) payment to the primary care physician or primary care provider of a capitation amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk being assumed.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Alicia M. Fechtel
General Counsel and Chief Clerk
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# Part II. Texas Workers' Compensation Commission

## Chapter 134. Guidelines for Medical Services, Charges, and Payments

## Subchapter K. Treatment Guidelines

### • 28 TAC §134.1002

The Texas Workers' Compensation Commission (the commission) adopts new §134.1002, with changes to the proposed text as published in the September 22, 1995, issue of the *Texas Register* (20 TexReg 7574).

Changes made to the proposed rule in response to public comment received in writing and at a public hearing held on October 11, 1995, are described in the summary of comments and responses section of this preamble. Changes made include changes to the following portions of the rule: (b)(2)(C), (c)(3), (d) (1)(E), (d)(1)(G), (d)(2)(F), (e)(2)(B), (e)(2)(F), (e)(3)(A), (f)(2)(A), (f) (2)(B), (f)(2)(C), (f)(6)(B), (f)(6)(V), and (f)(6)(Y). In addition, the commission has included in subsection (b)(1) that the guideline will expire one year from its effective date. By including this "Sunset" provision, the commission will be required to review and reevaluate the guideline in one year to determine if it is to continue in effect.

The Upper Extremities Treatment Guideline clarifies those services that are reasonable and necessary for operative and nonoperative care of the upper extremities for the injured workers of Texas. The guideline is not to be used as a fixed treatment protocol, but rather identifies a normal course of treatment, and reflects typical courses of interven-

tion. It is anticipated that there will be injured workers who will require less or more treatment than average. It is acknowledged that in atypical cases, treatment falling outside this guideline will occasionally be necessary. However, those cases that exceed the guideline level of treatment will be subject to more careful scrutiny and review and will require documentation of the special circumstances that justify the treatment. This guideline should not be seen as prescribing the type and frequency or length of intervention. Treatment must be based on patient need and professional judgement. The rule is designed to function as a guideline and should not be used as the sole reason for denial of treatments and services. It is anticipated that this guideline will be subject to review and possible revision on a regular basis.

The guideline has been designed to achieve the following goals:

(1) to assist all parties with regard to the appropriate treatment and management of upper extremity injuries;

(2) to establish elements against which aspects of care can be compared;

(3) to establish a guideline to identify clinically acceptable courses of treatment for specific disorders;

(4) to establish documentation standards which support the appropriateness of the level of service; and

(5) to provide a mechanism of prospective, concurrent, and retrospective review for efficient and effective health care utilization.

The clinical and diagnostic treatment guidelines contained in this new rule have been developed in conjunction with health care providers and other parties in the workers' compensation system. The development process involved a national search of state agencies administering workers' compensation programs, which revealed that only a few states had developed treatment guidelines. Research revealed a matrix approach to be the most understandable format for the guideline. A survey of the successful guidelines developed in the private sector identified that involvement from provider work groups achieved the best outcome regarding clinical policy development. The agency recognizes that the evaluation of the proposed guideline should be broad and include comments from employees, employers, health care providers and insurance carriers.

The guideline promotes quality health care, injury specific treatment and appropriateness of care, by identifying clinically acceptable courses of care for specific upper extremities injuries, and by facilitating communication between all parties in order to achieve rapid recovery from the effects of an injury. This communication will also promote a timely return to modified or full duty work that takes into account the job demands and the functional capabilities of the injured worker.

Comments generally supporting, but suggesting changes to the proposed §134.1002 were received from the following groups: Texas Workers' Compensation Insurance Fund, Texas Psychological Association, Texas Pain Medicine Clinic, Tyson Foods, Inc., PRIDE. Summaries of the comments and commission responses are as follows:

COMMENT: General support was expressed for the goals as outlined in (b)(2). However, concern was expressed regarding (b)(2)(C), which states "to establish a guideline to exemplify clinically acceptable courses of treatment for specific disorders." Commenter felt that this guideline should incorporate a greater flexibility, and encourage employers to create and implement treatment programs specific for their companies.

RESPONSE: The commission agrees with the need to revise the goal. This goal has been re-written to state: "to establish a guideline to identify clinically acceptable courses of treatment for specific disorders." Not all disorders that can occur as a result of a compensable injury are listed in this guideline; only those diagnoses most frequently seen, and possible complications of those diagnoses (e.g., avascular necrosis and reflex sympathetic dystrophy) are addressed in this guideline. It is also noted in this document that this is a guideline and that there may be injured workers whose treatment falls outside the parameters, requiring additional documentation substantiating the need for such treatment.

*The following comments were received regarding the role of the primary gatekeeper.*

COMMENT: Concern was expressed by the commenter that the proposed guideline appears to charge the health care provider with the responsibility of determining compensability issues. Suggestion was made to re-direct this section, through revisions, to treat the injured worker, not the claim. Suggestions for revisions of these sections include:

a. (c)(5)(B): "Health care providers must explain to the injured worker in clear terms the extent and severity of the injury and the treatment needed. Health care providers must define the symptomatology and specify treatment that is directly and/or indirectly related to the injury."

b. (d)(1)(D): "This guideline identifies the need to provide documentation which clearly explains the reason for the treatment and the relatedness to the workers' compensation injury alternative treatment."

c. (e)(4): "If it is determined that this treatment is not related to the compensable injury, the injured worker should be informed by the health care provider that this treatment will not be covered by the insurance carrier."

RESPONSE: The commission disagrees with the need to revise these sections. The requirements outlined in the guideline regarding the need for the treating doctor to separate those symptoms and treatments causally related to the compensable injury from those unrelated to the compensable injury are not new. These requirements have been present since the enactment of the law in 1991. This section is simply reiterating the need to separately treat and charge for both compensable and noncompensable signs and symptoms appropriately.

COMMENT: Suggestion was made by commenter to create a checklist for practitioners to utilize when determining the compensability of an injury and ruling out other non-related conditions which might be the cause of the injury. This suggestion was repeated for (e)(4).

RESPONSE: The commission disagrees with the need to create a checklist for providers. Such a checklist would be very difficult to formulate and very complicated. Determination of non-related conditions should be done on a case by case basis and is not a purpose or goal of this treatment guideline.

COMMENT: Although support was expressed for the primary gatekeeper's responsibility for "separation and referral of nonrelated health care services", contained in (c)(2)(A)(iv), commenter suggested that further clarification was necessary regarding this function. An in-depth analysis of this area was recommended.

RESPONSE: The commission disagrees with the request for additional clarification or an indepth analysis. The requirements outlined in the guideline regarding the need for the treating doctor to separate those symptoms and treatments causally related to the compensable injury from those unrelated to the compensable injury are not new. These requirements have been present since the enactment of the law in 1991. This section is simply reiterating the need to separately treat and charge for both compensable and noncompensable signs and symptoms appropriately. The creation of an additional form, i.e., a checklist, would place an additional burden on the health care provider, and would not necessarily address all issues or concerns. The determination of whether a sign/symptom or treatment is causally related to the compensable injury is dependent upon the injured worker's history and should be tailored for that specific individual.

*The following comments were received regarding application instructions for involved parties.*

COMMENT: Concern was expressed by the commenter that the review and approval of treatment plans was not explicitly delineated in the proposed guideline. Suggestion was made to include Application Tables, similar to those contained in the Spine Treatment Guideline, in the proposed guideline, outlining the responsibilities and documentation requirements for all parties, including the requirement for treatment plans. Suggestions for revision include:

a. New Subsection (d)(1)(G): "The health care provider is responsible for formulating a plan of treatment and revising the plan of treatment based on response to treatment. The plan of treatment should be provided to the insurance carrier as early as possible."

b. New Subsection (d)(2)(F): "The insurance carrier is responsible for performing a focus review of injury. This focus review will primarily consist of case management. The focus review must clarify and attempt to reach agreement that the proposed treatment is appropriate as early as possible. Concurrent case management and bill review activities should address and focus on adherence to treatment plans, clinical progress, return to work issues, medical necessity and the following:

(1) Injured worker compliance with the treatment

(2) Services provided consistent with treatment plan

(3) Response to treatment

(4) Improvement in injured workers' progress

(5) Recommendations for changes in treatment in situations where there is no compliance, plateau, and/or there is minimal or no progress

(6) Achievement of goals, improvement sooner than treatment plan indicated."

A suggestion was also made to revise section (e)(3)(B)(iii) as follows:

"A plan of treatment, including proposed methods of treatment, expected outcomes, and probable duration of treatment should be submitted to the insurance carrier for prospective and concurrent review and approval as early as possible."

RESPONSE:

a. The commission disagrees with the need to include application tables, similar to those created for the Spine Treatment Guideline, in the proposed guideline. Although application tables were included in the Spine Treatment Guideline, since its adoption many health care providers have found the table to be confusing and difficult to use.

b. The commission agrees with the need to provide more explicit instructions and has added the commenter's suggested instructions for (d)(1)(G) and (d)(2)(F).

c. The commission disagrees with the proposed revision for (e)(3)(B)(iii). The section, as currently written, is consistent with the Spine Treatment Guideline. The proposed revision appears to require insurance carrier approval prior to implementation of a treatment plan. Although the carrier is encouraged to review treatment plans, as part of a general review of the case, carrier approval of a treatment plan is not required prior to its implementation.

COMMENT: Suggestion was made to allow the employer to participate in the return to work decision as part of a cooperative effort between the health care provider, insurance carrier, injured worker, and employer.

RESPONSE: The commission disagrees with the need for additional clarification regarding employer participation. The responsibilities of the employer are clearly outlined in (d)(6) which states: "Employer. It is the responsibility of the employer to report the compensable injury in a timely fashion to ensure that there is no delay in the treatment of the compensable injury. It is also the responsibility of the employer to work with the insurance carrier and health care providers to ensure that the injured worker is afforded the opportunity to return to work in either a modified or full employment capacity as rapidly as possible within the medical limitations of his/her injury."

*The following comments were received regarding the ground rules.*

COMMENT: Support was expressed for the ground rule (subsection (e)(2)(K)) which referred the HCP to the Mental Health Treatment Guideline when the injured worker displays signs and symptoms which would require further evaluation by a Qualified Mental Health Provider. The commenter stated that this ground rule would provide a "bridge" between the Mental Health Treatment Guideline and other treatment guidelines.

RESPONSE: The commission agrees.

COMMENT: Concern was expressed by the commenter regarding the ground rule (subsection (e)(2)(F)) which referred to the ability of the injured worker to move between the levels of care or utilize interventions from more than one level of care simultaneously. Commenter contended that simultaneous use of care from two levels would not be considered to be within the normal limits of treatment. Suggested revision to this ground rule was:

"The injured worker may move between levels of care or utilize interventions in more than one level of care, depending on clinical indicators. "

RESPONSE: The commission disagrees with the need to revise this ground rule as suggested. Additional ground rules contained in that section, specifically (e)(2)(A)(iii) and (iv), and (e)(2)(G), require that the treatment of the injured worker should be provided in the least intensive setting, be cost effective, and that the level of service provided to the injured worker be substantiated in documentation submitted by the health care provider. For clarification, however, the following phrase has been added to subsection (e)(2)(F): "Although not the typical course of treatment, there may be circumstances in which . . . ".

COMMENT: Support was expressed for ground rules (e)(2)(H) and (J).

RESPONSE: The commission agrees.

COMMENT: Concern was expressed regarding ground rule (e)(2)(G). Commenter felt that the documentation required by the proposed guideline was not sufficient for an insurance carrier conducting a bill/reimbursement review. Suggested revision to this ground rule was:

"All health care providers providing services to an injured worker must substantiate in their documentation the level of service for which they request reimbursement. All payors have the responsibility to review all documentation submitted, and determine if additional documentation is needed, as the basis for the treatment and services provided."

RESPONSE: The commission disagrees with the need to revise this ground rule. This ground rule is consistent with a similar requirement outlined in the Spine Treatment Guideline, (e)(2)(K). The suggested changes do not add to the requirements or clarity of the ground rules. Documentation requirements are addressed in the Medical Fee Guideline.

*The following comments were received regarding the nonoperative treatment tables.*

COMMENT: Commenter supported mental and behavioral evaluation and treatment utilization at the secondary and tertiary levels of care; however, commenter also advocated the addition of mental and behavioral evaluation and treatment at the primary level of care in cases where such factors figure prominently in the clinical presentation and can aggravate physical symptom presentation. The concern expressed by the commenter was the failure to list these interventions in the primary level of care would limit access to those types of treatment when necessary.

RESPONSE: The commission disagrees with the need to include mental and behavioral evaluation and treatment in all primary levels of care. As is noted by the commenter, this type of evaluation and treatment is uncommon except in those diagnoses where such evaluation and treatment is already mentioned. In addition, by providing a ground rule which refers the health care provider back to the Mental Health Treatment Guideline, and noting in the Treatment Interventions section the phrase, "May include but not limited to", those rare instances in which an injured worker may require mental and behavioral evaluation and treatment in the acute phase of the injury (i.e., the primary level of care) can be addressed.

COMMENT: Suggestion was made by the commenter to include a reference to "return-to-work" in all levels of care, not just the tertiary level of care, as is outlined in the proposed guideline. Suggested revisions were:

a. For subsection (f)(2)(A): "The goals are the prevention of disease, alleviating or minimizing the effects of illness or injury and to maintain function, thereby reducing lost time and enabling return to work in some capacity."

b. For subsection (f)(2)(B): "It is designed to facilitate return to productivity, including return to work in either full or modified duty, before the onset of chronic disability. This level of care may also be indicated for the injured worker whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty."

RESPONSE: The commission agrees with the proposed revisions to further emphasize the need to reference "return to work" in all levels of care. The revisions proposed by the commenter have been included in the guideline.

COMMENT: Suggestion was made to specify that the tertiary level of care is differentiated from the secondary level of care "by virtue of its being under medical direction." Concern was expressed that the lack of this distinction between secondary and tertiary care would lead to poor quality tertiary programs run by persons not qualified to administer the proper level of care. In addition, this specification was recommended to bring the proposed guideline in line with the Spine Treatment Guideline.

RESPONSE: The commission agrees with the suggestion to include "medical direction" as part of the definition for the tertiary level of

care in subsection (f)(2)(C). The definition for this level of care now reads:

"Tertiary level of care. This level of care is interdisciplinary, individualized, coordinated and intensive, designed for the injured worker who demonstrates physical and psychological changes consistent with chronic disability. In general, differentiation from secondary treatment includes medical direction, intensity of services, severity of injury, individualized programmatic protocols with integration of physician, mental health, and disability or pain management services and specificity of physical/psychosocial assessment. There is a documented history ..."

COMMENT: Suggestion was made by the commenter to add diagnostic laboratory tests for the following to the secondary level of care for neuropathy, reflex sympathetic dystrophy, and myofascial pain: hypothyroidism, diabetes, B12 and folate deficiencies, neuromuscular conditions, infectious conditions, other systemic and metabolic diseases, autoimmune disorders, and conditions related to cancer.

RESPONSE: The commission disagrees with the need to further expand the list of diagnostic studies for those listed conditions. The treatment tables are not all inclusive and contain the caveat "May include but not limited to". If testing or treatment beyond that described in the treatment tables is necessary, additional documentation substantiating the need for such testing or treatment is required. Although testing for the disorders the commenter mentioned may be necessary to determine the causal relation of the symptoms to the compensable injury in some cases, those tests are not normally considered to be diagnostic work for a compensable injury. Therefore, these tests are not appropriate for inclusion in this guideline.

COMMENT: Suggestion was made by the commenter to add peripheral nerve blocks as a treatment to the secondary level of care for neuropathy, reflex sympathetic dystrophy, and myofascial pain disorder.

RESPONSE: The commission agrees. After reviewing the literature, and consulting with work group members, it appears that peripheral nerve blocks are considered to be normal and typical for the diagnoses listed by the commenter at the secondary level of care. This treatment has been added to the guideline.

COMMENT: Suggestion was made to revise the treatment tables as follows: remove arthrogram as a diagnostic procedure from the secondary level of care table for Olecranon Bursitis, Olecranon Impingement; remove arthrogram from the primary level of care and add MRI to the secondary level of care for Bicipital, Supraspinatus (rotator cuff), Musculotendinous and Periarticular Problems of the Shoulder; remove arthrogram from primary, secondary, and tertiary levels of cares for Sprain/Strain, Tear, Shoulder Impingement Syndrome; and include "regular physical activity" after "concurrent home program" in the primary, secondary, and tertiary levels of care for Intra-articular Pathology Traumatic Arthritis and Reflex Sympathetic Dystrophy.

RESPONSE: The commission disagrees with the proposed additions/deletions to the treatment tables.

a. The literature provided by the work group supports the use of arthrograms for Olecranon Bursitis/Olecranon Impingement as a confirmatory test and supports the use of arthrograms as a diagnostic test for Tendinitis: Bicipital, Supraspinatus, and Musculotendinous and Periarticular Problems of the Shoulder and for Rotator Cuff: Sprain/Strain, Tear, and Shoulder Impingement Syndrome.

b. Magnetic Resonance Imaging (MRI) was not felt to be appropriate as a diagnostic study at the secondary level of care for Tendinitis: Bicipital, Supraspinatus (rotator cuff) and Musculotendinous and Periarticular Problems of the Shoulder. It was felt to be appropriate, as a confirmatory test, at the tertiary level of care, to rule out other causes for continued symptomatology.

c. Separate mention of "regular physical activity" is not necessary. This is a component of a home program and does not require separate mention in the treatment tables.

COMMENT: Concern was expressed that the definitions of the levels of care are difficult to understand. It is not clear what role the employer has in the provision of these levels of care.

RESPONSE: The commission disagrees. The role of the employer was clearly outlined in (d)(6). The definitions of the levels of care are general descriptions regarding the types of elements that can be found in each of the three levels of care as well as goals for those levels of care. The role of the employer is not specifically addressed in the definitions.

COMMENT: General support was expressed regarding the description of levels of care. However, commenter expressed concern that goals were not as clearly outlined in the proposed guideline as they are in the Spine Treatment Guideline. Commenter suggested using the goals outlined in the Spine Treatment Guideline. In addition, the commenter stated that further clarification of clinical indicators for secondary and tertiary levels of care was necessary.

RESPONSE:

a. The commission disagrees with the need to include goal statements in each of the tables. A general outline of the goals has been included in the definitions for each level of care.

b. The commission disagrees with the need for further clarification of the clinical indicators for secondary and tertiary levels of care. The clinical indicators, as outlined in the proposed guideline, were based on information provided by the work group. Unlike the Spine Treatment Guideline, the movement from one level of care to the next is more likely to be triggered by the degree of severity of the injury, the persistence of symptoms and the response of the injured worker to treatment instead of separate, distinct clinical indicators that only occur after a period of time has lapsed. Where the literature indicated distinctive symptoms for each level of care, those symptoms were listed in the tables.

*The following comments were received regarding surgical indicators.*

COMMENT: Concern was expressed that the list of indicators, as outlined in (g)(1) is unclear. Should all three conditions be met prior to the recommendation for surgery?

RESPONSE: The commission disagrees. The indicators listed in (g)(1) are not all inclusive. The intention was that any or all of those indicators could represent a need for the health care provider to consider surgical correction of the clinical condition.

COMMENT: Suggestion was made that flow charts, similar to those used in the Spine Treatment Guideline, be used instead of the outline of surgical indicators that is currently present in the proposed guideline.

RESPONSE: The commission disagrees with the need to create a flow chart, similar to the ones utilized in the Spine Treatment Guideline, to outline a course of action for surgery. The work group, upon examination of the guideline, determined that the compiled information regarding the range of diagnoses contained within the proposed guideline did not lend itself to the use of a flow chart. Flow charting is more easily utilized when a clear series of yes/no questions can be asked and a clear set of answers can be provided. Due to the large number of diagnoses contained within this guideline, and the large number of possible scenarios regarding surgical options, the commission and work group were unable to create a simple, usable flow chart for this document.

*The following comments were received regarding the glossary.*

COMMENT: Concern was expressed that the definition of "functional capacity evaluation" ((h)(19)) is too open-ended, especially section (C) of this definition. Many machines/programs/devices claim to provide this type of service. The commenter states that this type of testing requires oversight.

RESPONSE: The commission disagrees. The definition of a "functional capacity evaluation" clearly requires that all three elements be present before the service can be charged as this type of test.

COMMENT: Concern was expressed that the definition of primary level of care ((h)(32)(A)) allows a partial or total cessation of work over a brief period of time. Commenter felt that clarification was needed, and suggested that the section be limited to situations where there is "no use of the affected area" or "affected muscle group".

COMMENT: The commission disagrees that brief work cessation (two to three days maximum) should be limited to those injuries where "no use of the affected area" is a requirement. For example, in the case of a minor sprain/strain, a minimum duration work cessation may be necessary to prevent a further exacerbation of the injury. In addition, if the injured worker is unable to return to work beyond that brief time period, further involvement by the health care provider is required.

*The following general comments were received regarding the proposed new rule.*

COMMENT: Most of the commenters expressed general support for the proposed guideline, with some specifically supporting the goals of the guideline and others commenting on the quality of the document.

RESPONSE: The commission agrees.

COMMENT: Suggestion was made that since the proposed Medical Fee Guideline may eliminate the need for the TWCC 64, that references to that report should be deleted from the proposed guideline.

RESPONSE: The commission agrees that there may be revisions to commission rules regulating required medical reports and has removed references to the TWCC 64 form to avoid any inconsistency with future guidelines.

COMMENT: Suggestion was made that the proposed guideline use directive vs. permissive language. The following revisions to sections of the guideline were recommended by the commenter:

a. (b)(2)(E): "to establish elements against which aspects of care can be compared to what is usual, customary, reasonable, and medically necessary."

b. (b)(2)(C): "to establish a guideline to identify clinically acceptable courses of treatment for specific disorders." (This suggestion tracks the language in the Spine Treatment Guideline.)

c. (c)(4): "Diagnostics. Diagnostic work should be performed in accordance with the recommended testing and timeframes contained in this guideline. If the need arises to deviate from the guideline, then a clinical rationale must be provided which adequately substantiates the need for this deviation. The need to repeat previously completed diagnostic procedures due to the quality of the study may trigger a review by the carrier. All health care providers involved in the treatment of an injured worker will share copies of all diagnostic studies, films, and reports in order to avoid unnecessary duplication of procedures. . ."

d. (c)(5)(A): "All health care providers must encourage injured workers to be active participants in their health care treatment regimens and must communicate in writing to the injured worker realistic expectations regarding the potential outcome of this treatment as it relates to his/her physical functioning and/or ability to return to work. Therefore, the health care provider will document the injured worker's compliance with his/her treatment regimen when reporting the progress of his/her recovery." (The commenter felt that the proposed revisions of this section would ensure consistency between the health care provider's verbal explanation and instructions to the injured worker and the health care provider's narrative report. The commenter also felt that these revisions would allow the insurance carrier to monitor the injured worker's compliance with the treatment plan.)

e. (c)(5)(B): "Health care providers must clearly explain to the injured worker in terms understandable to the injured worker the extent and severity of the injury and the treatment needed ..."

f. (d)(1)(E): "The health care provider is responsible for educating the injured worker about health care treatment appropriate to the workers' compensation injury."

g. (d)(1)(F): "This guideline requires the health care provider to address early return to work based upon the injured worker's functional capacity which includes ability, clinical status, and either full or modified job requirements."

h. (d)(4): "Consulting or Peer Review Health Care Provider. This guideline should be used as a reference when advising the Medical Review Division or when the need for an unbiased medical opinion is indicated. The consulting or peer reviewer should use his/her clinical expertise in conjunction with the clinical intent of the guideline to address issues."

i. (e)(2)(B): "All diagnostic studies, films, and reports and records must be made available to all health care providers to prevent unnecessary duplication of tests and examinations." (This suggested revision is consistent with previously recommended revisions to (c)(4).)

j. (e)(2)(D): "All parties in the workers' compensation system must work together to ensure that the injured worker returns to work at the earliest medically appropriate time. Return-to-work is an important therapeutic approach which benefits the injured worker. The health care provider must communicate with the injured worker, employer and the insurance carrier to coordinate a successful return to work."

k. (e)(3)(B): "Documentation must be provided by the health care provider to determine the level of care to be provided and the necessity for that care . .."

l. (e)(3)(C): "Permanent impairment for compensable injuries in workers' compensation should be limited to those injuries and illnesses for which doctors are able to demonstrate objective findings in accordance with "Guides to the Evaluation of Permanent Impairment" (§408.124, Impairment Rating Guidelines)."

RESPONSE:

a. The commission agrees with two of the proposed revisions (items b and f listed previously). Those revisions add clarity to the guideline and will make the text consistent with the Spine Treatment Guideline.

b. The commission disagrees with the remaining proposed revisions. Those revisions are not consistent with the wording contained in the Spine Treatment Guideline, nor do they substantively clarify the intent of the rule.

i. (b)(2)(B): The establishment of usual, customary, reasonable, and medically necessary treatment is a process of which the treatment guideline is only a part. The determination of medical necessity is based not only on the guideline, but also on the injured worker's presenting symptoms. As is noted in (b)(1), the guideline "shall not be used as the sole reason for requirement or denial of treatments and services."

ii. (c)(4): The carrier is not the only party that will use the guideline as a means to review the provision of care. This revision would limit that prerogative to the carrier. The replacement of the word "must" with "will" adds nothing to the meaning of the section.

iii. (c)(5)(A): To limit communication between the health care provider and injured worker to a written explanation could seriously handicap the injured worker who cannot read. It is recommended that the health care provider document what is communicated to the injured worker and that the information be written in the injured worker's file. This will allow monitoring of healthcare through review of the file.

iv. (c)(5)(B): This revision does not further clarify the intent of that statement.

v. (d)(1)(F): The proposed revision does not clarify the health care provider's responsibility or add to its effectiveness.

vi. (d)(4): The proposed revision is not necessary. The replacement of the word "and " with "or" in the context used does not change or clarify the meaning of the sentence. This section, as the heading suggests, applies to Consulting or Peer Review Health Care Provider.

vii. (e)(2)(B): This guideline assists parties in management of treatment by providing guidance and expectations as opposed to specific mandates. The proposed revision is not necessary. However, upon review of the ground rule, a clerical error was discovered by the commission. The corrected ground rule is as follows:

"Communication between all health care providers involved in treating the injured worker must ensure that all previous treatment and diagnostic tests are considered when developing a plan of treatment. All reports and records should be made available to all health care providers to prevent unnecessary duplication of tests and examinations. (As provided in subsection (c)(2), (3) and (4) of this section.)"

viii. (e)(2)(D): This guideline assists parties in management of treatment by providing guidance and expectations as opposed to specific mandates. The proposed revision is not necessary, nor does it reflect the intent of the ground rule.

ix. (e)(3)(B): This guideline assists parties in management of treatment by providing guidance and expectations as opposed to specific mandates. The proposed revision is not necessary, nor does it reflect the intent of the ground rule.

x. (e)(3)(C): The proposed revision is not necessary, nor does it reflect the intent of the ground rule.

COMMENT: Commenter made general comments regarding the treatment program currently provided to workers by commenter's company.

The new rule is adopted pursuant to the Texas Labor Code, §402.061, which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act; the Texas Labor Code, §413.011, which authorizes the commission to establish by rule medical policies and guidelines relating to necessary

**treatments for injuries, and §413.013, which authorizes the commission to establish by rule a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services; and to establish by rule a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the commission to ensure that the medical policies or guidelines are not exceeded.**

*§134.1002. Upper Extremities Treatment Guideline.*

(a) Table of Contents. The following headings and their corresponding subdivisions comprise a table of contents for this section:

(1) Introduction-subsection (b);

(A) Purpose-subsection (b)(1);

(B) Goals-subsection (b)(2);

(C) Development Process-subsection (b)(3);

(D) Philosophy of Care-subsection (b)(4);

(2) Role of the Primary Gatekeeper-subsection (c):

(A) Statutory Requirements-subsection (c)(1);

(B) Primary Gatekeeper Responsibilities-subsection (c)(2);

(C) Referrals-subsection (c)(3);

(D) Diagnostics-subsection (c)(4);

(E) Expectations and Compliance-subsection (c)(5);

(3) Application Instructions for Involved Parties/Concepts and Governing Principles-subsection (d);

(4) Ground Rules-subsection (e):

(A) Introduction-subsection (e) (1);

(B) Ground Rules-subsection (e)(2);

(C) General Documentation Requirements-subsection (e)(3);

(D) Documentation Requirements for Unrelated or Intercurrent Illness-subsection (e)(4);

(5) Nonoperative Treatment Tables-subsection (f):

(A) Introduction to Treatment Tables-subsection (f)(1);

(B) Definition of Levels of Care-subsection (f)(2);

(C) The Hand and Wrist-subsection (f)(3);

(D) The Elbow-subsection (f)(4);

(E) The Shoulder-subsection (f)(5);

(F) Upper Extremity-subsection (f)(6);

(6) Surgical Indicators-subsection (g):

(A) Hand and Wrist-subsection (g)(1);

(B) Elbow-subsection (g)(2);

(C) Shoulder-subsection (g)(3);

(D) Upper Extremities-subsection (g)(4);

(7) Glossary-subsection (h); and

(8) Bibliography-subsection (i);

(b) Introduction.

(1) This guideline shall become effective February 1, 1996, and remain effective until February 1, 1997.

(2) Purpose. The purpose of this guideline is to clarify those services that are reasonable and medically necessary for treatment of upper extremity injuries for the injured workers of Texas. This guideline identifies a normal course of treatment. It is anticipated that there will be injured workers who will require less treatment than the average and other injured workers who will require more treatment. This is a guideline and shall not be used as the sole reason for requirement or denial of treatments and services.

(3) Goals. The following outlines the primary goals of this guideline:

(A) to assist all parties with regard to the appropriate treatment and management of upper extremity injuries;

(B) to establish elements against which aspects of care can be compared;

(C) to establish a guideline to identify clinically acceptable courses of treatment for specific disorders;

(D) to establish documentation standards which support the appropriateness of the level of service; and

(E) to provide a mechanism of prospective, concurrent, and retrospective review for efficient and effective health care utilization.

(4) Development Process. The Texas Workers' Compensation Commission (TWCC), in conjunction with health care providers and other parties in the system, have developed clinical and diagnostic treatment guidelines. Three major components in the guideline development process are as follows:

(A) Design and Methodology. A search of all 50 workers' compensation state agencies revealed that only a few had developed treatment guidelines. The format and design of these guidelines were mainly in narrative presentation. The focus of this treatment guideline is toward a matrix approach versus straight text.

(B) Provider Work Group. Research into successful guidelines developed in the private sector identified that involvement from provider work groups achieves the best outcome regarding clinical policy development.

(C) Public Evaluation. The evaluation of the developed guideline should be broad and include comments from employees, employers, health care providers and insurance carriers.

(5) Philosophy of Care. The health care of the injured worker is a coordinated team effort. All parties including employees, employers, health care providers, insurance carriers and the Texas Workers' Compensation Commission should promote quality health care, injury specific treatment and appropriateness of care. Communication between all parties must remain open in order to achieve rapid recovery from the effects of the injury. This commu-

nication should promote a timely return to modified or full duty work that takes into account the job demands and the functional capabilities of the injured worker.

(c) Role of Primary Gatekeeper.

(1) Statutory Requirements. The following sections of the Texas Labor Code and specific Commission rules address key areas pertaining to those services that are reasonable and necessary for treatment of the upper extremity.

(A) Section 408.021(a) . An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

(i) cures or relieves the effects naturally resulting from the compensable injury;

(ii) promotes recovery; or

(iii) enhances the ability of the employee to return to or retain employment.

(B) Section 408. 021(b). Medical benefits are payable from the date of the compensable injury.

(C) Section 408.021(c). Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

(D) Section 408.025(b). The commission by rule shall adopt reasonable requirements for reports and records to be made available to other health care providers to prevent unnecessary duplication of tests and examinations.

(E) Section 408.025(c). The treating doctor shall be responsible for maintaining efficient utilization of health care.

(2) Primary Gatekeeper Responsibilities.

(A) The role of the treating doctor is an important role which requires the treating doctor to monitor all health care services being provided for the injured worker. These responsibilities of the treating doctor are vital aspects of the goal to ensure that the injured worker receives quality health care. This monitoring extends to ensure:

(i) the identification of the extent and severity of the injury initially;

(ii) the appropriateness of all services;

(iii) the relatedness of all services to the workers' compensation injury;

(iv) separation and referral of nonrelated health care services for management by other health plans;

(v) whether the treatment is duplicative, necessary and/or effective;

(vi) the appropriate cost of the services;

(vii) the quality of the treatment; and

(viii) enhancement and promotion of effective communication among all involved parties.

(B) Refer to Commission §126.9 of this title (relating to Choice of Treating Doctor and Liability for Payment) and §133.3 of this title (relating to Responsibilities of Treating Doctor) for responsibilities of the treating doctor.

(3) Referrals. The treating doctor is responsible for recommending timely and appropriate referrals. The treating doctor must clearly delineate the clinical rationale for all referrals. The documentation contained in the TWCC required reports should clearly outline whether the purpose of the referral is to corroborate the diagnosis and/or proposed course of treatment or to initiate ongoing treatment. Once a consultation or referral has occurred, the consulting or referral doctor should submit a summary report or initiate a case management phone call back to the treating doctor.

(4) Diagnostics. Diagnostic work should be performed in accordance with the recommended testing and timeframes contained in this guideline. If the need arises to deviate from the guideline, then a clinical rationale must be provided which adequately substantiates the need for this deviation. The need to repeat previously completed diagnostic procedures due to the quality of the study may trigger a review. All health care providers involved in the treatment of an injured worker must share copies of all diagnostic studies, films, and reports in order to avoid unnecessary duplication of procedures. Section 133.2 of this title (relating to Sharing Medical Reports and Test Results) addresses the need to share medical records, including diagnostic studies, to avoid duplication. Section 133.106 of this title (relating to Fair and Reasonable Fees for Required Reports and Records) addresses reimbursement for copies of records.

(5) Expectation and Compliance.

(A) All health care providers must encourage injured workers to be active participants in their health care treatment regimens and must communicate to the injured worker realistic expectations regarding the potential outcome of this treatment as it relates to his/her physical functioning and/or ability to return to work. Therefore, it is important to document the injured worker's compliance with his/her treatment regimen when reporting the progress of his/her recovery.

(B) Health care providers must explain to the injured worker in clear terms the extent and severity of the injury and the treatment needed. Health care providers must define the symptomatology that is directly and/or indirectly related to the injury and specify treatment not covered under workers' compensation.

(d) Application Instructions for Involved Parties-Concepts and Governing Principles.

(1) Health Care Provider. This guideline is to be used as a tool by the health care provider to establish the required elements for all providers to initiate and continue treatment. If, for example, a provider's treatment deviates from the guideline, this would require documentation of a clearly delineated rationale for the need for this treatment.

(A) This guideline identifies typical treatment based on normal tissue healing responses for the average injured worker.

(B) It is expected that a subset of injured workers will be found to be outside the parameters of these guidelines.

(C) This guideline should be used as a tool which identifies the recommended treatment parameters for treatment of injured workers within the workers' compensation system.

(D) This guideline identifies the need to provide documentation which clearly explains the reason for the treatment, the relatedness to the workers' compensation injury and alternative treatment.

(E) The health care provider is responsible for educating the injured worker about health care treatment appropriate to the workers' compensation injury.

(F) This guideline recommends early return to work based upon the injured worker's functional capacity which includes ability, clinical status, and either full or modified job requirements.

(G) The health care provider is responsible for formulating a plan of treatment and revising the plan of treatment based on response to treatment. The plan of treatment should be provided to the insurance carrier as early as possible.

(2) Insurance Carriers. The insurance carrier should use this guideline to compare treatment prospectively, concurrently and retrospectively with the predetermined elements contained in the guides.

(A) This document and its parameters serve only as a guideline and are not to be used as the sole reason for denial or requirement of treatments and services.

(B) This guideline provides a tool by which to monitor the injured worker's recovery process.

(C) This guideline serves as a tool to assist the insurance carriers in the medical audit process.

(D) This guideline is not to be used to direct care toward a specific health care discipline or to a specific type of treatment. It is the responsibility of the insurance carrier to provide their specific documentation and rationale if treatment is denied. This rationale may include elements of the guideline. Additional information regarding the rationale for denial of treatment may also be derived from the injured worker's medical records and from the professional opinion of a peer review, if utilized.

(E) It is expected that a subset of injured workers will be found to be outside the parameters of this guideline.

(F) The insurance carrier is responsible for performing a focus review of injury. This focus review will primarily consist of case management. The focus review must clarify and attempt to reach agreement that the proposed treatment is appropriate as early as possible. Concurrent case management and bill review activities should address and focus on adherence to treatment plans, clinical progress, return to work issues, medical necessity and the following:

(i) Injured worker compliance with the treatment;

(ii) Services provided consistent with treatment plan;

(iii) Response to treatment;

(iv) Improvement in injured workers' progress;

(v) Recommendations for changes in treatment in situations where there is no compliance, plateau, and/or there is minimal or no progress;

(vi) Achievement of goals, improvement sooner than treatment plan indicated.

(3) Medical Review Division. The Medical Review Division will use the guideline as a tool for the basis of their administrative review of prospective, concurrent and retrospective treatment. It will also be used as a tool in conducting on-site audits for both health care providers and insurance carriers.

(4) Consulting or Peer Review Health Care Provider. This guideline should be used as a reference when advising the Medical Review Division and when the need for an unbiased medical opinion is indicated. The peer reviewer should use his/her clinical expertise in conjunction with the clinical intent of the guideline to address issues.

(5) Injured Worker. It is essential that the injured worker understands his/her role in complying with recommended treatment. The recovery and return to work process requires active cooperation of the injured worker.

(6) Employer. It is the responsibility of the employer to report the compensable injury in a timely fashion to ensure that there is no delay in the treatment of the compensable injury. It is also the responsibility of the employer to work with the insurance carrier and health care providers to ensure that the injured worker is afforded the opportunity to return to work in either a modified or full employment capacity as rapidly as possible within the medical limitations of his/her injury.

(e) Ground Rules.

(1) Introduction. The guidelines are not to be used as fixed treatment protocols. The guidelines reflect typical courses of intervention. It is acknowledged that, in atypical cases, treatment may fall outside these guidelines. However, those cases that exceed the guidelines' level of treatment will be subject to more careful scrutiny and review and will require documentation of the special circumstances justifying that treatment. The guidelines should not be seen as prescribing the type, frequency, or duration of treatment. Treatment must be based on injured worker's need and the doctor's professional judgment.

(2) Ground Rules.

(A) Notwithstanding any other provision of this rule, treatment of a work related injury must be:

(i) adequately documented;

(ii) evaluated for effectiveness and modified based on clinical changes;

(iii) provided in the least intensive setting;

(iv) cost effective;

(v) consistent with this guideline or contain a documented clinical rationale for deviation from this guideline;

(vi) objectively measured and demonstrate functional gains; and

(vii) consistent in demonstrating ongoing progress in the recovery process by appropriate re-evaluation of the treatment.

(B) Communication between all health care providers involved in treating the injured worker must ensure that all previous treatment and diagnostic tests are considered when developing a plan of treatment. All reports and records should be made available to all health care providers to prevent unnecessary duplication of tests and examinations. (As provided in subsection (c)(2), (3) and (4) of this section.)

(C) Patient education is an essential component in ensuring patient compliance to all treatment. Education is essential for the active cooperation of the patient in all aspects of health care and as a means to prevent re-injury. It is essential that the patient understand his/her role in the recovery and return to work process.

(D) All parties in the workers' compensation system should work together to ensure that the injured worker returns to work at the earliest medically appropriate time. Return-to-work is an important therapeutic approach which benefits the injured worker. The health care provider should communicate with the injured worker, employer and the insurance carrier to coordinate a successful return to work.

(E) The level of service should be the same as the health care provider's usual and customary level of service regardless of the payor system.

(F) Although not the typical course of treatment, there may be circumstances in which the injured worker may move between levels of care or utilize interventions in more than one level of care simultaneously, depending on clinical indicators.

(G) All health care providers providing services to an injured worker have the responsibility to substantiate in

their documentation the level of service for which they request reimbursement. All payors have the responsibility to review all documentation submitted as the basis for the treatment and services provided.

(H) Treatment durations are cumulative; however it should not always be necessary to use full durations for any given level of care.

(I) Any new treatment must meet acceptable standards of care and may be subject to review by Texas Workers' Compensation Commission.

(J) Preauthorization of any treatments or services will be as required in the Commission's preauthorization rule.

(K) When the injured worker displays signs and symptoms which may require further evaluation by a Qualified Mental Health Provider, refer to the Mental Health Treatment Guideline for parameters regarding documentation, evaluation and treatment.

(3) General Documentation Requirements.

(A) The health care provider's documentation is vital as an information source of the injured worker's injury and treatment, it also provides information which impacts income benefits. For these reasons, many of the Commission's rules have set time requirements for submission of required reports. For example, the TWCC 61 could be the first report submitted which informs the insurance carrier of the injury, and the TWCC 69 provides the determination of MMI and an impairment rating which may result in a change in income benefits.

(B) Documentation should be provided by the health care provider to determine the level of care to be provided and the necessity for that care. The elements of the documentation may include:

(i) a description of the injury, including the events surrounding that injury and the extent and severity of that injury;

(ii) a description of any pre-existing condition(s), complicating conditions and/or any non-related conditions;

(iii) a plan of treatment, including proposed methods of treatment, expected outcomes, and probable duration of treatment;

(iv) updates to the plan of treatment as needed, including the clinical progress of the injured worker, and any revisions needed to the plan of treatment in light of the injured worker's response to treatment;

(v) education/information provided to the injured worker regarding his injury and plan of treatment, and the injured worker's compliance with this plan of treatment; and

(vi) documentation substantiating the need for deviation from the guideline, if necessary.

(C) Permanent impairment for compensable injuries in workers' compensation should be limited to those injuries and illnesses for which doctors are able to demonstrate objective findings.

(D) The need for emergency treatment must be based on the doctor's professional judgment. This documentation must provide a clear explanation of the nature of the emergency, the injured worker's medical condition, complications which could occur as well as any irreversible conditions which occurred or could occur as a result of this event.

(4) Documentation Requirements for Unrelated or Intercurrent Illness. Situations may arise where certain medical conditions need to be delineated or clarified prior to intervention. Treatment administered to other body areas (not a part of the original injury) or for a pre-existing medical condition(s) must be identified and the relation of this treatment to the compensable injury documented by the health care provider. If it appears that this treatment is not related to the compensable injury, the injured worker should be informed by the health care provider that this treatment may not be covered by the insurance carrier. The rationale for such treatment and its relation to the compensable injury should also be clearly documented for the insurance carrier by the health care provider.

(f) Nonoperative Treatment Tables.

(1) Introduction to Nonoperative Treatment Tables. The treatments, set out in the following tables, represent typical appropriate treatment for a given period of time according to the diagnosis(es). The "Treatment Interventions" sections and "Diagnostic Procedures" sections of the Treatment Tables are in alphabetical order and do not infer numerical sequence. It is anticipated that there will be some injured workers who will require less treatment, and other injured workers who will require more treatment than is outlined. This document serves as a guideline and should not be used as the sole reason for denial or requirement of treatment. The provision of specific services to an injured worker is dependent on the injured worker's diagnosis, and response to treatment.

(2) Definition of Levels of Care.

(A) Primary level of care. This level of care is generally considered to be appropriate for injured workers immediately following the compensable injury; however, the injured worker in this level of care may also be an early postoperative patient or may be experiencing an acute exacerbation of his/her chronic pain. Since partial or total cessation of work over a brief period of time (i.e., two to three days maximum) is also considered to be part of the primary level of care, further treatment by a health care provider may not be considered necessary at this level of care. Little or no deconditioning has occurred due to the injury, immobilization or decreased activity. The goals are the prevention of disease, alleviating or minimizing the effects of the illness or injury and to maintain function, thereby reducing lost time and enabling return to work in some capacity.

(B) Secondary level of care. This level of care is the first stage of rehabilitation for those injured workers who have not returned to productivity through the normal healing process. It is designed to facilitate return to productivity, including return to work in either full or modified duty, before the onset of chronic disability. This level of care may also be indicated for the injured worker whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty. It is individualized, time limited and of limited intensity. The injured worker has a history of a limited-to-good response to early primary treatment with persistent symptoms limiting activities of daily living. The objective physical examination demonstrates findings suggestive of early deconditioning including loss of range of motion and/or strength with limitation of activities of daily living. Evidence of mental health or psychosocial barriers may be present which impede the injured worker's clinical progress.

(C) Tertiary level of care. This level of care is interdisciplinary, individualized, coordinated, and intensive, designed for the injured worker who demonstrates physical and psychological changes consistent with chronic disability. In general, differentiation from secondary treatment includes medical direction, intensity of services, severity of injury, individualized programmatic protocols with integration of physician, mental health, and disability or pain management services and specificity of physical/psychosocial assess-

ment. There is a documented history of persistent failure to respond to nonoperative or operative treatment which surpasses the usual healing period for that injury. Psychosocial issues such as substance abuse, affective disorders, and other psychological disorders may be present. There is a documented inhibition of physical functioning evidenced by pain sensitivity, loss of sensation, and nonorganic signs such as fear which produce a physical inhibition or limited response to reactivation treatment. This level of care may also be indicated for the injured worker whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty. This situation would be evidenced by an excessive transitional period of light duty or significant episodes of lost work time due to the need for continued medical treatment. This level of care is also indicated for those injured workers who cannot tolerate either primary or secondary levels of care.

(D) Criteria to distinguish between secondary and tertiary level of care. Many factors may determine the choice between secondary and tertiary levels of care. In general, if lower cost secondary treatment can be effective, this level of care is preferred over the more expensive tertiary care. However, if the documented condition of the injured worker is indicative of the need for more intensive treatment, the tertiary level of care may be more appropriate. Key factors in determining the need for secondary versus tertiary care include:

(i) the time elapsed since injury;

(ii) the presence of psychosocial barriers to recovery such as depression, substance abuse, personality disorder, etc., and the severity of these barriers;

(iii) the lack of responsiveness to previously attempted treatment;

(iv) the severity of physical/functional deconditioning; and/or

(v) socioeconomic barriers to recovery.

(3) Hand and Wrist Treatment Tables.

(A) Figure 1: 28 TAC §134.1002(f)(3)(A).

(B) Figure 2: 28 TAC §134.1002(f)(3)(B).

(C) Figure 3: 28 TAC §134.1002(f)(3)(C).

(4) Elbow Treatment Tables.

(A) Figure 4: 28 TAC §134.1002(f)(4)(A).

(B) Figure 5: 28 TAC §134.1002(f)(4)(B).

(C) Figure 6: 28 TAC §134.1002(f)(4)(C).

(D) Figure 7: 28 TAC §134.1002(f)(4)(D).

(E) Figure 8: 28 TAC §134.1002(f)(4)(E).

(F) Figure 9: 28 TAC §134.1002(f)(4)(F).

(5) Shoulder Treatment Tables.

(A) Figure 10: 28 TAC §134.1002(f)(5)(A).

(B) Figure 11: 28 TAC §134.1002(f)(5)(B).

(C) Figure 12: 28 TAC §134.1002(f)(5)(C).

(D) Figure 13: 28 TAC §134.1002(f)(5)(D).

(E) Figure 14: 28 TAC §134.1002(f)(5)(E).

(F) Figure 15: 28 TAC §134.1002(f)(5)(F).

(6) Upper Extremities Tables.

(A) Figure 16: 28 TAC §134. 1002(f)(6)(A).

(B) Figure 16: 28 TAC §134.1002(f)(6)(B).

(C) Figure 18: 28 TAC §134.1002(f)(6)(C).

(D) Figure 19: 28 TAC §134.1002(f)(6)(D).

(E) Figure 20: 28 TAC §134.1002(f)(6)(E).

(F) Figure 21: 28 TAC §134.1002(f)(6)(F).

(G) Figure 22: 28 TAC §134.1002(f)(6) (G).

(H) Figure 23: 28 TAC §134.1002(f)(6)(H).

(I) Figure 24: 28 TAC §134.1002(f)(6)(I).

(J) Figure 25: 28 TAC §134.1002(f) (6)(J).

(K) Figure 26: 28 TAC §134.1002(f)(6)(K).

(L) Figure 27: 28 TAC §134.1002(f)(6)(L).

(M) Figures 28 and 29: 28 TAC §134.1002(f)(6)(M).

(N) Figures 30 and 31: 28 TAC §134.1002(f) (6)(N).

(O) Figure 32: 28 TAC §134.1002(f)(6)(O).

(P) Figures 33 and 34: 28 TAC §134.1002(f)(6)(P).

(Q) Figure 35: 28 TAC §134.1002(f)(6)(Q).

(R) Figure 36: 28 TAC §134.1002(f)(6)(R).

(S) Figure 37: 28 TAC §134.1002(f)(6)(S).

(T) Figure 38: 28 TAC §134.1002(f)(6)(T).

(U) Figure 39: 28 TAC §134.1002(f)(6) (U).

(V) Figure 40: 28 TAC §134.1002(f)(6)(V).

(W) Figure 41: 28 TAC §134.1002(f)(6)(W).

(X) Figure 42: 28 TAC §134.1002(f) (6)(X).

(Y) Figure 43: 28 TAC §134.1002(f)(6)(Y).

(Z) Figure 44: 28 TAC §134.1002(f)(6)(Z).

(g) Surgical Indications. Indications for surgery include but are not limited to the following list.

(1) Hand and Wrist. Tendinitis/Stenosing. Tenosynovitis/Musculotendinitis/Musculotendinous Problems. Indications for surgery include, but are not limited to:

(A) unresponsive to at least a four to eight week trial of conservative treatment;

(B) tendon is locked in position; and/or

(C) severe pain is present in the finger, thumb or wrist which is unresponsive to conservative therapy.

(2) Elbow.

(A) Musculotendinitis/Tendinitis (Lateral Epicondylitis, Medial Epicondylitis, Musculotendinous and Periarticular Problems of the Elbow) . Indications for surgery include, but are not limited to:

(i) failure to respond to non-operative treatment program after six to 12 months;

(ii) no improvement after a total of three corticosteroid injections;

(iii) presence of atrophy or weakness of the forearm extensors; and/or

(iv) early surgical intervention (before six months), which may be considered if the patient is severely disabled.

(B) Olecranon Bursitis. Indications for surgery include, but are not limited to:

(i) infection is present; and/or

(ii) bursitis is recurrent despite aspiration.

(3) Shoulder. Rotator Cuff (Sprain/Strain, Tear, Shoulder Impingement Syndrome). Indications for surgery include, but are not limited to:

(A) confirmed tear unresponsive to physical medicine; and/or

(B) profound weakness.

(4) Upper Extremities.

(A) Neuropathy.

(i) Indications for Surgery in Carpal Tunnel Syndrome. Indications for surgery include, but are not limited to:

(I) failure to respond to non-operative treatment;

(II) presence of thenar atrophy or weakness or significant hyperesthesia/dysesthesia (especially with objective impairment of sensibility as determined by two point discrimination or by light touch);

(III) progressive symptoms;

(IV) presence of space-occupying lesion in carpal canal; and/or

(V) presence of compartment syndrome or extensive injury to forearm and wrist.

(ii) General Indications. Indications for surgery include, but are not limited to EMG/NC studies indicative of neuropathy accompanying positive physical findings and symptoms that are persistent despite conservative management

(B) Muscle/Ligament/Capsular Injuries (Acute/Chronic).

(i) Indications for Surgery in Ulnar Collateral Ligament Injury of the Thumb (Sprain/Tear). Indications for surgery include, but are not limited to:

(I) any displaced or avulsed fracture with ligament attachment;

(II) complete ligament disruption;

(III) Stener's lesion (displacement of the ulnar collateral ligament superficial to the abductor tendon);

(IV) open wound; and/or

(V) open contaminated wound.

(ii) Indications for Surgery in DeQuervain's Stenosing Tenosynovitis. Indications for surgery include, but are not limited to:

(I) no response or incomplete response to nonoperative treatment after six to 12 weeks of treatment; and/or

(II) presence of a condition which is not amenable to nonsurgical treatment (e.g., separate abductor pollicis longus and extensor pollicis brevis tendon compartments).

(iii) General Indications. Indications for surgery include, but are not limited to:

(I) joint instability;

(II) joint malalignment; and/or

(III) pain impairing the functional use of the joint;

(C) Fractures.

(i) Indications for Surgery in Clavicle Fracture. Indications for surgery include, but are not limited to displaced fractures.

(ii) Indications for Surgery in Fracture Surgical Neck, Humerus. Indications for surgery include, but are not limited to:

(I) displaced or angulated fracture that needs closed reduction;

(II) displaced or angulated fracture needing open reduction and internal fixation of the fragments; and/or

(III) associated neurologic or vascular injury present.

(iii) Indications for Surgery in Distal Radius Fracture. Indications for surgery include, but are not limited to:

(I) displaced fracture requiring reduction and immobilization;

(II) comminuted displaced fracture requiring reduction and fixation;

(III) open fracture; and/or

(IV) acute carpal tunnel syndrome;

(V) associated complex soft-tissue injury (consideration of compartment syndrome); and/or

(VI) failure of outpatient treatment.

(iv) General Indications. Indications for surgery include, but are not limited to:

(I) displaced fracture requiring reduction and immobilization;

(II) comminuted displaced fracture requiring reduction and fixation;

(III) open fracture; and/or

(IV) nonunion of the fracture.

(D) Avascular Necrosis.

(E) Intraarticular Pathology (Traumatic Arthritis). Indications for surgery include, but are not limited to:

(i) persistent synovitis;

(ii) locking of the joint; and/or

(iii) painful traumatic arthritis documented radiologically.

(F) Joint Instability. Indications for surgery include, but are not limited to repeated episodes of instability despite conservative therapy

(G) Lacerations (Tendons, Nerves). Indications for surgery include, but are not limited to:

(i) open wound; and/or

(ii) open contaminated wound.

(H) Crush Injuries.

(h) Glossary.

(1) Acceptable standards of care.

(A) Standard-something established by authority, custom, or general consent as a model or example; the generally accepted norm for quality and quantity.

(B) Acceptable standards of care-outlines of the types of tests and treatments which are established as normal and warranted for a specific type of injury.

(2) Active care vs. passive care.

(A) Active care-modes of treatment or care requiring that the injured worker participate in the level of care received.

(B) Passive care-modes of treatment or care which do not require the injured worker to participate in his/her care; i.e., the care is "done to" or "applied to" the injured worker (e.g., hot packs or cold packs)

(3) Algorithm-a step-by-step procedural pathway for solving a problem or accomplishing some end.

(4) Assessment/Evaluation-the act or process of inspecting or testing for evidence of injury, disease or abnormality.

(5) Chronic pain management-a program which provides coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain syndrome.

(6) Clinical plateau-a period of time of relative stability in which the injured worker displays minimal or minor changes in his/her condition.

(7) Clinical progress vs. lack of clinical progress.

(A) Clinical progress-documented improvement in the condition of the injured worker, in response to the injured worker's current treatment program.

(B) Lack of clinical progress-documented absence of change in the condition of the injured worker over a period of time of no less than one month, requiring re-evaluation of the injured worker's condition and re-evaluation of the current treatment program.

(8) Consulting doctor-a doctor who provides an opinion or advice regarding the evaluation and/or management of a specific problem, as requested by the treating doctor, the Commission, or the insurance carrier. A consulting doctor may only initiate diagnostic and/or therapeutic services with approval from the treating doctor.

(9) Decompensation-the inability of the body to maintain adequate functioning in the presence of an injured, abnormal, or nonfunctioning body system

(10) Denial parameters-a set of established elements or boundaries beyond which testing or treatment may be denied.

(11) Diagnosis-the art or act of identifying a disease or injury from evaluation of its signs and symptoms.

(12) Diagnostic module-a standard which establishes normal parameters or boundaries of time within which to perform studies to assist in identifying a disease, injury, or abnormality.

(13) Diagnostic tests-objective studies performed to assist in identifying a disease, injury, or abnormality.

(14) Doctor-a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(15) Examination-the act or process of inspecting or testing for evidence of disease, injury, or abnormality.

(16) First doctor.

(A) First-preceding all others in time

(B) First doctor-the initial doctor who evaluates and treats the injured worker, and who may or may not ultimately become the treating doctor.

(17) Focus review-to critically examine the prospective, concurrent, and retrospective care received by the injured worker as related to the compensable injury.

(18) Frequency of intervention.

(A) Intervention-the process of interfering with a condition to modify or change its course.

(B) Frequency of intervention-the number of occurrences in a specified time in which the health care provider acts to treat the injured worker.

(19) Functional capacity evaluation-a battery of tests administered and evaluated to determine the injured worker's ability to perform tasks related to both his daily activities and his job performance. This evaluation consists of the following elements:

(A) a physical examination and neurological evaluation which includes an assessment of the physical appearance of the injured worker, flexibility of the extremity joint or spinal region, posture and deformities, vascular integrity, the presence or absence of sensory deficit, muscle strength and reflex symmetry;

(B) a physical capacity evaluation which includes quantitative measurements of range of motion and muscular strength and endurance; and

(C) a dynamic functional abilities test which includes activities of

daily living, hand function tests, cardiovascular endurance tests, and static positional tolerance.

(20) Health care facility-a hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(21) Health care practitioner. A health care practitioner is:

(A) an individual who is licensed to provide or render and provides or renders health care; or

(B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.

(22) Health care provider- a health care facility or health care practitioner

(23) Impairment-any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent.

(24) Interdisciplinary programs-programs in which the delivery of services is provided by more than one type of health care service (e.g., occupational therapy, physical therapy, counseling services, medical services) and in which there is a coordination between the disciplines regarding the care plan and the delivery of care to the injured worker. Examples of this type of program include work hardening, outpatient medical rehabilitation, and chronic pain management.

(25) Intervention-the act or fact of interfering with a condition to modify it or with a process to change its course.

(26) Level of service-refers to primary, secondary, or tertiary care.

(27) Maximum Medical Improvement (MMI)-the earlier of the following two items:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated; or

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue.

(28) Medical necessity-the determination that the tests or treatment provided is required based on the presenting signs and symptoms.

(29) Module-a standard or unit of measurement

(30) Objective findings.

(A) Objective-perceptible to persons other than the affected individual.

(B) Objective findings-signs, or test results that can be measured or quantified or are otherwise perceptible to persons other than the affected individual.

(31) Outpatient medical rehabilitation-a program of coordinated and integrated services, evaluation, and/or treatment with emphasis on improving the functional levels of the persons served. The program is interdisciplinary in nature and is applicable to those persons who have severe functional limitations of recent onset or recent regression or progression or those persons who have not had prior exposure to rehabilitation. Services may be directed toward the development and/or maintenance of the optimal level of functioning and community integration of the persons served.

(32) Primary/secondary/tertiary levels of care.

(A) Primary level of care-this level of care is generally considered to be appropriate for injured workers immediately following the compensable injury; however, the injured worker in this level of care may also be an early postoperative patient or may be experiencing an acute exacerbation of his/her chronic pain. Since partial or total cessation of work over a brief period of time (i.e., two to three days maximum) is also considered to be part of the primary level of care, further treatment by a health care provider may not be considered necessary at this level of care. Little or no deconditioning has occurred due to the injury, immobilization or decreased activity. The goals are the prevention of disease, alleviating or minimizing the effects of the illness or injury and to maintain function.

(B) Secondary level of care-this level of care is the first stage of rehabilitation for those injured workers who have not returned to productivity through the normal healing process. It is designed to facilitate return to productivity before the onset of chronic disability. It is individualized, time limited and of limited intensity. The injured worker has a history of a limited-to-good response to early primary treatment with persistent symptoms limiting activities of daily living. The objective physical examination demonstrates findings suggestive of early deconditioning including loss of range of motion and/or strength with limitation of activities of daily living. Evidence of mental health or psychosocial barriers may be present which impede the injured worker's clinical progress.

(C) Tertiary level of care-this level of care is interdisciplinary, individualized, coordinated, and intensive, designed for the injured worker who demonstrates physical and psychological changes consistent with chronic disability. There is a documented history of persistent failure to respond to nonoperative or operative treatment which surpasses the usual healing period for that injury. Psychosocial issues such as substance abuse, affective disorders, and other psychological disorders may be present. There is a documented inhibition of physical functioning evidenced by pain sensitivity, loss of sensation, and nonorganic signs such as fear which produce a physical inhibition or limited response to reactivation treatment. This level of care may also be indicated for the injured worker whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty. This situation would be evidenced by an excessive transitional period of light duty or significant episodes of lost work time due to the need for continued medical treatment. This level of care is also indicated for those injured workers who cannot tolerate either primary or secondary levels of care.

(33) Proper clinical documentation-written records which meet the requirements outlined by statute and rule and which convey the following information to the required parties:

(A) a description of the injury, including the events surrounding that injury and the extent and severity of that injury;

(B) a description of any preexisting condition(s), complicating conditions, and/or any non-related conditions;

(C) a plan of treatment, including proposed methods frequency and probable duration of treatment, and expected outcomes;

(D) updates to the plan of treatment as needed, including the clinical progress of the injured worker, and any revisions needed to the treatment plan in light of the injured worker's response to treatment;

(E) education/information provided to the injured worker regarding his injury and plan of treatment, and the injured worker's compliance with this plan of treatment; and

(F) documentation substantiating the need for deviation from the guideline, if necessary.

(34) Reason for denial-see denial parameters.

(35) Referral-the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment.

(36) Referral doctor-a consulting doctor who initiates health care treatments at the request of the treating doctor.

(37) Secondary treatment-see secondary level of care under primary/secondary/tertiary level of care.

(38) Self-referral-the direction of a patient to another doctor, institution or facility whereby the referring doctor has a financial or conflict of interest element.

(39) Significant neurological deficit-rapidly progressing symptoms of sensory impairment, progressive numbness, or increased physiological impairment such as severe weakness, bowel or bladder dysfunction directly related to the spinal injury.

(40) Single point of contact-one person whom the doctor/health care provider(s) may contact for all questions regarding a specific injured worker.

(41) Sprain-an injury to a ligament.

(A) Mild (Grade 1) -only a few fibers are torn; ligament is mostly intact and the joint is stable;

(B) Moderate (Grade 2)-more fibers are torn, resulting in some instability with abnormal joint motion and some functional loss;

(C) Severe (Grade 3)-ligaments are completely disrupted and instability may be severe (synonymous with marked).

(42) Static-characterized by a lack of movement or change.

(43) Strain-an injury to a muscle.

(A) Mild (Grade 1)-only a few fibers are torn; muscle is mostly intact and functional;

(B) Moderate (Grade 2)-more muscle fibers are torn resulting in muscle pain with contraction;

(C) Severe (Grade 3)-tendons are completely disrupted, extreme pain and loss of use of muscle.

(44) Subjective complaints-report of signs or symptoms, perceivable only by the injured employee, relating to the injury and which cannot be independently verified or confirmed by recognized laboratory or diagnostic tests or signs observable by physical examination.

(45) Time limited-a specific duration of clock or calendar time which is not exceeded on a routine basis.

(46) Treating doctor-the doctor primarily responsible for coordinating the employee's health care for an injury. (synonymous with Primary Gatekeeper)

(47) Treatment duration-calendar time allowed for treatment for a specific level of care.

(48) Treatment module-a standard which establishes routine parameters of time within which to provide therapy for the illness or injury.

(49) treatment plan-this is a written document which must contain the following components:

(A) type of intervention/treatment modality;

(B) frequency of treatment;

(C) expected duration of treatment;

(D) expected clinical response to treatment; and

(E) specification of a re-evaluation timeframe.

(50) Work conditioning-a highly structured, goal-oriented, individualized treatment program using real or simulated work activities in conjunction with conditioning tasks. Work conditioning is a single disciplinary approach.

(51) Work hardening-a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. Work Hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Work Hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors. Work Hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks. These activities are used to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic, behavioral, attitudinal, and vocational functioning of the persons served.

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This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Susan Cory
General Counsel
Texas Workers' Compensation Commission

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For further information, please call: (512) 440-3700

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# TITLE 30. ENVIRONMENTAL QUALITY

## Part I. Texas Natural Resource Conservation Commission

### Chapter 330. Municipal Solid Waste

The Texas Natural Resource Conservation Commission (TNRCC) adopts amendments to §330.4 and §330.41, and new §330.70, concerning certain municipal solid waste management facilities including those used in the recovery and use of gas. On-site transfer facilities and facilities that recover and beneficially use gas will be exempt from permit requirements, will be required to register with the TNRCC, and will be required to design and operate the facility in accordance with requirements set forth in a new section. Sections 330.4, 330.41, and 330.70 are adopted with changes to the proposed text as published in the August 29, 1995 issue of the *Texas Register* (20 TexReg 6732).

The amendments and new section are intended to encourage the development of certain facilities that recover and beneficially use gas. Pursuant to federal requirements of Subtitle D of the Resource Conservation and Recovery Act, landfills in Texas must manage landfill gases, thereby incurring costs. The beneficial use of such gases can, in some cases, offset the economic burden of managing landfill gases.

The adopted changes implement House Bill 2315, 74th Legislature (1995), which amended the Texas Solid Waste Disposal Act, Texas Health and Safety Code, §361.0861 and §361.092. The bill exempts permitted municipal solid waste management facilities (landfills) involved in the recovery and use of gas from the TNRCC municipal solid waste permit requirements. The facilities must comply with certain design and operational requirements to maintain the integrity of the landfill.

Comments were received from Browning-Ferris Industries and Texas Disposal Systems. Each commenter supports the adoption of the rule and expressed appreciation for the timely development of the rules. The TNRCC acknowledges their supportive comments. One of the commenters offered a number of suggested changes for clarification.

TNRCC has added clarified language in four instances based on comments received. The term "transfer station" has been inserted for the term "transfer facility" in §330.4(d)(4) because "transfer station" is a defined term. The term "landfill facility" has been inserted for the term "landfill" in §330. 4(d)(4) to clarify that transfer stations may be located on any land within the boundaries of a permitted municipal solid waste landfill facility and not just within the boundaries of a municipal solid waste landfill unit. The phrase "energy and material recovery" has been inserted for the phrase "material extraction" in §330.4(n) to be consistent with language in the statute. The words "permit and/or" have been deleted from §330.41(j) because by statute a permit will no longer be required for these types of facilities.

One commenter requested an explanation regarding the duration of a permit of a municipal solid waste landfill facility as used in conjunction with §330.4(d)(4). TNRCC believes that in reading §330.63 of this title (relating to Duration and Limits of a Permit) together with §330.10 of this title (relating to Closure) and Subchapter J of this title (relating to Closure and Post-Closure) that a permit is valid at least until the end of the facility's post-closure maintenance period, unless a different date is specified in the permit.

A suggestion was made by one commenter that a cross reference in §305.70 of this title (relating to Permit Modifications) be made to clarify the relationship between requirements for facilities that recover gas for beneficial use and requirements for facilities that use gas control systems. TNRCC will make this clarification in a future rulemaking.

Another suggestion was made that the public meeting could be eliminated. TNRCC finds that a public meeting is statutorily required for some registration authorizations in the municipal solid waste program, and consequently, TNRCC has elected to have each of the municipal solid waste registration authorizations have a public meeting for consistency.

Another comment in regard to §330.70(e)(2) suggests that instead of making reference to §330.52 of this title (relating to Technical Requirements of Part I of the Application) for registration requirements, a separate section should be written specifying requirements for this type of registration. TNRCC finds that the reference to §330.52 is currently in use for other types of municipal solid waste registrations, however, TNRCC believes that the concept to clarify registration requirements has merit and expects to make the suggested changes in a future rulemaking.

A comment in regard to §330.70(b), suggests that this section dealing with relationship to other rules be moved to §330.4(n). TNRCC believes that §330.70(b) regarding the relationship to other rules is adequately located for clarity.

The TNRCC has added §330.70(f) regarding motion for reconsideration to be consistent with Senate Bill 741, as passed by the 74th Legislature, which amends §5.122 of the Texas Water Code.

### Subchapter A. General Information

#### • 30 TAC §330.4

The amendments and new section are adopted under the authority of the Texas Water Code, §5.103, which provides the TNRCC with the authority to carry out the powers and duties under the provisions of the Texas Water Code and other laws of this state, under House Bill 2315, as passed by the 74th Legislature, under Senate Bill 741 as passed by the 74th Legislature; and pursuant to the Texas Solid Waste Disposal Act, Texas Health and Safety Code §361.024, which provides the TNRCC with authority to regulate municipal solid waste and adopt rules as necessary to regulate the operation, management, and control of solid waste under its jurisdiction.

*§330.4. Permit Required.*

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

(d) A permit is not required for a municipal solid waste transfer station facility that is used in the transfer of municipal solid waste to a solid waste processing or disposal facility from:

(1) (No change.)

(2) a county with a population of less than 85,000;

(3) a facility used in the transfer of municipal solid waste that transfers or will transfer 125 tons per day or less; or

(4) a transfer station located within the permitted boundaries of a municipal solid waste landfill facility.

(e)-(m) (No change.)

(n) For energy and material recovery and gas recovery operations relating to municipal solid waste, a registration is required. A permit is not required for a municipal solid waste facility-Type IX that recovers gas for beneficial use. Those Type IX facilities that recover gas for beneficial use that are exempt from permitting under this subsection shall be registered with the executive director in accordance with §330.70 of this title (relating to Registration of Facilities that Recover Gas for Beneficial Use). However, exploratory and test operations for feasibility purposes may be conducted after approval of the operation by the executive director.

(o)-(q) (No change.)

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515042

Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

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Proposal publication date: August 29, 1995

For further information, please call: (512) 239-6087

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## Subchapter D. Classification of Municipal Solid Waste Facilities

### • 30 TAC §330.41

The amendment is adopted under the authority of the Texas Water Code, §5.103, which provides the TNRCC with the authority to adopt any rules necessary to carry out the powers and duties under the provisions of the Texas Water Code and other laws of this state, and under House Bill 2315, as passed by the 74th Legislature; and pursuant to the Texas Solid Waste Disposal Act, Texas Health and Safety Code, §361.024, which provides the TNRCC with the authority to regulate municipal solid waste and adopt rules as necessary to regulate the operation, management, and control of solid waste under its jurisdiction.

*§330.41. Types of Municipal Solid Waste Sites.*

(a)-(i) (No change.)

(j) Municipal solid waste facility-Type IX. A closed disposal facility, an inactive portion of a disposal facility, or an active disposal facility, used for extracting materials for energy and material recovery or for gas recovery for beneficial use is classified as Type IX. Registration requirements are contained in §330.4 of this title (relating to Permit Required).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-9515041 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

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For further information, please call: (512) 239-6087

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## Subchapter E. Permit Procedures

### • 30 TAC §330.70

The new section is adopted under the authority of the Texas Water Code, §5.103, which provides the Texas Natural Resource Conservation Commission (TNRCC) with the authority to adopt any rules necessary to carry out the powers and duties under the provisions of the Texas Water Code, the Texas Solid Waste Disposal Act, Texas Health and Safety Code, §361.024 and §361. 061, which provides the TNRCC with the authority to regulate municipal solid waste and adopt rules as necessary to regulate the operation, management and control of solid waste under its jurisdiction.

*§330.70. Registration of Facilities that Recover Gas for Beneficial Use.*

(a) Applicability. This section shall apply to a municipal solid waste management Type IX facility which is exempt from permit requirements under §330.4(n) of this title (relating to Permit Required).

(b) Relationship with other rules. All municipal solid waste landfill facilities accepting waste after October 9, 1993, applying for a non-beneficial use gas control system for any area within the facility's permit boundary shall apply for a permit modification pursuant to §305.70 of this title (relating to Permit Modification).

(c) Relationship to previously permitted Type IX facilities. Type IX facility permits previously issued for the recovery and beneficial use of landfill gas are considered to remain valid under applicable permit provisions pursuant to the Texas Health and Safety Code, §361.092.

(d) Public meeting. The owner or operator of each facility that recovers gas for beneficial use shall conduct a public meeting in the local area at least 30 days before beginning facility operation, or as determined by the executive director, to describe the proposed action to the general public. A one time notice of the public meeting shall be provided by the facility owner or operator two weeks prior to the meeting in the format prescribed in the Health and Safety Code, §361.0791(d) and (e) (relating to Public Meeting and Notice Requirements). Evidence that the meeting was held shall be submitted to the TNRCC in the form of a copy of the meeting notice as published and a notarized statement from the facility owner or operator stating that the meeting was held and stating the meeting date and location.

(e) Registration application. The applicant shall submit an application as follows:

(1) Number of copies. Registrants shall submit four copies of the completed application for registration.

(2) Application. Part I of the application shall be in accordance with §330.52 of this title (relating to Technical Requirements of Part I of the Application). This part includes all items required by §330.45 of this title (relating to Contents of Application for Permit) and §§330.51-330.52 of this title (relating to Permit Procedures). The applicant should consult with the executive director to confirm the applicability of specific requirements. With regard to the submission of the Land Ownership Maps and a Land Ownership List with Part I of the application, upon request by the applicant, the executive director may waive these requirements if they are deemed unnecessary. This letter of request should be included with the application. The remaining parts of the application must be submitted in the form of an engineering plan signed and sealed in accordance with the Texas Engineering Practice Act.

(3) Air quality information. All information necessary to complete the Air Quality Review as prescribed by the TNRCC shall be submitted and approved by the executive director prior to receipt of approval of the registration.

(4) Plans and cross-sections. On a large-scale plan drawing of the site, the applicant shall show the following information:

(A) Site boundaries (show permit boundaries and/or boundaries and dimensions of tract or land or closed municipal solid waste landfill unit on which the gas recovery system is to be developed).

(B) General Plan layout of extraction system and well locations (identify all underground utility easements, limits of waste placement, final contours of facility).

(C) A plan layout showing landfill gas treatment, gas compression, electrical power generation equipment, and any other beneficial gas-use equipment, and indicating limits of waste placement, additional easements required, and existing underground and overhead utility easements.

(D) Streets and roads to provide ingress and egress to the processing facility.

(E) Typical cross sections of final cover with gas extraction system and wells.

(F) Typical details of well placement and manifold placement in conjunction with the final cover system.

(G) Provisions for control of drainage or related items concerning the final contours of the municipal solid waste unit or facility and any appurtenant drainage features that may result incidental to the constructions of a processing unit and/or fixed structure.

(H) Provisions to assure the integrity of the liner.

(I) For enclosed structures, provisions for fire control facilities (fire

hydrants, fire extinguisher, water tanks, and water well), continuous methane monitoring, and explosion-proof fixtures.

(J) A discussion of the proposed method for condensate disposal.

(5) Safety plans. The applicant shall provide written plans for personnel safety and contingency during the design, construction, and operation of the entire gas recovery system.

(6) Recovery system operating plan. The applicant shall provide a written plan for the operation of the entire gas recovery system. The plan shall include, but not necessarily be limited to, the following:

(A) Information necessary to demonstrate that the integrity of the final cover system will not be damaged as a result of the installation of the recovery system;

(B) Routine operational procedures for the entire gas recovery system;

(C) Emergency and contingency procedures for personnel and equipment;

(D) Startup procedures, shutdown, and closure procedures;

(E) Monitoring and maintenance procedures; and

(F) Post-closure care plan for the gas recovery system. The applicant shall provide a post-closure care plan that discusses operational procedures for the extraction and processing system once the municipal solid waste facility is undergoing post-closure care pursuant to §330.254 of this title (relating to Post-Closure Care).

(7) System descriptive data. The applicant shall provide the following:

(A) an estimation of average daily gas production.

(B) an estimation of the design daily gas production.

(C) a description of the process unit.

(D) list of monitoring and maintenance procedures.

(8) Evidence of financial assurance. Municipal solid waste landfill facilities are subject to the Subchapter K requirements of §330.9 of this title (relating to Financial Assurance).

(9) Requirements of statements and certification. The applicant shall include the following statements and/or applicable signatures.

(A) Statement of applicant. (Figure 1: 30 TAC 330.70(e)(9)(A).)

(B) Engineer's certification. (Figure 2: 30 TAC 330.70(e)(9)(B).)

(f) Motion for reconsideration.

(1) The applicant or a person affected may file with the chief clerk a motion for reconsideration of the executive director's final approval of an application.

(2) A motion for reconsideration must be filed with the chief clerk not later than the 20th day after the date on which the chief clerk mailed the applicant the signed registration. In addition to a specific motion for reconsideration, the commissioners shall consider as a motion for reconsideration any objection, protest, or request for hearing filed with the chief clerk not later than the 20th day after the date on which the chief clerk mailed to the applicant the signed registration.

(3) A decision by the executive director, including a registration issued by the executive director, is not affected by the filing of a motion for reconsideration under this section unless expressly so ordered by the commissioners. If a motion for reconsideration is not acted on by the commissioners within 45 days after the date on which the chief clerk mailed signed registration to the applicant, the motion shall be deemed overruled. When a motion for reconsideration is overruled by commission action or pursuant to this subsection, the Texas Government Code, §2001.146, regarding motions for rehearing for contested cases is inapplicable and no motions for rehearing shall be filed. To the extent applicable, the commission decision may be subject to judicial review pursuant to the Texas Water Code, §5.351 or the Texas Health and Safety Code, §361.321.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515043 Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission

Effective date: December 11, 1995

Proposal publication date: August 29, 1995

For further information, please call: (512) 239-6087

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# TITLE 37. PUBLIC SAFETY AND CORRECTIONS

## Part VI. Texas Department of Criminal Justice

### Chapter 152. Institutional Division

### Subchapter A. Prison Admissions

**• 37 TAC §152.2, §152.3**

The Texas Department of Criminal Justice (TDCJ) adopts the repeal of §152.2 and §152.3, concerning the allocation among counties of the number of Institutional Division admissions available and the allocation of admissions to TDCJ Institutional Division, without changes to the proposed text as published in the September 26, 1995, issue of the *Texas Register* (20 TexReg 7820).

The repeals are necessary due to the new scheduled admissions policy proposed under new §152.1, in accordance with Texas Government Code, §499. 071, and the need to remove obsolete language.

The repeals will remove obsolete language enabling the implementation of new language required by Texas Government Code, §499.071.

No comments were received regarding adoption of the repeals.

The repeals are adopted under the Government Code, §492.013, which grants general rulemaking authority to the Board, and §499.071 (as amended by the 74th Legislature, Regular Session).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515018 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Effective date: December 11, 1995

Proposal publication date: September 26, 1995

For further information, please call: (512) 463-9693

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### Chapter 163. Community Justice Assistance Division Standards

**• 37 TAC §163.34**

The Texas Department of Criminal Justice adopts new §163.34, concerning community supervision officers carrying weapons, without changes to the proposed text as pub-

lished in the September 26, 1995, issue of the *Texas Register* (20 TexReg 7820).

The new section is needed in order to address the issue of community supervision officers carrying handguns after the enactment of Article 4413(29ee), Revised Statutes. The new section will clarify authority that has been in question since the passage of Senate Bill 60, Article 4413(29ee), Revised Statutes.

One individual commented against the new section and argued that officers are exposed to dangerous felons and should be allowed to carry handguns. In addition, the Community Justice Assistance Division and the Judicial Advisory Council examined this issue in detail and conducted a survey of community corrections professionals–judges, directors of community supervision and corrections departments, and community supervision officers. The results of the survey, in summary, are: (1) 78% of respondents believe that community supervision officers should be authorized to carry concealed handguns while conducting work-related duties; (2) 78% of respondents believe that officers should not be mandated to carry handguns; and (3) 84% of respondents believe that legal authority to carry handguns should be in special legislation, as opposed to the Concealed Weapons Law, Article 4413 (29ee), Revised Statutes.

The agency has reviewed the comment and survey results received and determined that the original proposal should be adopted, based on the advice of the Judicial Advisory Council to the Board, which studied the issue extensively. This conclusion is reinforced by the survey results, indicating an 84% majority of community corrections professionals who believe that special legislation should address this issue, and such legislation has not been passed.

The new section is adopted under the Government Code, §492.013, which grants general rulemaking authority to the Board and Code of Criminal Procedure, Article 42.13 (Codified as of September 1, 1995, as Chapter 509, Government Code).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515017 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Effective date: December 11, 1995

Proposal publication date: September 26, 1995

For further information, please call: (512) 463-9693

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# TITLE 40. SOCIAL SERVICES AND ASSISTANCE

## Part I. Texas Department of Human Services

### Chapter 19. Nursing Facility Requirements for Licensure and Medicaid Certification

### Subchapter Z. Preadmission Screening and Annual Resident Review (PASARR)

**• 40 TAC §19.2500**

The Texas Department of Human Services (DHS) adopts an amendment to §19. 2500, without changes to the proposed text as published in the June 9, 1995, issue of the *Texas Register* (20 TexReg 4206).

The justification for the amendment is to ensure that individuals, who may lack capacity, have a surrogate decision maker or legal guardian to assist them in making decisions about their nursing facility stay.

The amendment will function by addressing the evaluation of an individual's capacity to understand and meaningfully participate in decisions about his nursing facility stay, receive specialized services, and/or initiate appeals. For persons where capacity is in question and no surrogate decision maker or legal guardian is identified, the department will make a referral to the court for the assignment of a legal guardian.

The department received no comments regarding adoption of the amendment.

The amendment is adopted under the Health and Safety Code, Chapter 242, which provides the department with the authority to regulate long-term care nursing facilities; the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendment implements the Health and Safety Code, §§242.001-242.186, and the Human Resources Code, §§22.001-22.024 and §§32.001-32.042.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 16, 1995.

TRD-9514923 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Effective date: December 7, 1995

Proposal publication date: June 9, 1995

For further information, please call: (512) 438-3765

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## Texas Department of Insurance Exempt Filing

Notification Pursuant to the Insurance Code, Chapter 5, Subchapter L

*(Editor's Note: As required by the Insurance Code, Article 5.96 and 5. 97, the Texas Register publishes notices of actions taken by the Department of Insurance pursuant to Chapter 5, Subchapter L, of the Code. Board action taken under these articles is not subject to the Administrative Procedure Act.*

*These actions become effective 15 days after the date of publication or on a later specified date.*

*The text of the material being adopted will not be published, but may be examined in the offices of the Department of Insurance, 333 Guadalupe, Austin.)*

The Commissioner of Insurance, at a public hearing held on November 9, 1995, at 1:30 p.m., under Docket Number 2183, in Room 100 of the Texas Department of Insurance Building, 333 Guadalupe Street in Austin, Texas, adopted amendatory mandatory endorsements to residential property insurance policies and amendments to the Texas Personal Lines Manual to provide that a claim that is filed under a residential property policy but is not paid or payable under the policy cannot be counted for purposes of premium surcharges or refusal to renew under Article 21.49-2B, §7 of the Insurance Code. The endorsements and Manual rule amendments were proposed by Department staff in a petition filed on September 20, 1995 (Reference Number P-0995-35-I). Notice was published in the September 29, 1995, issue of the *Texas Register* (20 TexReg 8014 and 7969)

The Commissioner adopted the amendatory mandatory endorsements and Manual rule amendments without any changes to the proposal as published. The adopted endorsements and the policies to which these endorsements must be attached are: (1) Endorsement HO-197 to be attached to all Texas Homeowner's Policies, (2) Endorsement Number TDP-097 to be attached to Texas Dwelling Forms 1 and 2, (3) Endorsement Number TDP-098 to be attached to Texas Dwelling Form 3, (4) Endorsement Number FRO-497 to be attached to all Texas Farm and Ranch Owner's Policies, (5) Endorsement Number TFR-097 to be attached to Texas Farm and Ranch Forms 1 and 2, and (6) Endorsement Number TFR-098 to be attached to Texas Farm and Ranch Form 3. The Commissioner adopted amendments to four Manual rules relating to permissibility of premium surcharges for number of claims filed: (1) Rule IV-C-6-A in the Homeowner's Section, (2) Rule IV-M-1 in the Dwelling Sec-

tion, (3) Rule IV-C-2-A in the Farm and Ranch Owner's Section, and (4) Rule IV-O-1 in the Farm and Ranch Section. The Commissioner also adopted amendments to four Manual rules relating to refusal to renew due to losses: (1) Rule V-G in the Homeowner's Section, (2) Rule V-J in the Dwelling Section, (3) Rule V-F in the Farm and Ranch Owner's Section, and (4) Rule V-J in the Farm and Ranch Section.

Article 21.49-2B, §7 of the Insurance Code provides that insurers may assess a premium surcharge in certain instances, including at the time a policy is renewed if the insured has filed two or more claims in the preceding policy year and if an insurer renews a policy of an insured who has filed three or more claims under the policy in a three-year period. Article 21.49-2B, §7 also provides that an insurer may decline to renew a policy if the insured has filed three or more claims under the policy in any three-year period and that an insurer may notify an insured who has filed two claims in a period of less than three years that the insurer may decline to renew the policy if the insured files a third claim during the three-year period.

House Bill 46 enacted by the 74th Texas Legislature (Acts 1995, 74th Legislature, page 4402, Chapter 888, §1, effective September 1, 1995) amended Article 21.49-2B, §7(a) to provide that a claim that is filed under a residential property policy but is not paid or payable under the policy cannot be counted for purposes of premium surcharges or refusal to renew under Article 21.49-2B, §7. This legislation applies only to those claims filed with the insurer on or after September 1, 1995. House Bill 46 was enacted by the legislature because of the practice of some insurers in Texas to count as claims, for purposes of premium surcharges or refusal to renew under Article 21.49-2B, §7 of the Insurance Code, situations of residential property losses less than the insured's deductible that result in no losses being paid by the insurer and simple inquiries by policyholders to agents or insurers about possible residential property losses which also do not result in any losses being paid by the insurer.

The Commissioner has determined that the amendatory mandatory endorsements and Manual rule amendments are necessary because of the passage of House Bill 46. While the statutory prohibition enacted in House Bill 46 is not required by Article 21.49-2B, §7 to be included in the residential property insurance policy forms, the Commissioner has determined that such inclusion is necessary to provide policyholders with notice of the prohibition.

Although the statutory prohibition enacted in House Bill 46 applies to all residential property insurance claims filed with the insurer on or after September 1, 1995, the Commissioner has determined that the new endorsements and Manual rules are to become effective for all residential property insurance policies issued or renewed on or after January 1, 1996.

The Commissioner has jurisdiction of this matter pursuant to the Insurance Code, Articles 21.49-2B, 5.35, and 5.96.

The endorsements and rule amendments as adopted by the Commissioner of Insurance are on file in the Chief Clerk's Office of the Texas Department of Insurance under Reference Number P-0995-35-I and are incorporated by reference by Commissioner Order Number 95-1217.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts action taken under Article 5.96 from the requirements of the Administrative Procedure Act (Government Code, Title 10, Chapter 2001).

Consistent with the Insurance Code, Article 5.96(h), prior to the effective date of this action, the Texas Department of Insurance will notify all insurers affected by this action.

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that Endorsement HO-197 to be attached to all Texas Homeowner's Policies, Endorsement Number TDP-097 to be attached to Texas Dwelling Forms 1 and 2, Endorsement Number TDP-098 to be attached to Texas Dwelling Form 3, and Endorsement Number FRO-497 to be attached to all Texas Farm and Ranch Owner's Policies, Endorsement Number TFR-097 to be attached to Texas Farm and Ranch Forms 1 and 2, and Endorsement Number TFR-098 to be attached to Texas Farm and Ranch Form 3, as specified herein and which are attached to this Order and incorporated into this Order by reference, are adopted. IT IS FURTHER ORDERED that amendments to Texas Personal Lines Manual Rule IV-C-6-A in the Homeowner's Section, Rule IV-M-1 in the Dwelling Section, Rule IV-C-2-A in the Farm and Ranch Owner's Section, and Rule IV-O-1 in the Farm and Ranch Section, relating to permissibility of premium surcharges for number of claims filed, as specified herein and which are attached to this Order and incorporated into this Order, are adopted. IT IS FURTHER ORDERED that amendments to Texas Personal Lines Manual Rule V-G in the Homeowner's Section, Rule V-J in the Dwelling Section, Rule V-F in the Farm and Ranch Owner's Section, and Rule V-J in the Farm and Ranch Section, relating to refusal to renew due to losses, as specified herein and which are attached to this Order and incorporated into this Order, are adopted. IT IS FURTHER ORDERED that these endorsements and rule amendments shall become effective for all residential property insurance policies issued or renewed on or after January 1, 1996.

This agency hereby certifies that the adopted endorsements and Manual rule amendments have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on November 20, 1995.

TRD-9515047

Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Effective date: January 1, 1996

For further information, please call: (512) 463-6327

# PUBLICATION SCHEDULE

The following is the 1995 Publication Schedule for the Texas Register. Listed below are the deadline dates for the June-December 1995 issues of the Texas Register. Because of printing schedules, material received after the deadline for an issue cannot be published until the next issue. Generally, deadlines for a Tuesday edition of the Texas Register are Wednesday and Thursday of the week preceding publication, and deadlines for a Friday edition are Monday and Tuesday of the week of publication. No issues will be published on July 7, November 10, November 28, and December 29. An asterisk beside a publication date indicates that the deadlines have been moved because of state holidays.

| FOR ISSUE PUBLISHED ON | ALL COPY EXCEPT NOTICES OF OPEN MEETINGS BY 10 A.M. | ALL NOTICES OF OPEN MEETINGS BY 10 A.M. |
|---|---|---|
| 75 Tuesday, October 3 | Wednesday, September 27 | Thursday, September 28 |
| 76 Friday, October 6 | Monday, October 2 | Tuesday, October 3 |
| Tuesday, October 10 | Wednesday, October 4 | Thursday, October 5 |
| 77 Friday, October 13 | THIRD QUARTERLY INDEX | |
| 78 Tuesday, October 17 | Wednesday, October 11 | Thursday, October 12 |
| 79 Friday, October 20 | Monday, October 16 | Tuesday, October 17 |
| 80 Tuesday, October 24 | Wednesday, October 18 | Thursday, October 19 |
| 81 Friday, October 27 | Monday, October 23 | Tuesday, October 24 |
| 82 Tuesday, October 31 | Wednesday, October 25 | Thursday, October 26 |
| 83 Friday, November 3 | Monday, October 30 | Tuesday, October 31 |
| 84 Tuesday, November 7 | Wednesday, November 1 | Thursday, November 2 |
| Friday, November 10 | No Issue Published | |
| 85 Tuesday, November 14 | Wednesday, November 8 | Thursday, November 9 |
| 86 Friday, November 17 | Monday, November 13 | Tuesday, November 14 |
| 87 Tuesday, November 21 | Wednesday, Novmber 15 | Thursday, November 16 |
| 88 Friday, November 24 | Monday, November 20 | Tuesday, November 21 |
| Tuesday, November 28 | NO ISSUE PUBLISHED | |
| 89 Friday, December 1 | Monday, November 27 | Tuesday, November 28 |
| 90 Tuesday, December 5 | Wednesday, November 29 | Thursday, November 30 |
| 91 Friday, December 8 | Monday, December 4 | Tuesday, December 5 |
| 92 Tuesday, December 12 | Wednesday, December 6 | Thursday, December 7 |
| 93 Friday, December 15 | Monday, December 11 | Tuesday, December 12 |
| 94 Tuesday, December 19 | Wednesday, December 13 | Thursday, December 14 |
| 95 Friday, December 22 | Monday, December 18 | Tuesday, December 19 |
| 96 Tuesday, December 26 | Wednesday, December 20 | Thursday, December 21 |
| Friday, December 29 | NO ISSUE PUBLISHED | |