ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER S. WHOLESALE MARKETS

16 TAC §25.510

The Public Utility Commission of Texas (commission) adopts new 16 Texas Administrative Code (TAC) §25.510, relating to the Texas Energy Fund (TEF) In-ERCOT Generation Loan Program. The commission adopts this rule with changes to the proposed text as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7267). The rule will be republished. New §25.510 implements Public Utility Regulatory Act (PURA) §§34.0104, 34.0106, and 34.0108, created by Senate Bill (S.B.) 2627 as enacted by the 88th Texas Legislature (R.S.). The new rule will establish procedures for applying for a loan for construction of dispatchable electric generation facilities within the ERCOT region, evaluation criteria, and terms for repayment. The new rule will also specify performance standards that will be included in the terms of the loan, to which a loan recipient must adhere. The rule is adopted in Project No. 55826.

The commission received comments on the proposed rule from Advanced Power, Brownsville Public Utilities Board (BPUB), Calpine Corporation (Calpine), Competitive Power Ventures Inc. (CPV), City Public Service Board (CPS Energy), Drax Group, Electric Reliability Council of Texas Inc. (ERCOT), Golden Spread Electric Cooperative Inc. (Golden Spread), Grid Resilience in Texas (GRIT), Hunt Energy Network LLC (HEN), Lower Colorado River Authority (LCRA), LS Power Development LLC (LSP), NRG Energy Inc. (NRG), Shell Energy North America (US) LP (Shell Energy), the Sierra Club, Targa Resources LLC (Targa), Texas Competitive Power Advocates (TCPA), Texas Electric Cooperatives Inc. (TEC), the Texas Oil & Gas Association (TXOGA), the Texas Public Power Association (TPPA), Texas Industrial Energy Consumers (TIEC), USA Compression Partners LLC (USA Compression), Vistra Corp. (Vistra), Wartsila North America Inc. (Wartsila), and WattBridge Texas LLC (WattBridge).

TCPA requested a public hearing, which was held on January 25, 2024. The following entities offered oral comments: Calpine, CPS Energy, Enchanted Rock, HEN, LCRA, LSP, NRG, Sierra Club, Targa, TCPA, TIEC, TPPA, Vistra, Wartsila, and WattBridge.

Note on Definition of Entities

The following terms are used in this order. "Applicant" refers to the entity applying to the In-ERCOT Generation Loan Program under §25.510. "Corporate sponsor" refers to the corporate parent entity of an applicant. Use of this term accommodates a scenario in which a project-specific corporate entity is established to own a newly built facility after the loan application process. If a project entity is formed just prior to the loan application process and therefore lacks history, the credit and experience of the corporate sponsor may be considered. "TEF administrator" refers to the individuals responsible for administering the TEF programs. The term may apply to commission staff or to a contractor hired to assist with certain program functions. The specific duties and responsibilities of any contractor hired to assist with the administration of the TEF programs are defined by the terms of the commission's contract with that entity, which will be publicly available on the commission's website. Decisions of the TEF administrator are subject to the oversight of the commission.

Duties of TEF Administrator and Commission Staff

The commission will evaluate applications for TEF funding with the assistance of commission staff and the contractor hired to perform duties assigned to the commission's TEF administrator. The contractor will be responsible for assessing each application for completeness, providing commission staff with recommendations for funding according to the requirements of PURA §§34.0104 and 34.0106 and the evaluation criteria listed in §25.510, and conducting due diligence on each application to gauge the feasibility of each proposal. Commission staff will review the contractor's recommendations and, again relying on the program's evaluation criteria, will provide recommendations for approval to the commission. The commission will approve an application in consideration of these recommendations, the statutory requirements, and the criteria listed in §25.510.

Evaluation Criteria Preferences

The TEF administrator's review will assess the extent to which an applicant has thoroughly addressed each of the evaluation criteria enumerated in §25.510. An applicant's response to criteria related to electric generation service history and to financial attributes, such as financial modeling, creditworthiness, and risk management strategies, will garner the closest scrutiny. For example, an applicant demonstrating more extensive and relevant generation service experience will receive a more favorable application assessment. Similarly, applicants proposing to use a larger ratio of equity to debt relative to other applications will also achieve a more favorable evaluation. Applications proposing financial structures with corporate guarantees of TEF project debt will also result in a more favorable evaluation.

Although §25.510(f)(1)(A)(iii) establishes as an evaluation criterion the history of generation operations in Texas and the United States, a lack of experience in either location will not disqualify an applicant from receiving a TEF loan. Additionally, applicants

proposing financial structures that rely on various forms of debt for the non-TEF portion of the funding will be considered, but preference will be given to applications with equity at the project level. More complex capital structures, such as those with multiple tiers of creditors, may require negotiated intercreditor agreements that can extend time to completion, resulting in a lower score.

Public Comments

The commission invited interested parties to address three questions related to the eligibility requirements of the proposed rule.

1. Should the rule require registration as a power generation company (PGC) with the commission as a condition for eligibility to receive a loan? Why or why not?

Among commenters that favored registration as a PGC, there were differing views as to the timing of the registration. Sierra Club suggested requiring registration as a PGC prior to applying for a TEF loan. WattBridge, HEN, Drax Group, NRG, LSP, and TCPA suggested requiring registration as a PGC prior to loan disbursement but opposed requiring registration at the time of application. Wartsila recommended adding this requirement as a condition to receive the loan but did not specify whether PGC registration should be a condition for eligibility to apply. HEN, Shell Energy, NRG, LSP, and TCPA suggested PGC registration should be received by the commercial operations date (COD) of the generator that is the subject of the loan application per §25.109, relating to Registration by Power Generation Companies and Self-Generators, and continuously maintained for eligibility.

TIEC and Calpine suggested that registration should not be required prior to applying for or receiving TEF funding. However, TIEC stated that a loan recipient should be required to register prior to generating energy as required by PURA and commission rules.

Targa did not oppose a PGC registration requirement if the commission desires applicants for the loan program to be subject to the regulatory requirements for PGCs.

TEC, CPS Energy, TPPA, BPUB, GRIT, TXOGA, Targa, and LCRA opposed a requirement to register as a PGC, because this would exclude municipally owned electric utilities (MOUs) and electric cooperatives. TXOGA suggested that eligibility should be based on new construction or upgrades of 100 megawatts (MW) or more of dispatchable generation, not a company's scope of business. GRIT stated that SB 2627 does not include a requirement to register as a PGC and applying it would potentially discriminate against certain generating facilities without regard for the facilities' potential contributions to the reliable generation of electricity for the ERCOT region.

Commission Response

The commission agrees with commenters who recommended requiring an applicant to register as a PGC prior to receipt of awarded loan funds. PURA §39.351 requires a person to register as a PGC prior to generating electricity in the ERCOT region. Therefore, it is appropriate to require PGC registration for awarded entities, but not require registration as a condition of application on the chance that the commission rejects an applicant's proposal.

However, the commission also agrees with TEC, CPS Energy, TPPA, BPUB and LCRA, who stated that requiring an applicant to register as a PGC would exclude MOUs, electric cooperatives, and river authorities. The commission modifies the rule at (h)(1)(G) to allow an exception to PGC registration for those three types of entities.

The commission disagrees with TXOGA's recommendation to limit eligibility requirements to only the scale of the project. PGC registration is required for all entities other than MOUs, electric cooperatives, and river authorities, notwithstanding upgrades to existing facilities or new construction for the reason noted above. The commission also disagrees with GRIT because PGC registration is required for a person prior to generating electricity in the ERCOT region as discussed above.

2. Should the rule require registration as a Generation Resource (GR) with ERCOT as a condition for eligibility to receive a loan? Why or why not?

Shell Energy, Sierra Club, BPUB, CPS Energy, and TPPA supported requiring registration with ERCOT as a GR. Wartsila and Vistra recommended adding this requirement as a condition to receive the loan but did not specify whether it should be a condition for eligibility to apply.

WattBridge, HEN, Calpine, NRG, LSP, and TCPA opposed requiring registration as a GR with ERCOT at the time of application for a TEF loan. Instead, these parties argued, registration timeline requirements should be consistent with existing ERCOT protocols. Specifically, HEN argued that some applicants might move forward with a project only if the project receives a loan from the TEF. LCRA and TIEC also asserted that registration should be required consistent with existing ERCOT protocols.

Targa did not oppose a GR registration requirement if the commission intends to make loan applicants subject to ERCOT's GR requirements. However, Targa commented that the commission should recognize that a GR that serves critical natural gas infrastructure may need to remain available to serve co-located critical load during an energy emergency, consistent with existing commission rule requirements and House Bill 3648 and S.B. 3, both enacted by the 87th Texas Legislature (R.S.).

GRIT opposed a requirement to register as a GR, arguing that such a requirement is improperly narrow given the much broader eligibility criteria in the statute. GRIT suggested that resources that are registered as Settlement Only Distribution Generators (SODGs), Private Use Networks (PUNs) with dispatchable generation, or GRs with ERCOT should be eligible to receive a TEF loan.

TXOGA, Drax Group, and TEC opposed a requirement to register as a GR.

Commission Response

In order for a generation facility to provide energy and ancillary services to the ERCOT system, be available for reliability unit commitment, and make energy offers, the facility must be registered with ERCOT as a GR. The commission finds that by describing loan-eligible projects as both dispatchable and primarily in service of the ERCOT system under PURA §34.0104(a) and §34.0106(b)(1), the most appropriate ERCOT asset registration type is GR.

The commission modifies §25.510(h) to require an applicant that is awarded a TEF loan to register the facility as a GR in the normal course of the ERCOT commissioning process. This requirement will ensure that these units can be available to ERCOT in the most efficient way.

3. How should the commission evaluate PURA §34.0106(b)'s prohibition against providing a loan to an electric generating facility that will be used primarily to serve an industrial load or private use network (PUN)?

TIEC recommended that eligibility of a "facility" under PURA §34.0106 should be determined by comparing the industrial site's net dependable capacity of generation to the maximum non-coincident peak (NCP) demand of the co-located load. Any new, excess capacity of 100 MW or more should be eligible for TEF participation on a pro-rata basis, according to TIEC's recommendation.

Wartsila agreed with TIEC, noting that excess capacity co-located with an industrial facility or PUN would be exported to the grid for market consumption. Therefore, that capacity would not be used "primarily to serve" the industrial facility or PUN.

Drax Group argued that serving additional load behind the meter should not preclude eligibility for the TEF loan program provided that 100 MW capacity requirement for ERCOT is met.

GRIT recommended that projects with excess dispatchable generation capacity within PUNs and resources behind an industrial customer's meter be eligible to participate in the loan program, provided that the dispatchable generation is primarily available for delivery to the ERCOT grid. GRIT also supported TIEC's comments filed under Project No. 54999, in advance of the September 21st workshop, which stated that there are companies considering building on-site dispatchable generating facilities and may oversize those facilities if the excess capacity were eligible for TEF loans.

LCRA recommended that a facility serving an industrial load or PUN be eligible for a loan if 100 MW of new capacity is dedicated to ERCOT. LCRA stated that if this criterion is met, the facility does not "primarily serve" the industrial load or PUN and is therefore eligible.

LSP recommended the commission evaluate "dual-use projects" based on energy, not on capacity.

Calpine commented that for a generator serving industrial load or within a PUN to qualify, it must always have 100 MW of capacity available for ERCOT wholesale markets, according to PURA §34.0104(a). Calpine expressed concern that allowing industrial load or PUN generation in the eligible pool of applicants potentially increases administrative costs and tasks to ensure the generation project is truly separated from the host load.

Calpine argued that the commission should not interpret §34.0106(b) as "precluding or deprioritizing" those PUN facilities that export full capacity to ERCOT but are also party to an "offtake" agreement with an industrial load that is served not by a PUN but by the ERCOT grid. In such an arrangement, the generator is exporting its power to the grid for market consumption while the dedicated offtaker buys it back pursuant to the terms of a contract. The full power of the facility is used to maintain overall ERCOT system frequency and is therefore primarily used in service of the grid. The generator, in this instance, is primarily serving the ERCOT grid, and has arrangements that are similar to a generator having power sales agreements with other retail electric providers serving residential or commercial customers.

Enchanted Rock suggested that excess dispatchable generation capacity within PUNs and behind industrial customer meters be eligible to participate in this program where dispatchable generation is primarily available for delivery to the ERCOT grid. Enchanted Rock further suggested that, if a percentage threshold is adopted, 90 percent of the total potential annual output from the generating facility should be supplied to the grid.

Shell Energy recommended that any cost directly linked to a PUN be excluded from eligibility for a TEF loan and that the loan should only cover prorated project costs for the total net capacity that will be injected into ERCOT.

Sierra Club urged the commission to focus on resources intended to serve the ERCOT wholesale market and not to allow taxpayer funds to be used for PUNs or industrial load facilities that, for the most part, are intended to self-provide energy to industrial loads.

TEC did not oppose the funding of facilities that are built to serve both the bulk power system and a PUN. TEC recommended that the commission require any entity submitting a loan application for a facility that will serve a PUN or industrial load to provide supporting documentation as to how the facility will support the ERCOT grid.

TCPA commented that the commission should interpret PURA §34.0106(b) to mean that the commission should not use the TEF funds to subsidize private, behind-the-meter generation. TCPA recommended that any costs that are not directly related to the production of electricity and its delivery to the ERCOT grid be excluded from the estimated project costs for the purpose of calculating the eligible loan amounts. Specifically, TCPA referred to facilities that would serve an industrial load in PUNs that are attempting to participate in the TEF.

TPPA submitted comments that were joined by BPUB and CPS Energy. TPPA did not oppose facilities that serve both the bulk power system and a PUN being eligible for the loan but provided a list of factors that the commission should consider for evaluating applications for such facilities.

Commission response

To determine whether an electric generating facility will be used primarily to serve an industrial load or PUN, the adopted rule relies upon a calculation of excess dispatchable capacity of the generation resources located at the facility. An applicant for a TEF loan must attest that it will provide at least the greater of 100 MW or 50 percent of the nameplate capacity to the ERCOT market. For example, a 300 MW co-located facility with a generation resource or resources that dedicates 160 MW to the ERCOT region will be deemed to primarily serve the ERCOT region. However, a 300 MW co-located facility with a generation resource or resources that dedicates 140 MW to the ERCOT region will be considered to primarily serve the associated industrial load or PUN. The capacity of a new facility will be evaluated as a whole--not on a net export basis--and it must exceed 100 MW. Accordingly, the entire facility must not primarily serve an industrial load or PUN. This determination will be based on a comparison between the sum of nameplate capacity of each new or upgraded generation resource at the facility and the maximum NCP demand of the associated industrial load or PUN. The portion of the entire facility's total nameplate capacity that will be expected to serve the industrial load or PUN must be less than 50 percent. Furthermore, the commission will consider the percentage of nameplate capacity of a new or upgraded generation resource that will be used to serve an industrial load or PUN as a factor in evaluating applications. The commission declines to adopt additional factors as recommended by TPPA, because the single factor provides a clear and replicable calculation that determines eligibility.

TXOGA recommended that "primarily serve" should not include critical gas suppliers and critical customers because maintaining energy to those entities is necessary for reliability.

Targa requested clarification on whether a facility may be eligible if the facility has 100 MW of nameplate capacity that either serves critical gas suppliers or critical customers or provides excess energy generation to the grid.

Commission response

The commission declines to accept the recommendation of TXOGA to exclude critical gas suppliers and critical customers when evaluating if the new capacity is primarily serving industrial load or PUN. Whether capacity is used to serve critical gas suppliers or critical customers is not a factor in determining if a facility primarily serves an industrial load or PUN.

3.a. Should the commission prescribe a percentage of total energy output that an electric generating facility must achieve to be eligible for a loan? If so, what percentage should the commission prescribe?

Wartsila disagreed that a percentage of total energy output should be prescribed as a threshold for TEF loan eligibility. Wartsila stated that a facility that provides 100 MW of capacity to ERCOT should be eligible, regardless of how much capacity provided to a PUN.

TIEC opposed an eligibility threshold based on percentage of the generator's output that is exported to the grid and instead recommended using the amount of generation capacity as the threshold. TIEC argued that as long as 100 MW of generation capacity is being dedicated to the ERCOT market, then the facility should be eligible.

LCRA recommended that the eligibility threshold for TEF loan should be a minimum of 100 MW of new capacity dedicated to serving and participating in the ERCOT wholesale market. LCRA suggested this in conjunction with requiring appropriate facility configurations, metering schemes at the outset, and an affidavit from the applicant committing that no less than 100 MW of capacity will be dedicated to serving the grid. LCRA explained that using such factors for the eligibility threshold avoids needless complexity and policing of meter data to determine whether the energy output of the facility met the statutory requirements during a historical look-back period.

GRIT recommended that, if percentage of output is used, an eligibility threshold of 90 percent or greater of the total potential annual energy output from the electric generating facility must be supplied to the ERCOT grid via dispatchable load reduction or export. GRIT noted that a total energy threshold is not necessary for a facility within a PUN if it reserves over 100 MW of dispatchable generating capacity to serve the grid in excess of the capacity reserved to serve the co-located load. GRIT concluded that "primarily serve" is therefore met because a defined amount of capacity is committed to ERCOT and not to on-site loads.

Shell Energy commented that although the total energy output will vary by technology and market price signals, generation facilities must be required to demonstrate the ability to meet more than 50 percent capacity level. Shell Energy also recommended that during emergency conditions, if the facility does not make 100 percent of the net capacity projected in the loan application available to the grid, any liquidated damages from the Engineering, Procurement, and Construction contract should be passed back to the fund as loan pre-payment.

Sierra Club recommended that to the extent funding is available, at least 50.1 percent of the energy from a PUN or industrial load should be intended for the ERCOT wholesale electricity market and that the commission should only allow loans on the part of the generation that serves the larger market.

TEC recommended that the commission develop factors for evaluation, such as the percent of time power flows to ERCOT, ERCOT's functional control of the facility, regular use of the unit, and percentage of output used by ERCOT versus the industrial load or PUN. TEC did not recommend a specific qualifying threshold.

TCPA recommended that, if the commission permits PUNs to qualify for the TEF, it should prescribe a percentage of no less than 51 percent of total facility net output in the ERCOT wholesale market to be eligible for the loan. TCPA further asserted that the eligible amount of the loan should be tied directly to the percentage of total net energy output in the ERCOT wholesale market.

TPPA provided several factors that the commission must consider when evaluating the eligibility of facilities serving both the ERCOT market and an industrial load or PUN. These include assessment of whether the energy generated at the facility's low sustainable limit would initially serve industrial load or PUN or be offered into ERCOT market; percentage of nameplate capacity that is expected to serve load or PUN at any time and under seasonal net capacities for peak load seasons; energy offering practices; number of hours that any energy generated is expected to serve ERCOT; availability of full generation output during emergency conditions; benefits to other industrial processes such as from the use of steam from cogeneration units; and any other factors that the commission deems appropriate.

TIEC opposed an eligibility threshold based on the percentage of the generator's output that is exported to the grid and instead recommended using the amount of capacity as the standard. TIEC argued that as long as 100 MW of generation capacity is dedicated to the ERCOT grid, then the facility is eligible.

TXOGA stated that it would be overly prescriptive to mandate that a specific percentage of a PUN's total energy output serve the grid rather than the PUN or industrial load.

Commission response

The commission determines that the eligibility threshold for a project will be measured by nameplate capacity, rather than energy output. The factors determining security-constrained economic dispatch can be outside a generation entity's control and could affect the amount of its energy output that is exported to the grid. Therefore, it is appropriate to rely on nameplate capacity rather than energy output measured over a period of time as a criterion for project eligibility.

3.b. Should the commission employ another method to ensure that an electric generating facility primarily serves the ERCOT grid? If so, what method is appropriate and why?

Shell Energy argued that a GR must be primarily dedicated to providing energy and ancillary services to the ERCOT market to be eligible for a TEF loan. A facility that is switchable to another grid, must only be able to do so upon approval from ERCOT and would be required to switch back if needed.

As stated above, TEC recommended that the commission develop factors for evaluation, including but not limited to ERCOT's functional control of the facility and regular use of the unit.

TCPA recommended that the commission use North American Electric Reliability Corporation (NERC) Generating Availability Data System (GADS) definitions for "availability", based on the facility's Equivalent Unplanned Outage Factor (EUOF), rather than EAF, and that performance should be calculated on a rolling average of at least 12 months as opposed to on an hourly basis. TCPA recommended that the commission specify a methodology that prohibits a facility from allocating less equivalent outage hours to the portion of the facility serving ERCOT load.

TPPA recommended that the rule include clawback provisions for facilities whose market behaviors did not align with the description in the initial application, and facilities that end up primarily supporting an industrial load or PUN should be considered in default of the loan.

As stated above, TIEC argued that as long as 100 MW of generation capacity is being dedicated to the ERCOT grid, then the facility is eligible to participate in the TEF program.

TXOGA recommended introducing a "Support Service Requirement" that would condition the receipt of the loan on the facility providing certain grid support services during critical periods.

Commission Response

An electric generating facility that will serve an industrial load or a PUN is eligible to apply for a TEF loan if it fulfils the eligibility conditions described under subsection (c). The capacity of a new facility will be evaluated as a whole for purposes of determining if it primarily serves an industrial load or a PUN. Whether the entire facility primarily serves an industrial load or PUN will be based on a comparison between the sum of the nameplate capacity of each new or upgraded generation resource at the facility and the maximum NCP demand of the associated industrial load or PUN. For an electric generating facility that will not provide all capacity exclusively to the ERCOT power region, only the additional cost to upgrade or construct the capacity that exclusively serves the ERCOT region will be eligible for a loan under this program and will be funded proportionally. The commission modifies the rule accordingly.

General Comments

Relationship among Texas Energy Fund Programs

TPPA, TCPA, and Vistra requested clarification on how much of the TEF will be allocated toward each program within each fund: In-ERCOT Generation Loan Program, Completion Bonus Grants (CBG), Grants for Facilities Outside ERCOT Power Region, and the Texas Backup Power Package (BPP). TPPA shared concerns that total appropriations will be depleted in the In-ERCOT Generation Loan Program with none left over for the other three programs.

TPPA requested clarification on how the loan program will interact with the BPP. TPPA alleged that an applicant cannot participate in both the TEF and BPP and recommended this be stated explicitly in the rule.

LCRA stated that knowing whether and to what degree participation in TEF and CBG programs is permissible "will be a significant determinant for entities in deciding whether they will apply for the loan program."

Wartsila favored allowing loan program recipients to be eligible to apply for a CBG, if eligibility requirements are met. Wartsila also recommended that loan program recipients be eligible for a CBG and recommended that evaluations for both programs be independent. Wartsila specifically referred to proposed §25.511(d)(1)(J), relating to Texas Energy Fund Completion Bonus Grant Program, in Project No. 55812. This provision requires "a statement of whether the applicant applied for a loan under 16 TAC §25.510 as well as the commission's determination on the loan application." To reduce bias, Wartsila recommended independent evaluations for both the In-ERCOT Generation Loan Program and the CBG, and that grant applicants who did not receive a loan be considered "equivalently" for the CBG.

Commission Response

PURA Chapter 34 provides independent eligibility and evaluation criteria for each TEF program. While PURA §34.0106(e)(2) allocates an aggregated maximum of $7.2 billion from the TEF to both programs, applicants or projects for each of the two programs need not be related or known in advance. Each TEF program is independent with respect to eligibility and evaluation criteria. Therefore, it is unnecessary to modify proposed §25.510 to refer to other TEF programs.

Because the universe of applicants for each TEF program is not known at this time, the total amount of funds that should be allocated toward each program also cannot be determined. For this reason, the commission declines to revise the proposed rule to add specific amounts to be allocated among each of the four programs.

Regarding Wartsila's comment on independent evaluations, the In-ERCOT Generation Loan and CBG programs have different goals and criteria. Applications to each will be evaluated within the scope of the relevant program. Thus, application, receipt, or denial of a loan does not increase or decrease the likelihood of being awarded a CBG.

Public reporting

TXOGA asked if the commission has considered how the agency will report to stakeholders and the public on the program, if there would be monthly or quarterly updates via the commission open meetings or filings in the appropriate docket, and if there are other considerations, for transparency, that the commission is considering.

Sierra Club recommended making public information on any application for a loan available through the commission's filings interchange and allowing public comments to be made. In addition, Sierra Club suggested that the commission create a quarterly report on any applications received or any loans approved or denied. Sierra Club commented that this would allow policymakers and the public at large to see if the program has been successful in incentivizing new construction of dispatchable generation.

Commission Response

The commission may require public reporting on the TEF at open meetings, but any such specific requirement is beyond the scope of this rulemaking. The commission declines to modify the proposed rule to add any specific public reporting.

MOUs and River Authorities

CPS Energy noted several ways in which the proposed rule appeared to exclude participation by MOUs, while LCRA had similar comments regarding river authorities. Their concerns centered on proposed §25.510(g)(2), which requires the TEF loan to be "the senior debt secured by the electric generating facility to be completed." CPS Energy and LCRA pointed out that, as political subdivisions of the state, they are prevented from

pledging their real estate as security, but they can pledge the revenues of their utility systems as security for senior debt. In addition, both MOUs and river authorities have statutory restrictions on the seniority of their debt. For example, CPS Energy stated that "Chapter 1502 places a statutory first lien on gross revenues for payment of operations and maintenance expenses of the system." Because of these statutory limitations applicable to MOUs and river authorities, both CPS Energy and LCRA recommended modifying the proposed rule to allow for their participation. Specifically, LCRA suggested defining "senior debt" as "debt having no senior rights to the security securing the fund loans, but which may be on parity with or equal to the borrower' s other senior debt." CPS Energy also suggested adding a subsection to the proposed rule that lists the relevant security requirements and loan agreements exclusively applicable to MOUs consistent with Texas statutory law.

Commission Response

PURA §34.0104(e) contemplates the inclusion of river authorities and MOUs as potential borrowers in the in-ERCOT Generation Loan Program. The commission acknowledges that these public power entities are subject to other laws governing project financing and the encumbrance of utility assets. Accordingly, the commission modifies subsections (g) and (h) to allow an MOU or river authority to obtain a TEF loan on terms equivalent with corporate applicants.

Timing of Loan Funds

CPV recommended modifying the rule to "allow sponsors to access the program [funds] for construction financing, term financing, or for combined construction and term financing" which could benefit project progression. CPV remarked that this would facilitate initial institutional construction bridge financing with the expectation and commitment of the TEF as "construction take-out financing." CPV stated that this additional flexibility in the program would avoid potential delays in projects that may occur if sponsors purposely delay a project until it qualifies for the TEF.

Commission Response

Under PURA §34.0104, loans combine construction and term financing into a single project loan with a 20-year term. Therefore, the loan structure will not be a series of financings that change from initial construction bridge financing to take-out financing or other loans as hypothesized. The commission declines to modify the rule to allow for serialized loans or refinancings of TEF loans.

Standards for Evaluating Loan Repayment Ability

LSP recommended identifying, well in advance of the notice of intent (NOI) due date, what practices the commission will adopt regarding sizing project debt. LSP suggested applying more conservative standards when evaluating an applicant's ability to repay over the term of the loan and sizing the loan appropriately.

Commission Response

Under PURA §34.0104(b)(2), the TEF loan is for an amount not to exceed of 60 percent of estimated costs of the facility to be constructed. However, a particular applicant's credit profile may not support the maximum statutory loan amount. The amount for which an applicant may qualify cannot be known until after the TEF administrator conducts its due diligence. It is, therefore, unnecessary to identify further detail on sizing project debt.

Debt Sizing and Project Prioritization

LSP requested clarification on how TEF funds would be allocated in the event the total funds requested by qualified loan recipients exceed the available amount. LSP also recommended requiring project applicants to disclose the minimum amount of TEF debt that would make projects viable.

NRG recommended establishing prioritization criteria and prioritizing projects that are in the best position from a project viability standpoint. NRG specifically recommended that priority be given to projects that are close to financial close. Similarly, LCRA suggested prioritizing projects that are at an advanced stage of development and are the most likely to be eligible for CBG.

Vistra disagreed with NRG about prioritizing projects that are nearest to financial close and recommended establishing several tranches to fund loans, each with its own application window.

Commission Response

The commission disagrees with NRG's suggestion to prioritize projects based on their proximity to financial close. One major TEF objective is to solicit proposals to develop up to 10,000 MW of newly installed, dispatchable generation, and the commission seeks to develop as broad a pool of applicants as reasonably possible in order to meet this objective. Prioritizing projects that are closer to financial close unreasonably limits the applicant pool.

Additionally, the commission disagrees with Vistra's suggestion to segregate portions of the TEF into distinct funding tranches. The commission will allocate funds based on the applications received and the goals of the TEF, not an arbitrary amount of funding at a set time. The commission accordingly declines to state the priorities requested by the commenters.

Interconnection

Vistra suggested the rule language, or another commission rule, should expressly state that ERCOT and transmission service providers (TSPs) are obligated to prioritize interconnection of projects awarded TEF loans and should mirror the requirement of SB 2627 that requires ERCOT to prioritize these interconnections.

Commission Response

The prioritization of interconnection for projects awarded a TEF loan is beyond the scope of this rulemaking. Therefore, the commission declines to modify the rule as recommended by Vistra.

Proposed §25.510(b)-Definitions

Proposed §25.510(b) defines certain terms used in the rule.

TIEC recommended adding a definition for the term "electric generating facility" and proposed that it mean "an entire generation unit, or specified portion of a generation unit's capacity." TIEC suggested that the definition would allow facilities serving co-located industrial load that may oversize generation facilities with the intent to sell excess capacity to the ERCOT system, to participate.

LCRA recommended either adding a definition of "senior debt" or for the commission to explicitly document its interpretation of "senior debt" in the preamble adopting the rule, as described further below in response to §25.510(g).

Vistra recommended adding §25.510(b)(3) to define EUOF. Vistra advocated for the use of EUOF instead of the equivalent

availability factor (EAF) as the required performance threshold for borrowers.

Commission Response

The commission declines to define "electric generating facility" in the rule because the term is already defined in §25.5.

The commission disagrees with LCRA's recommendation to add to the rule a definition of "senior debt." PURA §34.0104(b)(3) specifies TEF loans to be "the senior debt secured by the facility." However, the commission adds a provision at (g)(2) to allow only MOUs and river authorities to pledge an interest in net revenues of the utility system the TEF-funded facility is a part of, even if the MOU or river authority has previously made a pledge of those same net revenues of the utility system.

The commission declines to use EUOF as the required performance threshold for borrowers. Instead, the commission will rely on ERCOT availability data to determine generation resource performance and modifies §25.510(b)(3) to define the 12-month performance availability factor (PAF) that reflects the use of such ERCOT data.

Proposed §25.510(b)(2)-Definition of COD

Proposed §25.510(b)(2) defines the term "commercial operations date" (COD) as the date on which the electric generating facility has completed all qualification testing administered by ERCOT and is approved for participation in the ERCOT market, as identified by ERCOT in the applicable monthly generator interconnection status (GIS) report.

WattBridge recommended tying the definition of COD to Part 3 approval within the ERCOT commissioning process. WattBridge noted that Part 3 approval would allow a new generator to participate in the day-ahead market.

Vistra recommended the commission accept any ERCOT record demonstrating the COD rather than solely relying on the ERCOT GIS report.

HEN stated that it is unclear what is meant by "completed all qualification testing administered by ERCOT and is approved for participation in the ERCOT market" and recommended removing it. Vistra and HEN recommended removing the phrase "as identified by ERCOT in the applicable monthly generator interconnection status report" from the COD definition. HEN recommended tying COD to ERCOT Part 2 approval and using ERCOT's New Generator Commissioning Checklist.

TPPA and Calpine noted that the definition of COD is different between proposed §25.510 and proposed §25.511 and recommended consistency in definitions across rules.

Commission Response

The commission agrees with Vistra that COD should not depend on the ERCOT monthly GIS report. The commission agrees with commenters that recommended tying COD to the ERCOT generator commissioning checklist and modifies the definition of COD to align it with ERCOT's resource commissioning date as defined in ERCOT protocols. The resource commissioning date represents the conclusion of the commissioning process and indicates a generation resource's fully interconnected status with the ERCOT power region.

The commission agrees with TPPA and Calpine that the definition of COD should be consistent between §25.510 and §25.511. The commission modifies the rule and will subsequently align §25.511 in Project No. 55812.

Proposed §25.510(c)(2) - Eligible Activities

Proposed §25.510(c)(2) describes activities that are eligible for a loan.

Aggregation

TXOGA suggested considering ways to allow for smaller generation units or aggregated units to be eligible for funds from the TEF to disperse needed dispatchable resources throughout the state. GRIT proposed adding language in §25.510(c)(2)(A) to include facilities across multiple locations.

USA Compression recommended aligning §25.510(c)(2) with proposed §25.511(c)(1), which defines "capacity of at least 100 MW" by including all the MWs provided by "(A) The construction of new dispatchable electric generating facilities providing power for the ERCOT region; or (B) The addition of new dispatchable electric generating facilities at an existing location providing power for the ERCOT region." USA Compression stated this modification would incentivize distributed generation in the loan program.

Commission Response

The commission disagrees with the commenters' recommendations to allow entities that aggregate electric generating facilities across multiple locations to apply for TEF funding. To be eligible for TEF funding, a project must be an upgrade of an existing facility or new facility construction and install at least 100 MW in nameplate capacity behind a single point of interconnection. PURA §34.0104(a) explicitly describes an eligible upgrade project as one that would result in the net increase of 100 MW for "each facility." Similarly, construction of new facilities that "each have a generation capacity of at least 100 megawatts" is required for the projects to be eligible for TEF funding.

New eligible activity

TIEC recommended adding a new provision to the eligible activities for a loan: "For an electric generating facility that serves load behind the retail meter, any new net dependable capacity that exceeds the maximum non-coincident peak demand of the co-located loads by at least 100 MW." TIEC suggested the rule should base facility eligibility on the total net dependable capacity of the generation facility in excess of the maximum NCP demand of the associated load.

CPV recommended revising the rule to allow a power project with carbon capture to be eligible for the loan program as a single entity. CPV suggested allowing costs for both energy production and carbon capture to be included in the loan program. CPV noted that if the Environmental Protection Agency's proposed 111B and D regulations take effect as currently written, the regulations would negatively affect plants that do not build decarbonization technology and result in significant extra costs for Combined Cycle Gas Turbine technology and associated carbon capture facility.

Commission Response

TIEC's position regarding net dependable capacity fails to address the term "primarily" in PURA §34.0106(b). Whether an electric generating facility primarily serves a co-located load is based on a comparison between the sum of the nameplate capacity of each generation resource at the new or upgraded facility and the maximum NCP demand of the associated industrial load or PUN. The portion of nameplate capacity that will be expected to serve the industrial load or PUN must be less than 50 percent, and the remaining capacity serving the ERCOT market

must be greater than 100 MW. For this reason, the commission declines to modify the proposed rule based on TIEC's suggestion.

The commission clarifies that components not clearly required for generation, such as carbon capture, are not eligible loan costs. Even if such components may be related to generation, carbon capture technology does not result in a net capacity increase for the ERCOT power region, and therefore, such costs are not authorized under PURA §34.0104. Accordingly, the commission declines to make any changes in response to CPV's recommendation to allow estimated costs related to carbon capture devices associated with the facility.

Measuring capacity increase

TPPA recommended clarifying that the 100 MW requirement is based on nameplate capacity rather than summer or winter net dependable capability.

Calpine requested that the commission measure "net increase" for upgrades to existing facilities based on a facility's average High Sustained Limit (HSL) in the year prior to filing for a TEF loan. Calpine advised against measuring "net increase" using the facility's installed capacity rating, because the installed capacity rating is the maximum power that a generating unit can produce during normal sustained operating conditions as specified by the equipment manufacturer.

Commission Response

The commission agrees with TPPA that the 100 MW "net increase" eligibility threshold should be measured by nameplate capacity and modifies the provision accordingly. PURA §34.0104 does not establish a preference for seasonal capacity ratings and, therefore, consideration of a project's potential to operate during normal conditions is appropriate. The commission disagrees with Calpine that "net increase" for upgrades should be calculated based on average HSL because this measurement cannot be applied to new construction. To quantify capacity during application evaluation, the commission must use a standard and easily identifiable metric that is relevant to both new construction and upgrades to existing facilities.

Definition of "new construction" and "upgrades to existing"

LSP suggested clarifying the categories of "new construction" and "upgrades to existing." LSP recommended classifying the addition of a new prime mover and generator set at an existing power plant as "new construction." LSP proposed limiting "upgrades to existing" to the modifications of an existing prime mover or generator.

Vistra suggested mirroring statute by removing the word "new" in "new construction" as the term "new construction" is undefined and injects uncertainty into determinations of eligibility. Vistra recommended replacing the word "new" in proposed §25.510(c)(2)(A) with a cross reference to §25.510(c)(4)(C) or removing it.

Commission Response

The commission modifies the rule to clarify that "new construction" refers to an instance when an electric generating facility will be built where no point of interconnection exists, while "upgrades to existing" refers to construction where a point of interconnection already exists, and an additional point of interconnection is not required for the deliverability of energy from the upgraded capacity.

Proposed §25.510(c)(3)-Eligibility Requirements for Proposed Facility

Proposed §25.510(c)(3) defines the requirements to which a proposed facility must adhere.

Golden Spread and TEC held similar positions regarding switchable facilities. Golden Spread advised that existing facilities that serve a non-ERCOT interconnection should be eligible for loans if the existing facility newly interconnects to ERCOT. Golden Spread requested modification to the language to recognize that switchable resources may not always provide power to the ERCOT grid during the term of a loan. TEC recommended allowing generators that can provide power to ERCOT and other independent system operators (ISOs) to participate in the program.

TPPA opposed permitting loan awards to facilities capable of switching power from ERCOT to a neighboring regional transmission organization. TPPA expressed concern that a facility could be designed to provide energy to ERCOT (as switchable), receive a loan, then not provide any energy to ERCOT.

Commission Response

The commission declines to modify the rule to include switchable facilities as eligible loan projects. GRs that can switch operations between two separate transmission networks are governed by agreements between the reliability coordinators for those networks, and thus it becomes increasingly difficult to ensure that generation capacity supported by TEF funding primarily provides power to the ERCOT network. The commission modifies the rule at (c)(4)(D) to clarify that projects to construct or operate switchable facilities are not eligible for a TEF loan.

Vistra recommended requiring applicants to register as a "generation entity" because this will ensure the commission's weatherization rules at §25.55 apply.

Commission Response

Facilities that receive loans under this program must register as a GR with ERCOT and therefore must adhere to the requirements of §25.55. The commission modifies §25.510(h) to require an applicant that is awarded a TEF loan to register the facility as a GR in the normal course of the ERCOT commissioning process.

Proposed §25.510(c)(3)(A) and (c)(3)(B)-Eligibility Requirements for Proposed Facility

Proposed §25.510(c)(3) states that a proposed facility must be designed to interconnect and provide power to the ERCOT power region and must be designed to participate in the ERCOT wholesale market.

TPPA recommended the removal of the phrase "be designed to" in §25.510(c)(3)(A) and (c)(3)(B) because a strict reading could allow a facility that is designed, but is ultimately not built, to receive a loan. TPPA noted that a facility could be designed to provide energy to ERCOT (as switchable), receive a loan, then not provide any energy to ERCOT.

Commission Response

The commission disagrees with TPPA's comments because new and upgraded facilities must necessarily be in the design phase of development, not existing, and other provisions of the rule guard against the possibility that an applicant will receive a loan but not build a facility.

Proposed §25.510(c)(4)(A)-Non-Eligible Activities

Proposed §25.510(c)(4)(A) prohibits the construction or operation of an electric energy storage facility from being eligible for a loan.

Sierra Club suggested an amendment to add language that allows for electric energy storage to be included as part of an overall facility, but that portion must be excluded from the application for a loan, and that thermal energy storage facilities be eligible for a loan.

TPPA stated that "electric energy storage facility" is an undefined term and requested clarity on its distinction with "energy storage resource."

Commission Response

The commission disagrees with Sierra Club's proposed modification to the rule. PURA §34.0104(a) states an electric energy storage facility is not eligible. Although it is unnecessary to define the term "electric energy storage facility," the commission notes that the incidental presence of some electric energy storage at a facility is insufficient by itself to classify it as an "electric energy storage facility." Whether the presence of some energy storage renders the facility an electric energy storage facility will be determined on a case-by-case basis and will generally be based on whether the energy storage will be used to support operations or will be used for later resale. With respect to energy storage more broadly, the commission notes that the TEF is directed to "dispatchable electric generating facilities"--not energy storage. Accordingly, to the extent that a dispatchable electric generating facility is configured to store some of its energy output, such storage is outside the scope of this rule. Other types of storage, such as thermal, may be included as part of the proposed facility.

The commission agrees with TPPA that the term "electric energy storage facility" is not explicitly defined. The commission declines to define the term electric energy storage facility but clarifies that "electric energy storage facility" and "energy storage resource" are not synonymous.

Proposed §25.510(c)(4)(B)-Non-Eligible Activities

Proposed §25.510(c)(4)(B) prohibits the construction or operation of a natural gas transmission pipeline from being eligible for a loan.

TPPA recommended adding language to ensure that infrastructure constructed and operated as part of interconnecting the natural gas generation facility to its fuel supply is not excluded from eligibility.

Commission Response

The commission agrees with TPPA's recommendation and modifies the rule to explicitly include natural gas interconnection infrastructure as part of the facility.

Proposed §25.510(c)(4)(D)-Non-Eligible Activities

Proposed §25.510(c)(4)(D) prohibits operations that primarily serve an industrial load or PUN from being eligible for a loan.

TPPA suggested the commission should require an annual affidavit from loan recipients that serve an industrial load or PUN regarding their activities in the wholesale market. TPPA also suggested that commission staff conduct an annual review of these facilities' operations. TPPA noted that these actions would provide assurance that facilities supported by TEF loans primarily serve the overall ERCOT market, rather than individual consumers. TPPA made the same recommendation for §25.510(h)(1)(H), regarding compliance and audit covenants.

Targa recommended allowing generators that serve critical gas suppliers and critical customers to be eligible if the generators also serve ERCOT. Targa cited rules of statutory construction and stated that the commission must examine the changes to PURA since Winter Storm Uri, referring to changes made by S.B. 3, H.B. 3648 (87th Legislature, R.S), and H.B. 5066 (88th Legislature. R.S.). Targa provided redlines consistent with the recommendations.

Calpine recommended prioritizing generators that deliver all generation capacity to the ERCOT system over co-located generators and noted in many instances that a PUN generator or generator serving a dedicated industrial load is in the service of primarily serving its dedicated load and, therefore, cannot also primarily serve the ERCOT wholesale market. Calpine suggested clarifying what else it might mean to "primarily serve an industrial or PUN load." Calpine recommended that a PGC should not be considered as "primarily serving an industrial or PUN load" if it exports its full capacity to the ERCOT grid while also being party to an offtake agreement with an industrial load.

Vistra suggested the commission should not evaluate proposed projects that serve an industrial load or a PUN on the limited grounds of whether the project will be available during an Energy Emergency Alert (EEA). Rather, it recommended that the commission should examine how much output the project will provide to the bulk power system holistically. Vistra recommended the commission prioritize facilities that will participate fully in the market and, if the PUNs are funded, then the loan funding should be appropriately prorated relative to the participation in the market. Vistra also recommended that "Operation" be changed to be "Construction or operation of a facility."

GRIT supported TIEC's comments that, if an electric generating facility is offering 100 MW exclusively to the ERCOT bulk power system, it should qualify regardless of how much capacity it supplies to a co-located load, but if a facility is idle most of the time and is considered by its co-located load as backup, it could offer its currently unused potential to the bulk power system as long as less than 10 percent of its energy output is going toward the co-located load. GRIT provided redlines consistent with its recommendations.

TCPA recommended that the commission not embrace anything less restrictive than what is already contained in the proposed rule. TCPA also recommended avoiding tying eligibility to point in time capacity snapshots or EEA event or NCPs. TCPA suggested focusing on standalone projects first that are dedicated to generation and ERCOT and that, if the projects are not behind the meter and they are a hedge between customer and generator or if the energy is flowing to the transmission system, then it should qualify.

Commission Response:

The commission disagrees with Targa's proposal and declines to provide an exception for proposed facilities that will primarily serve critical gas suppliers and critical customers. Such proposed facilities are subject to the same requirements as other proposed facilities.

The commission agrees with commenters that generation facilities that primarily serve the ERCOT market should be prioritized for funding over facilities that primarily serve dedicated industrial load and clarifies the eligibility conditions for such facilities under subsection (c). The commission also agrees with the redlines provided by Vistra and modifies subsection (c)(4)(D) accordingly.

Proposed §25.510(d)(1)-Notice of Intent (NOI) to Apply

Proposed §25.510(d)(1) states that an applicant must submit an NOI at least 60 days before submitting an application and defines the requirements that must be included.

Sierra Club recommended adding a requirement for information about regulatory and environmental permits in the NOI to apply, including the applicant's efforts to meet such requirements.

Calpine recommended the addition of new rule language to require a Generation Interconnection or Change Request, a completed ERCOT screening study, and a Full Interconnection Study agreement at the NOI stage to demonstrate the applicant has sufficient capital to cover the 40 percent of projected costs not covered by the loan. Calpine asserted that this information would also demonstrate the viability of the proposed facility and construction timeline. Calpine suggested that the applicant should also have demonstrated site control to ERCOT and submit an attestation of compliance with the Lone Star Infrastructure Protection Act under the ERCOT Planning Guide. Calpine urged the development of forms for the NOI, the application, and all other required ancillary documents.

CPV recommended reducing the 60-day period for the NOI to 30 days to reduce unnecessary delays for resources in advanced development stages and approaching the commencement of construction.

WattBridge recommended allowing NOIs so that applicants may apply as soon as possible. WattBridge remarked that it does not see June 1st as the start of application acceptance, but as the date when the first batch of applications is ready for awarding. WattBridge suggested that this approach prevents further compression of the timeline and helps avoid jeopardizing the COD target of Summer 2026.

Commission Response

The commission intends the NOI to serve as a statement of interest and expression of initial project viability for program management and planning purposes only. Incorporating the information requested by Sierra Club and Calpine is unnecessary because it does not relate to loan program administration. However, the commission will require regulatory and environmental compliance information as part of the application phase and will be assessed during the due diligence. Accordingly, the commission declines to modify the rule.

In response to Calpine's request that standardized forms be developed for the application process, the commission will develop a web-based portal to receive information required in the NOI.

The commission agrees with CPV's recommendation to reduce the 60-day period for submission of a NOI. Instead of requiring NOI submission at least 30 days before an application, as CPV suggested, the commission modifies the rule to require an applicant to submit the NOI no later than May 31, 2024, correlating to an application open date of June 1, 2024.

Proposed §25.510(d), (e), and (f)-Notice of Intent to Apply, Application Requirements and Process, and Evaluation Criteria

Proposed §25.510(d) describes requirements for an applicant to submit an NOI and to separately file a letter with the commission. Proposed §25.510(e) defines the application requirements, all of which must be submitted by "the applicant." Proposed §25.510(f) defines the evaluation criteria the commission will use when approving or denying an application, all of which refer to evaluation of "the applicant."

Vistra recommended revisions to the rule to allow a corporate parent of a subsidiary applicant to submit an NOI, application, and supporting information on behalf of its subsidiary because at the time of application, the project company might not be formed, capitalized, or have sufficient stand-alone resources. Vistra further stated that some projects might not be economically viable without a TEF loan, and the program will be more efficient and effective if a corporate parent can apply on behalf of a subsidiary. Vistra proposed changes to allow corporate parents to submit the NOI on behalf of subsidiary applicants. Vistra also recommended that the commission consider the corporate parent's creditworthiness when evaluating the subsidiary's application.

Commission Response

The commission agrees with Vistra that a project entity applicant may not yet exist at the time of the NOI. Accordingly, a corporate sponsor or parent entity may submit an NOI or apply on behalf of a project entity so long as the project entity is the eventual party to the loan agreement and provides appropriate evidence confirming it is the subsidiary of the corporate sponsor or parent. The commission modifies the rule accordingly.

Proposed §25.510(d)(1)(A), (d)(2), and (e)(1)-Notice of Intent to Apply, Application Requirements and Process

Proposed §25.510(d)(1)(A) requires the NOI to include the applicant's corporate name and the name of the electric generating facility for which it seeks a loan. Proposed §25.510(d)(2) states that the applicant must separately and concurrently file a letter with the commission stating the applicant's corporate name and the MW capacity that the requested loan amount will finance. Proposed §25.510(e)(1) states an application must include the applicant's corporate name and the name of the electric generating facility for which it requests a loan.

CPS Energy recommended removing the term "corporate" and replacing it with "legal" in §25.510(d)(1)(A), (d)(2), and (e)(1) because municipalities do not have a corporate name and would therefore be ineligible to apply based on the requirement.

TPPA recommended adding the term "proposed" before "name of the electric generating facility" in §25.510(d)(1)(A) because the name of the electric generating facility may change.

Commission Response

The commission agrees with CPS Energy that an applicant's "legal name" is more appropriate to capture all types of applicants. The commission modifies the rule accordingly. The commission agrees with TPPA that the name of an electric generating facility may change after submission of the NOI. The commission therefore modifies the rule to request the proposed name of the electric generating facility in the NOI.

Proposed §25.510(d)(1)(E)-Notice of Intent to Apply

Proposed §25.510(d)(1)(E) requires that for each electric generating facility, information demonstrating that the applicant is capable of financing project-related costs not supported by a loan awarded under this section to be submitted as part of the NOI.

Advanced Power recommended allowing the applicant to establish its ability to fund the necessary equity through a combination of a non-binding equity commitment(s) and an established track-record of successfully financing thermal generation projects in the United States. Advanced Power also recommended allowing a phased process where a non-binding equity commitment(s) is included as part of the initial NOI for TEF funding, followed by a binding equity agreement closer to financial

close and prior to the disbursal of TEF funds where the state's involvement in the financing of the project is known.

NRG recommended allowing applicants to submit an attestation regarding proposed financing of all non-TEF loan amounts. NRG stated this would be simpler than requiring financial statements or equity commitment letters at NOI stage, which is early for a project.

Commission Response

The commission agrees with Advanced Power that it is not commercially reasonable to require an applicant to provide a binding equity agreement at the NOI stage. For the NOI, an applicant proposing to use equity must include a non-binding equity commitment letter to demonstrate that the applicant is capable of financing project-related costs not supported by a TEF loan. For the application, an applicant proposing to use equity must submit a binding equity commitment letter with its application. An applicant proposing to fund the balance of costs through subordinated debt must submit evidence of its ability to fund those costs at both the NOI stage and in its application. The commission modifies (d)(1) and (e)(4)(C)(i) accordingly.

With the exception of a requirement to provide a non-binding equity commitment letter, the commission declines to specify the form or format of information provided in section (d)(1)(E). Accordingly, the commission declines to incorporate NRG's proposed change to allow an applicant to provide an attestation of a proposed financing plan.

Proposed §25.510(d)(2) -NOI to Apply Requirements

Proposed §25.510(d)(2) states that in concurrence with the NOI, the applicant must separately file a letter with the commission stating the applicant's corporate name and the MW capacity that the requested loan amount will finance.

TIEC recommended requiring applicants to include the anticipated COD in the NOI letter separately required by §25.510(d)(2) and also suggested adding language to the rule to track loan program progress at least quarterly for transparency. TIEC commented that the public should have visibility into this program, and the information submitted in the NOI will be publicly available in ERCOT reports later anyway.

TPPA requested clarification on whether the letter filed with the commission is publicly available information.

Calpine recommended requiring a demonstration of creditworthiness at the time of NOI submission. Calpine stated that this will assist the commission in evaluating an applicant's financial fitness and access to financing for the 40 percent of anticipated project costs not covered by the TEF loan.

Commission Response

The commission notes that estimated COD in the NOI may be commercially sensitive information. The fact that some NOI information may become public through ERCOT data tracking does not consider the status of an applicant's business activities at the time of NOI submission. The commission declines TIEC's request to include estimated COD in the letter separately filed under paragraph (d)(2). Further, the commission declines to add specific language to track loan program progress because any such reporting is beyond the scope of this rule.

In response to Calpine's position that the NOI should include a showing of creditworthiness, the commission notes that the NOI is not a TEF loan application. Instead, the NOI will serve as a diagnostic tool to allow the commission to gauge potential program participation. The commission will appraise an applicant's creditworthiness upon submission of an application. The Commission therefore declines to make Calpine's requested change.

The commission confirms that the letter filed pursuant to paragraph (d)(2) will be publicly available.

Proposed §25.510(e)-Application Requirements and Process

Proposed §25.510(e) prescribes the form and manner a loan application must be submitted to the commission.

NRG requested the provision specify June 1, 2024 as the date the commission will begin accepting applications.

TCPA requested communication on whether applications are going to be reviewed in batches with an opening and closing date.

Commission Response

The commission modifies the rule to state that the application process will be open for a minimum of an eight-week window, beginning on June 1, 2024, at 12:00 a.m. and through at least July 27, 2024, at 11:59 p.m. The commission also modifies the rule to allow the executive director to extend the application window by providing public notice of the extension at least 30 days prior to the previously announced window closure date. In addition, the commission further modifies the rule to allow the executive director to open additional application windows if necessary to achieve the objectives of the TEF. The rule is also modified to state that an applicant that submits an NOI will receive a description of the application and due diligence process.

Proposed §25.510(e)(4)(A)-Application Requirements and Process

Proposed §25.510(e)(4)(A) requires an applicant to submit a copy of any information submitted to ERCOT regarding the applicant's attestation of market participant citizenship, ownership, or headquarters.

TPPA recommended requiring a separate attestation directly from the applicant to ensure compliance with the Lone Star Infrastructure Protection Act (LSIPA) in case the applicant has yet not submitted such information to ERCOT by the time it applies for a TEF loan. TPPA explained that if an applicant has not submitted such information to ERCOT at the time of the application because the facility has not yet been constructed and interconnected, the applicant could therefore apply for a TEF loan without providing this information.

Commission Response

The commission agrees with TPPA's recommendation and modifies subsection (e)(4)(A) to require an applicant to submit a direct attestation relating to the information required under this subsection, if this information has not already been submitted to ERCOT.

Proposed §25.510(e)(4)(A), (f)(1)(A)(i), and (f)(1)(A)(iii)-Application Requirements and Process

Proposed §25.510(e)(4)(A) requires applicants to submit information regarding attestation of market participant citizenship, ownership, or headquarters. Proposed §25.510(f)(1)(A)(i) and §f)(1)(A)(iii) establish that the commission will evaluate applications, in part, based on the applicant's history of electricity generation in Texas and the United States.

Wartsila recommended granting equal consideration to applicants from any North American country or applicants with a successful history of electricity generation within North America.

Commission Response

The commission declines to modify the rule as recommended by Wartsila because it is unnecessary and out of scope. The commission's review under PURA §34.0104(c)(1)(C) is limited to an evaluation of each applicant's history of operations in Texas and the United States, but the statute does not preclude evaluation of the applicant's operations in other North American countries.

The commission will evaluate sponsors and applicants based on experience developing, owning, and operating relevant power generation assets in Texas and the United States. However, the commission will evaluate applications holistically, and a lack of experience in Texas or the United States will not in itself disqualify an applicant from being eligible for or receiving a TEF loan.

Proposed §25.510(e)(4)(B)-Applicant's Prior Experience with Dispatchable Electric Generating Facilities

Proposed §25.510(e)(4)(B) details evidence of the applicant's prior experience with siting, permitting, financing, constructing, commissioning, operating, and maintaining dispatchable electric generating facilities to provide reliable electric service in competitive energy markets.

TPPA recommended not requiring evidence of an applicant's prior experience with dispatchable electric generating facilities because this conflicts with PURA §34.0104(c)(1)(C), which requires the commission to evaluate an applicant's entire history of electric generation operations, which may include non-dispatchable generation operational experience. TPPA requested additional information on the necessity of this provision.

Calpine recommended requiring evidence that an applicant has fifteen years of experience with siting, permitting, financing, constructing, commissioning, operating, and maintaining dispatchable electric generating facilities to provide reliable electric service in competitive energy markets.

Commission Response

The commission agrees with TPPA that the word "dispatchable" can be deleted to account for an applicant's experience with any type of generation, not just dispatchable facilities, to align the rule more closely with the statute. The commission modifies the rule accordingly.

The commission rejects Calpine's recommendation to require at least fifteen years of experience because it would unnecessarily limit potentially feasible projects and because the commission will assess an applicant's overall history of electric generation operations as one of the evaluation criteria.

Proposed §25.510(e)(4)(C)(i)-Ability to Fund Project

Proposed §25.510(e)(4)(C)(i) requires evidence of an applicant's creditworthiness, including an equity commitment letter demonstrating the ability to fund the necessary project equity (40 percent of the remaining estimated cost of construction) plus the required three percent construction escrow deposit amount.

CPV supported the proposed rule's requirement for firm equity commitments to be equal to 40 percent of the project cost.

To address possible contingencies not included in the initial estimated cost of construction, Calpine suggested requiring applicants to cover contingency costs with non-TEF sources. Calpine recommended that the additional amount either be five percent of the overall estimated project costs or another amount to be determined on a case-by-case basis, as approved by the commission, based on a quantitative risk analysis. Calpine further recommended that an applicant should be required to confirm that the contingency funds are liquid, immediately available, and unrestricted funds, dedicated exclusively to development of the dispatchable generation facility for the purpose of mitigating the facility's performance risk.

Vistra recommended adding "at least" in front of "40 percent of the remaining estimated cost of construction."

LCRA recommended removing the term "equity" from §25.510(e)(4)(C)(i) while TIEC and CPV also suggested replacing "equity" with "financial commitment letter." LCRA commented that non-TEF costs may be funded through debt, not equity. TIEC stated that applicants may want to borrow less than 60 percent of project costs from TEF and may want to finance the remaining costs rather than use equity and recommended that applicants should be allowed to do so.

Golden Spread recommended reducing the equity commitment from 40 percent to 20 percent because electric cooperatives may be unwilling or unable to contribute 40 percent equity to a construction project.

Commission Response

The commission agrees with Calpine that contingency costs must be covered by non-TEF sources. However, the commission declines to set a particular contingency cost level in the rule because such a determination will be made on a case-by-case basis.

An applicant must provide evidence of its ability, or the ability of the borrower's corporate sponsor, to fund the required balance of 40 percent or more of the project costs that are not financed by a TEF loan. The balance of financing separate from the TEF loan can be structured and proposed at the discretion of the applicant; however, a non-binding equity commitment letter for the balance of costs plus the required three percent construction escrow deposit amount is required under §25.510(d)(1), in accordance with PURA §34.0104(g). The commission modifies the provision accordingly. The commission declines to require a specific equity commitment for the final funding of the non-TEF portion of the financing requirement; however, the commission modifies the proposed rule to state that if an applicant is proposing to use equity to fund any of the non-TEF portion, the applicant must provide a binding equity commitment letter with the application. Therefore, it is unnecessary to use 20 percent as an equity requirement, as requested by Golden Spread. Accordingly, the commission modifies §25.510(e)(4)(c)(i) and (h)(1)(B)(i) to remove the requirement for at least 40 percent equity and to clarify that other sources of funding besides equity contributions may be used to fund the non-TEF portion of the project costs.

Proposed §25.510(e)(4)(C)(ii)-Applicant Financial Statements

Proposed §25.510(e)(4)(C)(ii) requires evidence of an applicant's creditworthiness including financial statements, statements of the applicant's total assets, total liabilities, net worth, and credit ratings issued by major credit rating agencies.

Advanced Power recommended that a lack of credit rating at the time the application is submitted should not disqualify a project from receiving TEF funding; otherwise, the commission risks "significantly limiting the number of applications received to only those larger developers that have a credit rating at the time the

application is filed." Instead, Advanced Power proposed that applicants may demonstrate the ability to arrange credit financing and an established track record of successfully financing thermal generation projects. Advanced Power made similar comments on subsection (d)(1)(E).

WattBridge suggested requiring financial statements only if the applicant has financial statements available. WattBridge noted that power plant developers often create a new and separate legal entity for specific projects, and this new entity may not have financial statements prior to financial closing. In addition, WattBridge stated that projects' financial viability to repay the TEF loan hinges on ERCOT market revenues and the generation resource meeting the required availability and performance metrics.

NRG recommended requiring financial statements and associated total assets, liabilities, net worth, and credit ratings to come from the applicant or the entity providing the applicant with the equity commitment letter under §25.510(e)(4)(C)(i).

CPV recommended qualifying the requirement to provide credit ratings with "if applicable" to allow for privately held companies to participate in the TEF.

HEN suggested requiring credit ratings only if the applicant is rated by major credit agencies. Privately held companies may not have a credit rating but can provide financial statements to demonstrate creditworthiness.

Wartsila and GRIT recommended adding three new subparagraphs adopting a holistic review of an applicant's net worth, liquidity, and other financial statements.

Commission Response

The commission modifies the rule to require an applicant to provide financial statements, if available, for itself and its parent company. The commission also clarifies that sponsors or applicants are not required to have credit ratings issued by major credit rating agencies but do need to provide audited financial statements for a minimum of five years. If sponsors or applicants do have credit ratings, those ratings will be considered during the TEF administrator's due diligence.

Proposed §25.510(e)(5)-Application Requirements and Process

Proposed §25.510(e)(5) describes the project information that is required to be included in the application process.

Sierra Club recommended adding a requirement for applicants to show how the facility will contribute to meeting "overall energy use" in the ERCOT region.

Commission Response

The commission declines to modify the rule as requested by the Sierra Club because it is unnecessary given the performance standards that are required under §25.510(h)(1)(A). However, applicants are free to include this information in the narrative response to §25.510(e)(5)(A).

Proposed §25.510(e)(5)(A)-Project Information

Proposed §25.510(e)(5)(A) requires an applicant to provide a narrative explanation that details how the facility will contribute to reliability during peak winter and summer load in the ERCOT region, including the project's plans for ensuring adequate fuel supplies and preparations for compliance with 16 TAC §25.55 (relating to Weather Emergency Preparedness).

Vistra recommended that registration with ERCOT as a generation entity should be required of all facilities receiving state funds, such as from the TEF, to ensure the weatherization requirements of §25.55 apply and to be consistent with SB 2627's goal of improving reliability.

Commission Response

The commission agrees with Vistra and, while registration of the facility's GR as a generation resource with ERCOT already would require the recipient to adhere to the requirements of §25.55, the commission modifies the rule to explicitly require the electric generating facility qualifying for the TEF loan to adhere to the requirements of §25.55.

Proposed §25.510(e)(5)(C)-Project-Specific Information

Proposed §25.510(e)(5)(C) requires an applicant to submit project-specific information that will allow the commission to determine and evaluate the viability and attributes of the electric generating facility.

Shell Energy recommended the commission require that projects undergo a certification of feasibility by an independent engineer to address the feasibility of the project, its location, and all supporting commercial agreements relating to fuel, water, site control, and interconnection.

USA Compression recommended that the application allow applicants to list each "individual electric generating facility" that is part of the applicant's "new/upgraded electric generating facility"; provide separate descriptions of the operational attributes of each individual electric generating facility that is a part of the applicant's new or upgraded electric generating facility; and include separate construction schedules and commercial operations dates for each individual electric generating facility that is a part of the applicant's new/upgraded electric generating facility.

Commission Response

The commission agrees with Shell Energy and adds subsection (f)(3) to the proposed rule to state that an applicant must submit a feasibility study at the applicant's expense, prepared by an independent engineer, that aligns with leading industry practice for review by the TEF administrator. The feasibility study is not required at the time of application but can be included in the application as supporting documentation if it is available.

The commission disagrees with USA Compression's recommendation to permit listing, descriptions, and construction schedules and commercial operations dates for individual facilities because the aggregation of discrete facilities to meet the requirements of a TEF loan is not permissible. However, the commission notes that a single facility may comprise multiple GRs, and additional detail for each GR is appropriate. The commission modifies the provision to explicitly require resource-level detail.

Proposed §25.510(e)(5)(C)(i) - Application Requirements and Process

Proposed §25.510(e)(5)(C)(i) requires a table with the resource operation attributes, including nameplate capacity, seasonal net maximum sustainable ratings during winter and summer, cold and hot temperature start times, and the original equipment manufacturer's estimated EAF calculation in NERC GADS be submitted during the application.

USA Compression recommended the commission prioritize flexible, fast-ramping, multi-hour-duration dispatchable generation

projects for In-ERCOT Generation Loans and to add "resource ramp rate" as an attribute as a required field in the table.

Commission Response

Though it is not definitive, ramp rate is an indicator of generator flexibility, which can support reliability. The commission notes that ramp rate is listed in §25.510(f)(1)(A)(iv). Therefore, the commission modifies the rule to align the requested information in §25.510(e) with the evaluation criteria in §25.510(f).

However, the commission declines to specifically prioritize an application for flexible, fast-ramping, multi-hour-duration dispatchable generation projects because the commission prioritizes applications that best meet statutory criteria, and the TEF administrator will assess projects holistically after first accounting for statutory criteria.

Proposed §25.510(e)(5)(C)(i), (f)(1)(A)(ii), and (f)(1)(A)(iv)-Application Requirements and Process, Evaluation Criteria

Proposed §25.510(f)(1)(A)(ii) evaluates the applicant's quality of services and management, as shown by the applicant's prior history of electricity generation in Texas and the United States, and proposed organizational structure for the project for which the applicant seeks a loan. Proposed §25.510(f)(1)(A)(iv) evaluates the applicant's resource operation attributes, including fuel type and heat rate, seasonal net maximum sustainable rating, resource ramp rate, and capacity factor.

Wartsila recommended implementing a three-step framework to evaluate loan applications so that funding is prioritized based on project readiness, financial solvency, and resource attributes. Wartsila suggested that applicants must earn a satisfactory evaluation in each phase of the application process. Wartsila's proposed three-phase evaluation process incorporated the following steps: verification of project diligence and timeline; evaluation of applicant creditworthiness and project suitability; and evaluation of proposed project's resource attributes and benefit to the ERCOT bulk power system.

Commission Response

The commission will evaluate applications for program eligibility based on the requirements enumerated in PURA §§34.0104 and 34.0106 and for compliance with the criteria detailed in §25.510(f). Applications will be assessed based on their response to statutory and regulatory evaluation criteria, which does not necessarily align with a project's phase of development.

Each application will undergo a due diligence review, an evaluation of the applicant's or sponsor's creditworthiness, and an assessment of project feasibility, to include a review of the proposed resource's operational attributes, as detailed in the evaluation criteria enumerated in §25.510(h). Accordingly, it is unnecessary to modify the rule as recommended by Wartsila.

Proposed §25.510(e)(5)(C)(ii)-Project-Specific Information

Proposed §25.510(e)(5)(C)(ii) requires the applicant to submit a statement indicating whether the electric generating facility will serve an industrial load or PUN, and if so, a description of how the electric generating facility will primarily serve and benefit the ERCOT bulk power system given its relationship to an industrial load or PUN. Additionally, the rule requires an applicant to state whether full generation output would be available to the ERCOT bulk power system during any EEA, and provide a copy of any information submitted to ERCOT regarding PUN net generation capacity availability.

HEN recommended revisions to strengthen the requirements for a GR located within a PUN or serving a retail load to qualify for a loan. Specifically, HEN recommended the statement include details of all obligations or commitments of the generating facility to provide capacity to the industrial load or PUN as well as information regarding the facility's metering and interconnection arrangements.

Commission Response

The commission agrees with HEN's recommendation and modifies the rule to specify that a generating facility that is serving an industrial load or PUN must provide an attestation relating to (i) the net nameplate capacity that will be dedicated to ERCOT, (ii) details of the facility's obligations or commitments to the industrial load or PUN, and (iii) availability of its entire available capacity to ERCOT during an energy emergency alert. However, the commission notes that the metering and interconnection arrangements should be reflected on the required one-line diagrams and declines to restate that requirement here.

Proposed §25.510(e)(5)(C)(iii)-Project-Specific Information

Proposed §25.510(e)(5)(C)(iii) states an applicant should provide a one-line diagram of the proposed project, if available.

TPPA requested that the commission provide a definition and clarify the meaning of a "one-line diagram." Specifically, TPPA asked whether the requested one-line diagram would be at the plant level or for transmission planning, as there is a substantial difference between the two. TPPA recommended that, if the one-line diagram is to "locate the project within the ERCOT transmission system" then it be a "firm" requirement and the phrase "if available" be removed from the rule.

Commission Response

The commission notes that the term "one-line diagram" is a generally understood term in the electric industry and does not require a definition. However, the commission agrees that additional clarity regarding the subject matter of the requested "one-line diagram" is appropriate. The commission notes that the requested one-line diagram is at the facility level. The commission also agrees with TPPA's suggestion to remove the phrase "if available," as a proposed one-line diagram should be available at the time of application.

Proposed §25.510(e)(5)(C)(vi) and (e)(5)(C)(xii)-Project-Specific Information

Proposed §25.510(e)(5)(C)(vi) requests a description of the electrical interconnection plan, including, among other things, a copy of the executed standard generation interconnection agreement (SGIA). Proposed §25.510(e)(5)(C)(xii) requests a proposed project schedule with anticipated dates for major project milestones, such as execution of the SGIA.

Vistra and HEN recommended changing the requirements in §25.510(e)(5)(C)(vi) for submitting for the signed SGIA. Vistra suggested removing the SGIA requirement and instead requiring completion only of the screening study as an application prerequisite because it is not required by statute and would "impede the TEF program's ability to meet the statutory deadline of disbursing all initial funds before December 31, 2025." Vistra explained completion of a screening study, which takes 45-90 days, is a reasonable filter to show that an applicant is sufficiently committed to the proposed projects. Vistra also noted other SGIA prerequisites, such as a full interconnection study with the TSP, may take up to a year to complete and that

a generator will be incurring administrative, engineering, and legal fees during that time. HEN recommended requiring the provision of the executed interconnection agreement in the loan application only if available because a utility may not execute an SGIA until the full interconnection studies are completed. HEN noted that such a change would also align the provision with 25.510(e)(5)(C)(xii) which requires the proposed project schedule, including the expected date to execute the interconnection agreement.

TPPA requested clarity as to whether an executed SGIA is a requirement for the application or if a timeline with an anticipated date of execution would satisfy both proposed §25.510(e)(5)(C)(vi) and (e)(5)(C)(xii). TPPA also recommended that the rule require a signed letter of intent or memorandum of understanding for MOUs and electric cooperatives instead of a full SGIA because the SGIA requirement would force MOUs and electric cooperatives to execute an interconnection agreement with themselves when interconnecting their own generation to their own transmission facilities.

Wartsila approved of the requirement for a signed SGIA and recommended removing the language "if completed" related to the interconnection screening study found in §25.510(e)(5)(C)(vi).

Commission Response

The commission agrees with commenters that completion of the SGIA is a step that arrives later in project planning and, as a result, requiring applicants to submit a copy of an executed SGIA may unnecessarily limit the number of eligible projects. Therefore, the commission agrees with HEN's recommendation to eliminate the requirement and modifies the provision accordingly. In addition, the commission modifies (e)(5)(C)(vi) to require a copy of the ERCOT screening study and the full interconnection study only if completed. If these studies have not been completed at the time of application, the applicant should provide projected dates for these milestones in its proposed project schedule, as required by (e)(5)(C)(xii). In response to TPPA, the commission modifies (e)(5)(C)(xii) to require a projected date for execution of the SGIA only if applicable.

Proposed §25.510(e)(5)(C)(ix)-Project-Specific Information

Proposed §25.510(e)(5)(C)(ix) requires a list of all required environmental, construction, and operating permits with current approval status.

Advanced Power recommended the commission require a comprehensive permitting matrix that includes an outline of timeframes and methodology, or confirmation that certain permits are not required. Advanced Power expressed concern that the proposed language creates ambiguity regarding the required status of the permitting included in the matrix. Advanced Power also suggested the provision be revised for clarity regarding the required status of all necessary permits at the time the application is submitted.

Sierra Club recommended requiring applicants to give a timeline for receiving final permit approval.

Commission Response

The commission confirms that applicants will be required to submit permitting information and status on all necessary permits and approvals as part of the application process. The necessary permits depend, in part, on the design and characteristics of the facility. Thus, the commission declines to provide an exhaustive and exclusive list. The commission will use this information to evaluate project feasibility as described under §25.510(f)(2)(D).

Proposed §25.510(e)(5)(C)(x)-Project-Specific Information

Proposed §25.510(e)(5)(C)(x) requires a description of the air emissions compliance plan, including evidence of receipt of any required air emissions credits.

WattBridge recommended removing the requirement to have air emission credits in hand at time of application due to the expense and risk associated with their purchase prior to the start of construction.

Commission Response

Section 25.510(e)(5)(C)(x) does not require the applicant to have air emissions credits in hand at the time of application, though an applicant may submit any evidence showing that it has obtained air emissions to demonstrate project readiness.

Proposed §25.510(e)(5)(C)(xi)-Project-Specific Information

Proposed §25.510(e)(5)(C)(xi) requests a detailed financial forecast of cash available for debt service, covering a period equal to the repayment period of the loan, including sources of revenue and an annual operating and maintenance budget.

Calpine recommended requiring applicants to include financial forecasting of cash available for emergency conditions in addition to the currently required financial forecasting. Further, Calpine suggested the commission should give preference to applicants who can demonstrate sufficient financial resources to address emergency circumstances to ensure public confidence that a TEF loan recipient will be ready and available to perform in the event of an emergency.

Vistra recommended adding the requirement of sources of capital to §25.510(e)(5)(C)(xi).

Commission Response

The commission confirms that, as part of the application process, the borrower will be requested to provide a detailed financial model including forecasted revenues, expenses, cash flows, and all financial statements. The commission modifies the rule to reflect this.

The commission declines, however, to require applicants to demonstrate access to specific financial resources for use in emergency conditions. Facilities must adhere to the commission's weather preparedness requirements under §25.55, and thus financial resources needed to meet those regulations will already be incorporated into the project's financial forecasts.

Proposed §25.510(e)(6)-Estimated Cost

Proposed §25.510(e)(6) lists the costs to be included in the estimated costs provided in a project application.

Shell Energy recommended that development fees associated with affiliate transactions and any dedicated PUN costs should not be considered a project cost for purposes of the loan program and that no program funds should be forwarded for payment of these types of items.

TPPA recommended requiring projections for ongoing maintenance and operational costs, such as staffing and fuel, to ensure efficient use of taxpayer dollars.

NRG suggested that project costs should include a reasonable project contingency of up to 5 percent for potential unknown costs, loan interest accrued during construction, and property

tax payments. NRG stated the inclusion of such costs is standard industry practice and recommended these costs be explicitly stated to be covered by a TEF loan to remove any ambiguity.

CPV recommended including additional estimated project costs in §25.510(e)(6) for items such as consultants, contingency costs, and taxes and insurance.

TCPA recommended if the commission permits PUNs to qualify for the TEF, no less than 51 percent of total facility net energy output in the ERCOT wholesale market should be eligible for a loan. TCPA argued that the eligible amount of the loan should be tied directly to the percentage of total net energy output in the ERCOT wholesale market. TCPA added that costs directly attributable to or associated with the portion that serves the PUN or industrial load should not be eligible.

HEN recommended the commission require applicants to provide total estimated dollar cost per MW so that applications can be comparatively evaluated.

Calpine and HEN requested the commission clarify what costs are intended to be included in §25.510(e)(6)(H), related to interest rate protection costs. HEN stated that because the interest rate in the loan is fixed at three percent, protection should not be required for the loan itself. HEN suggested that, if the intent is for the interest rate protection to apply to the financing for the remaining 40 percent of the project, such protection may not be necessary or applicable in all instances.

Commission Response

The commission confirms that applicants must include all estimated projects costs directly related to the project under consideration for a TEF loan. These costs should be described in detail in the independent engineer's report described in (f)(3) or other supporting information submitted by the applicant. Where the costs in CPV's list are directly related to the project under consideration, the commission confirms that these costs should be submitted as part of an application. The commission agrees with NRG's suggestion for interest accrued and capitalized during construction to be included as a project cost and modifies the provision accordingly. However, the commission disagrees with NRG's suggestion for contingency costs to be included because if a contingency occurs and must be covered by the TEF, it could result in the TEF loan funding more than 60 percent of project costs.

The commission agrees with Shell Energy and TCPA that costs for a PUN that will finance provision of service to the PUN and not to the ERCOT market should not be eligible for a TEF loan. The commission accordingly modifies (g)(1) to clarify that in the case of an electric generating facility that serves an industrial load or PUN, eligible costs will consist of no more than 60 percent of a percentage of total estimated facility costs equal to the percentage of the total capacity of the facility that is dedicated to ERCOT. However, the commission declines to specify in the rule that costs for affiliate transactions are not allowed because it is unnecessary.

The commission declines to modify the rule as suggested by TPPA because a financial forecast that includes an operating and maintenance budget is already required in (e)(5)(C)(xi).

The commission agrees with HEN that interest rate protection costs are not required as TEF loans will be fixed-rate loans and removes the provision. However, the commission disagrees with HEN's suggestion to require applicants to submit their dollars per MW costs. Consideration of total estimated costs is a statutory requirement. Applicants must provide, and the commission must evaluate, the total estimated costs of the facility.

Calpine recommended specifying acceptable documentation to adequately prove up each category of cost described in §25.510(e)(6) and suggested the rule include a process to confirm an applicant's projected costs within a margin of accuracy. Calpine proposed that applicants exceeding this margin must fund the excess through equity, or otherwise without reliance on TEF loan distributions. Calpine stated this would help ensure accountability and the exercise of due diligence by applicants to estimate total project costs. Calpine further recommended the commission be permitted to consider exigent circumstances resulting in increased project costs above the amounts disclosed in the application and should have discretion to continue an applicant's eligibility if an applicant or recipient exceeded the established margin of error.

Advanced Power recommended the provision be revised to clarify how the estimated project costs will be considered because project developers are unlikely to have executed agreements at the time the application is submitted. Advanced Power explained that project cost estimates may change significantly during the course of the application, which would make any estimates provided to the commission become outdated. Accordingly, Advanced Power suggested that the applicant provide the estimated project costs with the application, and that an opportunity to re-evaluate and potentially update those cost estimates prior to financial close be provided under the rule.

Commission Response

The commission declines to modify the rule as suggested by Calpine and Advanced Power because no additional clarification is warranted. The commission modifies the rule at (f)(3) to require an applicant to provide an independent engineer's report as a required project document during the due diligence phase of the application, and the TEF administrator will evaluate these documents to verify estimated project costs, including contingency costs. Additionally, the project costs provided by the applicant should align with the project cost inputs in its financial forecast model. Material changes in project cost estimates during the review of an application will be considered on a project-by-project basis and may result in the reduction of eligible loan proceeds or the rejection of a loan application amount because the material changes in project cost estimates could impact the feasibility of the project or the creditworthiness of the applicant or the sponsor.

Proposed §25.510(e)(6)(A)-Application Requirements and Process

Proposed §25.510(e)(6)(A) requires applicants to provide expenses related to development, construction, and capital commitments required for the project to reach completion.

Calpine recommended adding the term "contingency" as one type of commitment required to be provided in the application.

Commission Response

The commission confirms that the level of contingencies required will be determined during due diligence and must be funded by sources other than the TEF loan. For these reasons, the commission declines to modify the provision as requested by Calpine.

Proposed §25.510(f), §25.510(h)(1)(B)(iii), (h)(1)(G), and (i)(4)-Evaluation Criteria, Loan Term and Agreements, Deposits

Proposed §25.510(f) describes the evaluation criteria for a loan application. Proposed §25.510(h)(1)(B)(iii) establishes that the commission will review a borrower's construction drawdown certificate. Proposed §25.510(h)(1)(G) requires a borrower to register with the commission as a power generation company, unless the borrower is an MOU, cooperative, or river authority, and to register the project facility with ERCOT as a generation resource. Proposed §25.510(i)(4) establishes that the commission will evaluate notices of satisfaction to determine whether a borrower is entitled to withdraw its deposit.

NRG recommended the commission set a 90-day timeline for application evaluation because applications are not contested cases, and CBG applicants need to quickly begin construction of plants. NRG also stated that it would appreciate a document that outlines the process, including communications protocols.

TPPA recommended expanding §25.510(f) to include procedural details like discrete timelines for the commission review process, who will be conducting the review, whether evaluators will be permitted to contact an applicant directly or request additional information or modifications to an application, and whether applications would be processed in the order filed or under a prioritization process. TPPA recommended the same request in §25.510(h)(1)(B)(iii), (h)(1)(G), and (i)(4).

Sierra Club suggested a process where an applicant can fix a deficiency if it has been identified and recommended that there be parameters in place to prevent repeat deficiencies. Sierra Club also requested that applicants be walked through any deficiencies.

Commission Response

The commission declines to provide a specific timeline under which it will evaluate applications, as requested by NRG and TPPA. The timeline of the loan approval process will depend on the completeness of the application, complexity of the project, and preparedness of the applicant. However, the commission agrees with TPPA that additional details on the evaluation process would be helpful and adds (f)(3) to include such details.

The commission modifies the rule to add the completeness of an application as an evaluation criterion in new subsection (f)(1)(C). Should an application not contain sufficient information for the TEF administrator to conduct a thorough evaluation, the TEF administrator may notify the applicant through a web-based application system of such a deficiency.

Proposed §25.510(f)(1)-Evaluation Criteria

Proposed §25.510(f)(1) describes the criteria the commission will use to evaluate applications.

WattBridge suggested prioritizing funding for applicants based on resource attributes and project location with respect to demand in ERCOT. WattBridge recommended prioritizing projects using a weighted assessment of resource flexibility, fuel efficiency, historical availability, thermal derate, and water consumption. Further, WattBridge suggested prioritizing projects that have flexible fuel-efficient resources that derate marginally in extreme weather and can support dual or backup fuel for resilience.

LSP suggested the commission specify the minimum project requirements as evaluation criteria, place more emphasis on the developer's track record and reputation, and develop clear and concise guidance that assists project developers in evaluating tradeoffs and allows the applicant to propose highly responsive projects that serve the needs of the commission. LSP also requested the commission identify the characteristics or combination of characteristics it values the most and recommended the commission require project applicants state in their applications the minimum amount of TEF debt that would make their projects viable.

HEN commented that cost is a critical component of prioritization. HEN suggested the commission consider a diversity of resources and geographical locations as components in its evaluation criteria.

TPPA requested clarification on whether the criteria in §25.510(f)(1) are individual, nondiscretionary requirements or if the requirements are part of a holistic review. TPPA encouraged the commission to consider MOU applicants as eligible for funding.

Drax Group recommended that the commission evaluate generators that have successfully operated generation assets internationally, even if the applicant has not operated generators domestically.

TCPA recommended complete transparency on how the applications will be scored and that if there are any criteria beyond the statutory requirements, then those criteria should be communicated to the market very clearly prior to any NOI to apply is taken.

Calpine, LSP, NRG, LCRA, WattBridge, Vista, and HEN all agreed with the idea of a scoring rubric. HEN further supported a detailed application form with clarification on the specific pieces of evidence that the commission is seeking. HEN recommended that the rubric should strike a balance that allows for a variety of projects that meet the fundamental requirements of the statute while not being too specific.

NRG commented that it is important to understand what needs to be submitted as part of the application process.

LCRA recommended that the statutory requirements be the primary criteria that are evaluated. LCRA also requested clarification on what the weighting will be and what specific evidence the commission is looking for in each of the criteria.

Commission Response

The commission intends to evaluate the information requested of and provided by an applicant on a holistic basis, as explained above in Loan Application Evaluation Methodology, and so disagrees with commenters' requests that the commission declare preference for any particular project attribute or applicant profile that is not explicitly enumerated in §25.510(f). Instead, the commission seeks to encourage a broad range of applicants to submit viable proposals that address the goals of the TEF.

Similarly, it is unnecessary to specify minimum project requirements as evaluation criteria, as suggested by LSP, because the proposed rule already contains minimum eligibility criteria to apply, which all applicants and projects must meet. It is also unnecessary to require an applicant to state the minimum amount of a TEF loan that would make its project viable, as suggested by LSP, because the TEF administrator will determine during due diligence the amount of funding each proposed project and applicant merit. However, in response to TPPA's comments, the Commission notes in that the evaluation criteria are not independent requirements.

The commission agrees with TPPA that MOUs are eligible to apply for a TEF loan and modifies §25.510(g)(6) and (h)(1)(G) accordingly.

Regarding commenters' requests to clarify the TEF loan application evaluation process, §25.510(c), (e), and (f) together state the bases on which the commission will make its TEF funding decisions. Applications will be assessed against these criteria and against other applicants' responses to those criteria. Providing a predetermined weighting rubric may unnecessarily restrict the commission's ability to evaluate unique proposals. Additionally, providing a scoring rubric could lead to applicant gamesmanship, and therefore, the commission declines to accept the recommendations of Calpine, LSP, NRG, LCRA, WattBridge, Vista, and HEN to provide a scoring rubric.

Proposed §25.510(f)(1)-Evaluation Criteria

Proposed §25.510(f)(1) describes the criteria on which the commission will evaluate a project proposal.

Shell Energy recommended that priority be given to projects that have a robust hedge strategy with contracted revenues for the capacity and energy of the facility with a financially sound energy trading partner. Shell Energy suggested that this requirement would be superior to an evaluation based solely on the forecasted energy price and ensure certainty around contract revenues with credit-worthy counterparties.

NRG recommended that the commission not evaluate a project's hedging strategy as part of its prioritization criteria.

Commission Response

The commission will evaluate an application holistically based on its entire business plan, including market prices and hedging strategies, if any, to determine the feasibility of the project. To make this evaluation criterion clearer and align it more closely with the requested information in §25.510(e)(5)(C)(xi), the commission modifies §25.510(f)(1)(B) to include evaluation of total forecasted revenues generated by the project alongside the total estimated costs of the facility.

Proposed §25.510(f)(1)(A)(i) and (f)(1)(A)(iii)-Evaluation Criteria

Proposed §25.510(f)(1)(A)(i) lists as an evaluation criterion the quality of services and management, as shown by the applicant's prior history of electricity generation in this state and this country. Proposed §25.510(f)(1)(A)(iii) lists as an evaluation criterion the history of electricity generation in this state and country.

TPPA recommended that §25.510(f)(1)(A)(iii) not repeat the language of §25.510(f)(1)(A)(i). TPPA commented that the Legislature presumably intended for separate evaluation criteria to require separate analyses, and that the proposed rule appears to collapse these two criteria into one.

Commission Response

The commission agrees with TPPA's recommendation and amends the rule to remove the redundancy. However, to align more closely with PURA §34.0104(c)(1)(C), the commission removes the reference in §25.510(f)(1)(A)(i) rather than the reference in §25.510(f)(1)(A)(iii). Although "prior history of electricity generation in this state and this country" can be indicative of an applicant's quality of services and management, it is not the exclusive manner of demonstrating such quality. Accordingly, the commission modifies the rule to remove any such implication.

Proposed §25.510(f)(1)(A)(i), (f)(1)(A)(ii), and (f)(1)(A)(iii)-Applicant's Quality of Services and Management & Efficiency of Operations & History of Electricity Generation Operations

Proposed §25.510(f)(1)(A)(i), (f)(1)(A)(ii), and (f)(1)(A)(iii) evaluate the applicant's quality of services and management & efficiency of operation & history of electricity generation operations.

Calpine recommended the commission determine a minimum number of years' experience that an applicant must have in each of these categories, or establish a different objective threshold, for an applicant to make a sufficient showing to qualify for a TEF loan.

Commission Response

Although years of experience is a consideration in evaluating an application, the commission declines to impose a strict minimum that might exclude an otherwise acceptable application.

Proposed §25.510(f)(1)(A)(i) and (f)(1)(A)(ii)-Applicant's Quality of Services and Management & Efficiency of Operations

Proposed §25.510(f)(1)(A)(i) and (f)(1)(A)(ii) evaluate the applicant's quality of services and management and efficiency of operations.

Wartsila recommended the commission consider an applicant's experience in any Northern American country, instead of limiting it to Texas and the United States. Wartsila provided redlines consistent with its recommendations.

Commission Response

The commission will evaluate sponsors and applicants based on experience developing, owning, and operating relevant power generation assets in Texas and the United States. However, the commission will review applications holistically, and a lack of experience in Texas or the United States will not disqualify an applicant from receiving a TEF loan.

Proposed §25.510(f)(1)(A)(iv)-Applicant's Resource Operation Attributes

Proposed §25.510(f)(1)(A)(iv) evaluates the applicant's resource operation attributes, including fuel type and heat rate, seasonal net maximum sustainable rating, resource ramp rate, and capacity factor.

USA Compression recommended adding cold and hot temperature start times to the evaluation criteria to align with the application requirements.

Commission Response

The commission agrees with USA Compression's recommendation and modifies the rule to align more clearly the requested information in §25.510(e)(5)(C)(i) with evaluation criteria in §25.510(f)(1)(A)(iv).

Proposed §25.510(f)(1)(A)(v)-Ability to Address Regional and Reliability Needs

Proposed §25.510(f)(1)(A)(v) evaluates the applicant's ability to address regional and reliability needs.

TXOGA commented that there is a need for flexibility among resources available to help support the grid by having units throughout the state instead of in major generation pockets like the state currently has installed.

Commission Response

The commission confirms that proposed §25.510(f)(1)(A)(v) does include "ability to address regional and reliability needs" as a consideration, and no further changes to the proposed rule are needed to address siting diversity concerns.

The commission modifies subsection (e)(5)(A) of the rule to explicitly require resources availing the TEF funds to adhere to §25.55, Weather Emergency Preparedness.

Proposed §25.510(f)(1)(A)(vii)-Evidence of Creditworthiness

Proposed §25.510(f)(1)(A)(vii) evaluates the applicant's evidence of creditworthiness and ability to repay the loan on the terms established in the loan agreement.

Calpine recommended the commission review an applicant's other assets to determine creditworthiness and that an applicant should be required to show it has sufficient credit to operate in the ERCOT wholesale market and not just to obtain a loan. Calpine commented that, if a facility that has received loan proceeds should default on its obligations to ERCOT, the facility would also undoubtedly default on the terms of its loan.

TPPA suggested referencing text from PURA §34.0104(c)(1)(G) ("total assets, total liabilities, net worth, and credit ratings issued by major credit rating agencies").

Vistra recommended adding "access to capital" to this evaluation criteria.

Commission Response

The commission agrees with TPPA's suggestion and modifies the rule to include the examples listed in PURA §34.0104(c)(1)(G), which will be considered, if applicable. Although the commission will evaluate other evidence of creditworthiness, if provided, the commission declines to add additional requirements as proposed by Calpine and Vistra.

Proposed §25.510(f)(1)(B)-Nameplate Generation Capacity and Total Estimated Cost

Proposed §25.510(f)(1)(B) evaluates nameplate generation capacity and total estimated costs of the facility for which the loan is requested.

CPV recommended removing the total estimated cost from the evaluation criteria as the costs of dispatchable generation may vary from site to site but will predominantly fall within a predictable range of costs per kilowatt. CPV further stated that utilizing this measure as part of the evaluation tool promotes "gaming" in the application process and an applicant could artificially lower the project's total cost to receive a loan, only to increase those costs later.

Vistra recommended that loan applications should be evaluated primarily based on those statutory criteria in SB2627 and that statutory requirements should be prioritized.

Commission Response

The commission recognizes that an applicant's projected nameplate generation capacity and project costs are subject to error and gamesmanship. However, the commission's ability to provide loans using the TEF is limited in terms of MWs and dollars. Applicants are in the best position to provide accurate estimates for their projects. Therefore, the commission rejects CPV's recommendation. The commission further notes that PURA §34.0104(d) imposes a 10,000 MW limitation, and the amount of money held by TEF is finite. Accordingly, consideration of nameplate capacity and total estimated costs is effectively a statutory requirement. Applicants must provide the nameplate generation capacity and total estimated costs of the facility. Additional project costs beyond the TEF loan proceeds must be funded by the applicant.

Proposed §25.510(f)(1)(B) and §25.510(f)(2) - Multiple Evaluation Criteria

Proposed §25.510(f)(1)(B) evaluates nameplate generation capacity and total estimated costs of the facility for which the loan is requested. Proposed §25.510(f)(2) outlines additional considerations for evaluation criteria.

HEN recommended moving some criteria from the permissive evaluation provision in §25.510(f)(2) to the mandatory evaluation provision in §25.510(f)(1). HEN suggested that most of the evaluation criteria relating to the proposed generating facility itself are not mandatory, and nearly all the mandatory considerations relate to the applicant and not the project. HEN provided redlines consistent with its recommendations, including the addition of a new subparagraph, §25.510(f)(3), that states "As part of its evaluation process, the commission shall consider the portfolio of qualified loan applications and award loans to a diversity of generating facilities to enhance reliability and resiliency, including different geographical locations with ERCOT, differing fuel types and fuel supply sources and arrangements and a range of commercial operation dates. Final loan awards may not exceed the amount requested by the applicant in its application and evaluated by the commission in selecting among qualified loan applicants."

Drax Group recommended adding new subsections §25.510(f)(2)(K) and (f)(2)(L) for onsite fuel capabilities to enhance reliability by encouraging generation with onsite fuel storage capabilities. Drax Group provided redlines consistent with its recommendations.

NRG stated that neither the project technology nor the project costs should factor in as part of the prioritization to review.

Vistra commented that access to capital or liquidity is a reasonable addition, but additional evaluation criteria added by the commission should be prioritized as secondary features to the statutory criteria.

WattBridge commented that it is concerned about timing and recommended that some of the priorities be scored on a pass or fail basis.

Commission Response

The commission will evaluate applications holistically using the criteria and priorities described in the rule and this document. In response to commenters' suggestions to evaluate the operational attributes, including fuel types and project technology, the commission modifies the rule to clearly indicate that the information requested in (e)(5)(C)(i) will be part of the evaluation criteria in (f)(1)(A)(iv).

The commission declines to explicitly prioritize the diversity of resource type and geographic location of proposed projects because the applicant pool is unknown at this time, and such a restriction could unnecessarily limit the number of projects funded through the TEF.

Although onsite fuel storage capability may be beneficial, it is not a necessary attribute for an application. ERCOT currently procures firm fuel supply service (FFSS) for reliability purposes. The commission declines to further incentivize this program via additional priority in evaluation criteria. However, the expected

ability to provide FFSS can be considered in other criteria where applicable (e.g., forecasted revenue).

The commission has already given more weight to statutory criteria, as suggested by Vistra, and no changes are needed as a result.

Proposed §25.510(f)(2)-Additional Considerations for Evaluation Criteria

Proposed §25.510(f)(2) outlines additional considerations that the commission may use to evaluate applications.

Calpine recommended prioritizing applications that do not need to draw on the loan after COD and applications that can demonstrate firm fuel supply capabilities as this will ensure that the first loan recipients have sufficient access to capital to cover the requisite 40 percent of anticipated construction costs, plus the three percent deposit, plus contingencies, while also providing an incentive to undertake construction of new dispatchable generation in line with the intent of SB 2627. Calpine suggested that this prioritization would also serve to protect taxpayers' interests by increasing the likelihood that the applicant will not default on its loan payment obligations. It also recommended that the commission prioritize loan applications that can ensure firm fuel procurement, such as through onsite storage or through firm fuel contracts, over those that cannot, as this is consistent with the goal of SB2627 to ensure increased reliable dispatchable generation in the ERCOT region. Calpine provided redlines consistent with its recommendations.

Shell Energy recommended giving preference to projects based on locational advantages to serve load, proximity to load centers, lower cost to interconnect, lower project cost per MW, and ability to reduce congestion.

Targa recommended adding a requirement specifying that a PUN that serves a critical gas supplier or critical customer is eligible for a loan due to the reliability function it serves, regardless of whether it provides excess energy to the ERCOT grid.

Commission Response

The commission intends to consider the complete financial picture associated with a proposed project and declines to place special emphasis on whether an applicant will need to utilize TEF proceeds after COD, as suggested by Calpine.

Although onsite fuel storage capability may be beneficial, such capability is already incentivized via the existence of FFSS. The commission declines to further incentivize this program via additional priority in evaluation criteria. However, the expected ability to provide FFSS can be considered in other criteria where applicable (e.g., forecasted revenue and the ability to address reliability needs).

In response to Shell Energy's comments, the commission notes that there are already programs in place to encourage siting GRs near load and declines to further incentivize it in the application evaluation process. Furthermore, the commission notes that the ability to address regional and reliability needs is already an evaluation criterion under §25.510(f)(1)(A)(v). The commission will review applications and their ability to meet the goals of the TEF holistically.

Regarding Targa's recommendation, PURA §34.0104(a) and §34.0106(b) collectively require that TEF loans explicitly prioritize the provision of power to the ERCOT power region over industrial loads or PUNs. It does not contain an exception for load attributable to critical gas suppliers or critical customers. Without a statutory basis for Targa's recommendation, the commission declines to modify the proposed rule as requested.

TPPA requested more details about considerations of the permissive criteria. TPPA stated that applicants must understand evaluation criteria and that, if the commission uses different set of criteria to evaluate one application versus another, it will be difficult to ensure applications were evaluated fairly and non-arbitrarily.

Commission Response

The commission declines to provide more detail about the permissive evaluation criteria because it is unnecessary. Both the mandatory and permissive sets of criteria are described in the rule, and all applicants will be evaluated by those same sets of criteria.

Proposed §25.510(f)(2)(H)-Sufficiency of the Applicant's Proposed Sources of Equity

Proposed §25.510(f)(2)(H) indicates that the commission may consider the sufficiency of the applicant's proposed sources of equity to cover the costs of the facility not funded through a loan provided under this section.

LCRA recommended including "debt" as a funding source that applicants can use for the non-TEF-funded project costs.

Commission Response

Consistent with LCRA's suggestion, the commission modifies (f)(2)(H) by adding "or other funding sources" to reflect alternative means of financing the facility costs not funded through a loan under this section.

Proposed §25.510(g)(1)-Loan to be no more than 60 percent of Estimated Cost

Proposed §25.510(g)(1) states that the approved loan will consist of no more than 60 percent of the estimated cost of the electric generating facility to be completed.

Sierra Club suggested allowing interconnection costs to be included in project cost information.

Wartsila requested clarification on whether the receipt of a loan entitles an applicant the full amount of the loan requested, and if not, what the criteria for awarding a partial loan would be.

Commission Response

§25.510(e)(6)(K) of the rule as proposed includes interconnection costs among estimated project costs, so the commission does not make any change in response to Sierra Club's comment.

The commission may elect to partially fund a project based on the relative creditworthiness of the applicant and feasibility of the project. However, the commission will prioritize TEF loan awards to projects that can be fully funded up to the requested loan amount, which cannot exceed 60 percent of the project estimated costs. Only after all applications have been submitted and initial evaluations are complete can the commission know the amount of funds that may be available for partial loan awards.

Proposed §25.510(g)(1), (g)(2), and (g)(5)-Multiple Loan Structure Requirements

Proposed §25.510(g)(2) and (g)(5) state that the approved loan will (2) be the senior debt secured by the electric generating facility to be completed; and (5) be structured as senior debt secured

by a first lien security interest in the assets and revenues of the project.

LCRA recommended clarifying that all references of "senior debt" throughout this rule are meant to include the borrower's parity debt that is secured by a pledge of and lien on revenues. LCRA suggested for further protection that the commission add rule language to specify that "senior debt" includes debt secured by a lien on assets or other pledge of or lien on revenues, provided that in the case of debt secured solely by a pledge of or lien on revenues, the borrower has a credit rating no lower than investment grade as determined by Moody's Investors Service, Inc., Standard & Poor's Rating Group, or Fitch Ratings (or any successor to such respective credit rating agency).

CPV suggested modifying §25.510(g)(2) to allow applicants to rely on additional senior funded credit facilities to optimize capital sourcing and all-in cost of capital to fund the full cost of the project.

CPS Energy recommended changes to allow MOUs to participate in the loan program notwithstanding public debt obligations of municipal entities in Chapter 1502 of the Texas Government Code. CPS Energy also recommended that a loan secured by an MOU with existing revenue debt obligations should (i) be considered a priority lien pledged on system net revenues on parity with other outstanding priority lien debt; and (ii) be required to include a covenant not to issue additional debt secured by system net revenues except on parity with or subordinate to such priority lien debt.

Commission Response

PURA §34.0104(b)(3) specifies TEF loans to be the senior secured debt and does not specify any other senior level debt. However, CPS Energy and LCRA have identified other statutory restrictions on the ability of an MOU or river authority to grant lien interests in its utility assets. Under the proposed rule, these lien restrictions would effectively preclude their participation in the in-ERCOT Generation Loan Program. At the same time, PURA §34.0104(e) specifically contemplates the inclusion of river authorities as potential borrowers in the in-ERCOT Generation Loan Program. Reading PURA Chapter 34 in its entirety, the commission interprets the legislation to allow river authorities and MOUs to obtain a loan, but only when those entities secure repayment of the debt with the highest form of security permissible under governing law. This interpretation is consistent with the Texas Code Construction Act, which clarifies that, in enacting a statute, it is presumed that "a result feasible of execution is intended." Accordingly, the commission modifies (g)(6) and (h)(1)(G) to allow MOUs and river authorities to secure repayment of a TEF loan with a pledge of revenues of the applicant's utility system. The commission also adds subsections (g)(7) to reflect that a borrower that is an MOU or river authority may meet the loan structure terms through the issuance of a public security in accordance with governing Texas law. This form of securitization is only available to river authorities and MOUs.

The commission declines to modify the rule as recommended by CPV. All applicants must submit information related to their proposed financing structures, which the commission will evaluate as part of the project proposal. While applicants may propose project financing structures with various forms of subordinated debt, applications proposing to use other senior-level debt will not be considered for applicants that are not MOUs or river authorities.

Applicants who wish to use subordinated debt in place of equity are required to assume the cost of drafting intercreditor agreements. The commission modifies the rule to add new paragraph (h)(8) to reflect the necessity of one or more subordination agreements when a borrower intends to use subordinated debt in place of equity.

Proposed §25.510(g)(3)-Loan Repayment of 20 Years

Proposed §25.510(g)(3) states that the approved loan will have a repayment term of 20 years.

LCRA recommended the repayment term of the loan may be "up to" 20 years to ensure consistency between the language of §25.510(g) and the voluntary prepayment provisions in §25.510(h)(1)(E). LCRA provided redline language in line with the recommendation.

NRG recommended clarifying the repayment term. NRG commented that under PURA, the loan is to be for a term of 20 years with repayment starting on the third anniversary of COD and expressed confusion around whether this results in a total term of 23 years. NRG stated that this issue could be addressed in the rule, guidance documents, or loan agreements, but recommended removing "repayment" to preserve flexibility.

Commission Response

Under PURA §34.0104(f), loan repayment is coordinated with the project's respective estimated COD. The loan has an interest-only period during construction and for the first three years after the estimated COD. The entire tenor of the loan does not exceed 20 years, including the interest-only period. The commission modifies the rule to reflect this.

The commission declines to modify the rule as requested by LCRA because including the words "up to" in paragraph (g)(3) would create ambiguity as to whether some loans may be structured for a term shorter than 20 years. All loans will have a 20-year term, and in accordance with the loan agreement details provided in clause (h)(1)(E), all loan agreements will incorporate prepayment conditions.

Proposed §25.510(g)(4)-Loan to be Payable on a Pro Rata Basis

Proposed §25.510(g)(4) states that the approved loan will be payable on a pro rata basis starting on the third anniversary of the estimated COD of the electric generating facility as stated on the application.

LCRA suggested defining "pro rata basis" to mean level debt service.

WattBridge recommended making the repayment terms negotiable between the commission and the applicant. WattBridge also provided redlines in line with its recommendation.

Commission Response

For consistency with PURA §34.0104(f)(2), the commission modifies the rule by replacing "on a pro rata basis" with "ratably."

The commission modifies the rule to reflect WattBridge's recommendation to allow for negotiated repayment terms. The commission agrees that the repayment profile of a given loan should appropriately reflect the project's expected revenue stream. Accordingly, the commission declines LCRA's proposal for level debt service and modifies subsection (g)(5) to structure debt service on a negotiated basis correlated with the applicant's expected revenue.

Proposed §25.510(g)(5)-Loan to be Structured as Senior Debt

Proposed §25.510(g)(5) states that the approved loan will be structured as the senior debt secured by a first lien security interest in the assets and revenues of the project.

LCRA recommended that the pledge of a security interest in assets and revenues of a project should only be required to the extent permitted by law. LCRA noted that Texas law outside of PURA Chapter 34 limits some public entities' ability to grant a lien interest in physical assets. Similarly, CPS Energy stated that Chapter 1502 of the Texas Government Code does not allow a municipal utility to pledge a lien interest in assets of the utility system.

LCRA also recommended that the commission interpret senior debt to include a borrower's parity debt that is secured by a pledge of a lien on revenues. Under this approach, "senior debt" would mean debt having no senior rights to the security interest securing the loan, but which may be on parity secured status with the borrower's other senior debt.

Commission Response

PURA §34.0104(b)(3) requires any TEF loan to be the "senior debt secured by the facility," meaning the assets of the project. However, the commission recognizes that an MOU and a river authority are limited in their ability to provide a lien on utility assets. Therefore, the commission modifies subsection(g)(2) and (g)(6) to allow an MOU or river authority borrower to make a revenue pledge to secure its indebtedness.

Proposed §25.510(h)-Loan Terms and Agreements

Proposed §25.510(h) requires the borrower to enter into one or more agreements with the commission that includes the terms of this section.

LSP suggested allowing customary intercreditor arrangements among the providers of the TEF loan and such other secured indebtedness.

For MOUs, CPS Energy suggested that the terms and covenants to be embedded in these agreements should be in a debt authorization ordinance or resolution consistent with Chapter 1502 of the Texas Government Code, instead of a separate credit agreement. CPS Energy commented that it would be difficult to have a standardized loan agreement because MOUs have different statutory financing obligations than privately-owned entities. Further, CPS Energy recommended that the commission have a separate standard form for MOUs or carve-out provisions in a standard form agreement.

Calpine suggested the commission clarify whether the agreements listed will be developed and negotiated on an applicant-by-applicant basis or if standard form agreements will be developed.

LCRA noted that Texas Special District Local Laws Code Chapter 8503 prohibits LCRA from encumbering its property with a lien interest. Accordingly, LCRA suggested a change to reflect that a secured interest in TEF-funded assets should only be required "to the extent permitted by law."

LSP argued that a standard credit document would not be practical because credit agreements are typically tailored to specific projects. LSP acknowledged that some basic loan terms and conditions could be applicable to all borrowers. LSP recommended developing a term sheet that lists the basic loan tenets such as requirements for term, rate, payment terms, notice, cure, and default provisions, and circulating it for public comment.

NRG supported working towards a standardized form of a loan agreement for borrowers but proposed that certain elements of the credit agreement will need to be tailored for each individual project via exhibits and schedules. NRG recommended that the commission seek stakeholder feedback on the initial draft of the loan forms in a workshop session.

Vistra supported limited contested case proceedings that would allow for a standardized loan agreement while allowing parties to seek modification for good cause.

Commission Response

The commission notes that the first sentence of subsection (h) only reflects that the lending relationship between the commission and a borrower must be memorialized in one or more loan agreements. This means that an approved applicant must enter into a standardized, commercially typical loan agreement that includes terms described in the various paragraphs of subsection (h). In response to Calpine, LSP, and NRG, the commission acknowledges that each TEF-funded project will have specific attributes that call for individualized loan documentation for each borrower. Project-specific attributes will therefore be addressed in each loan agreement on a borrower-by-borrower basis. However, all loan agreements must incorporate the requirements described in the entirety of subsection (h).

The commission agrees with LSP that the loan agreement should allow various creditors to confirm their lien status with respect to facility assets. The commission adds paragraph (h)(8) to require the subordination of any other creditors with respect to the commission. Borrowers that require this arrangement will be responsible for the preparation and cost of any such subordination agreements.

The commission acknowledges the comments of CPS Energy and LCRA identifying laws specific to public power authorities that restrict the ability to provide a security interest in utility assets. The commission modifies subparagraph (h)(1)(F) to carve out an MOU or river authority from the requirement to grant a lien interest in utility assets in favor of the commission.

Proposed §25.510(h)(1)(A)-Performance Covenant

Proposed §25.510(h)(1)(A) requires an EAF performance of 50 for the electric generating facility financed by the loan during its term. The EAF indicates the fraction of an operating period where a generating unit is available to produce electricity, free of outages or equipment deratings.

ERCOT recommended revising the rule to state that ERCOT's availability data be used rather than using North American Electric Reliability Corporation (NERC) Generating Availability Data System (GADS). ERCOT stated that NERC GADS is confidential. ERCOT suggested it could provide a report on an annual basis (or other specified period) documenting the EAF for each unit that is the subject of a loan agreement and recommended that such a reporting obligation be specified in the rule. ERCOT stated if the telemetered status for the entirety of a given hour during the period of the loan is anything other than "OUT," "EMR," or "EMRSWGR," the unit would be considered available unless the telemetered HSL for the unit is less than the unit's seasonal net maximum sustainable rating by some defined margin established by ERCOT. (ERCOT Nodal Protocols §3.9.1). ERCOT also recommended that, if the commission expects ERCOT to calculate the EAF under this rule, the rule be revised to allow ERCOT to establish such a margin or the EAF calculation in §25.510(h)(1)(A) be revised to provide for a reduction in the

EAF proportional to the magnitude of the derate, rather than considering any derate to mean the unit is entirely unavailable.

Advanced Power recommended adding clarity related to the measurement of EAF performance goals but did not provide an explanation of what required further clarification.

Calpine urged clarification on EAF performance and definition. Calpine recommended defining EAF as "the fraction of a given operating period in which a generating unit is available to produce electricity without any outages or equipment deratings."

WattBridge recommended that the EAF performance be evaluated annually on a site-wide basis, and, if the electric generating facility fails to meet the EAF, the facility should have a one-year cure period to meet the EAF performance requirement. WattBridge also recommended that the GADS calculation for EUOF be used, instead of EAF, to remove planned outages because "it is industry and prudent practice to take planned outages."

Sierra Club suggested 70 as an appropriate performance standard, while TIEC suggested increasing required EAF to 80.

TPPA proposed calculating overall EAF at regular intervals rather than applying EAF performance covenant to each operating hour during the term of the loan because requiring performance in each operating hour is too stringent.

NRG, WattBridge, TCPA, and LSP all recommended using NERC GADS EUOF to calculate availability. NRG further recommended excluding Outside Management Control events when calculating performance, and recommended calculating performance monthly as an annual average over a rolling 24-month period, instead of for each hour of the loan term. NRG believed the proposed performance covenant based on EAF is too strict and imposes unacceptable risk of default.

LSP and TCPA recommended calculating EAF on a 12-month rolling average as a single hour below 50 could trigger a breach. TCPA further suggested a proscriptive performance calculation methodology that does not allow the facility to allocate less equivalent outage hours to the portion of the facility serving ERCOT load.

Golden Spread suggested there is conflicting EAF information between §25.510(h)(1)(H) and (h)(1)(A) and requested clarification on whether EAF is measured annually or if EAF of 50 is measured for all hours during the term of the loan. Golden Spread recommended measuring EAF over the life of the loan instead of every year because consequences for default are severe and poor performance in a single year for an otherwise well-performing unit could result in loan default.

Vistra recommended the commission use a different performance metric or provide clarity on EAF performance standard. Vistra suggested using NERC EUOF definitions. Alternatively, Vistra suggested that the commission could adopt a phased-in approach to compliance where, in the first three years of operation, facilities are held to a lower performance standard that scales up over time.

HEN suggested that identifying the "given operating period" for EAF calculation as the time period over which the availability factor is calculated is essential to determine whether an EAF of 50 is a reasonable performance requirement. HEN recommended that the "given operating period" should be a calendar year.

Commission Response

The commission modifies the rule to use two performance standard metrics based on ERCOT real-time telemetered and COP data: the PAF and the Planned Outage Factor (POF). The EAF metric used in the proposed rule relies on confidential NERC GADS data that is not readily available to ERCOT or the commission, so the commission removes that metric from the rule.

The PAF will be calculated monthly to determine availability over the trailing 12 months, measured as the average of the ratio of real-time HSL to the available capacity expressed as a percentage, to avoid single-hour risk of default. Available capacity will be based on the adjusted seasonal net max sustainable rating, as registered with ERCOT. The available capacity for a GR associated with an industrial load or a PUN will use the net capacity that is allocated to primarily serve the ERCOT market. The PAF calculation will exclude intervals of planned maintenance that result in an outage of the entire resource, and projects will be required to maintain a PAF of 85 percent to reflect this consideration.

The second metric, the POF, is defined to evaluate the amount of time that a GR spends in planned outages during any evaluation period. POF will be calculated monthly to determine the percentage of time that a GR spent in planned outages during the trailing 12 months. A GR that is part of a facility financed by a TEF loan is required to maintain a POF no greater than 15 percent.

The PAF and POF will be incorporated into the performance covenant of the credit agreement, and so the commission modifies (b)(3), (b)(4), and (h)(1)(A) accordingly.

Additionally, the commission clarifies that the loan agreement will contain a cure provision that enables a borrower in breach of the performance covenant requirements, under §25.510(h)(6)(B), to cure its breach within a time specified in the loan agreement. If a borrower has not cured its breach within the specified time period, it will be considered in default of the loan agreement.

Proposed §25.510(h)(1)(B)-Construction and Term Loan Facility

Proposed §25.510(h)(1)(B) states that a senior secured first lien construction and term loan facility will advance to the borrower upon closing of the credit agreement. The construction loan converts to a term loan after project operation. Borrowers can request loan disbursements up to 60 percent of incurred costs and must fund a minimum of 40 percent equity during construction. Amounts repaid during construction cannot be re-borrowed after conversion to term loan.

CPS Energy suggested allowing for the deposit of the full amount of loan proceeds into an escrow account established under an escrow agreement because the Attorney General, which must approve all issuances of public securities by Texas municipalities, has previously expressed reluctance to approve certain draw-down loan structures. The escrow account and escrow agreement would allow for periodic draws to fund construction upon satisfaction of delineated conditions precedent.

Advanced Power recommended the term conversion to occur within a specified period after the project reaches the COD. Advanced Power suggested clarifying that debt-first draws are allowed when necessary to assist the equity model.

Commission Response

The commission declines CPS Energy's suggestion for the rule to specifically allow for a deposit of loan proceeds into an escrow account. However, the commission acknowledges the lim-

itations faced by public power entities regarding drawdown loan structures. Accordingly, the commission adds new paragraph (h)(9) to allow an MOU to provide substitute documentation customarily associated with the issuance of a public security to meet all preceding requirements of subsection (h). Any such substitute documentation must be prepared by an MOU or river authority at that entity's expense and must be on terms satisfactory to the commission.

Regarding Advanced Power's comments concerning loan conversion, the commission clarifies that TEF loans do not have term conversion. Per PURA §34.0104(f)(2), the loans are structured with interest accruing during construction and with payments commencing three years after the estimated COD. As stated in §25.510(g)(4), payments start on the third anniversary of the commercial operations date. The commission modifies (h)(1)(D) to clarify that interest begins to accrue at disbursement.

Proposed §25.510(h)(1)(B), §25.510(h)(1)(B)(i), and (h)(1)(B)(ii)-Construction and Term Loan Facility, Borrower's Request for Loan Disbursement Upon Initial Closing, Borrower's Request for Loan Disbursements, and Equity Commitment During the Term of the Construction Loan

Proposed §25.510(h)(1)(B)(i) and (h)(1)(B)(ii) state that at the initial closing of a credit agreement, the borrower can request a loan disbursement of up to 60 percent of documented incurred expenses. During the loan term, the borrower may request disbursements up to 60 percent of project costs, while contributing agreed-upon equity.

TIEC suggested that, before allowing a borrower to receive TEF loan disbursements, the commission should require an applicant to demonstrate that the first 30 percent of anticipated construction costs have been funded. TIEC reasoned that the proposed rule creates a risk that a borrower could receive its TEF loan early in construction and then fail to achieve commercial operation. Calpine had a similar recommendation, but for 40 percent of anticipated construction costs, and that such funds should go into the project first, prior to the applicant receiving funds from the loan program to further ensure the applicant's creditworthiness.

Golden Spread recommended reducing the equity requirement from 40 percent to 20 percent in §25.510(h)(1)(B)(ii).

Vistra suggested that loan disbursements should not be limited to 60 percent of incurred costs.

Advanced Power stated that §25.510(h)(1)(B) does not address the issue of re-borrowing and requested clarification on whether TEF will include revolving facilities.

Commission Response

The commission agrees with suggestions by TIEC and Calpine that, prior to TEF loan distributions, a borrower should fund a portion of its equity or other sources of funding contribution to project costs. However, the commission declines to predetermine the percentage of project costs to be funded using the applicant's other sources of funding before releasing TEF loan funds, and instead modifies §25.510(h)(1)(B) to allow for pro-rata contributions of other sources of funding based on the applicant's or its corporate sponsor's creditworthiness and the discretion of the commission.

The commission has eliminated from the rule the minimum 40 percent equity requirement, and so the modification recommended by Golden Spread is unnecessary.

The commission declines Vistra's recommendation to not limit funding to 60 percent of incurred costs. PURA §34.0104(b)(2) limits loans to "an amount that does not exceed 60 percent of the estimated cost of the facility to be constructed."

Proposed §25.510(h)(1)(B)(iii)-Construction and Term Loan Facility: Drawdown Certificates

Proposed §25.510(h)(1)(B)(iii) requires borrowers to submit a construction drawdown certificate to request disbursement of loan funds.

Calpine recommended using an independent third-party subject matter expert, in the field of dispatchable generation project development engineering, to assist in developing a form drawdown certificate. Calpine stated the use of a subject matter expert will reduce administrative burden and facilitate a more expedient review of drawdown certificates, as the form should require certification by an industry expert.

Commission Response

The required content of drawdown certificates will be determined during due diligence. The commission declines to specify the precise contents of a drawdown certificate in the rule and will use industry best practices in its development.

Proposed §25.510(h)(1)(C)-Equity Capital Contributions

Proposed §25.510(h)(1)(C) states that the commission will verify the borrower's required equity capital contributions (40 percent of the estimated capital cost of the project).

LCRA recommended removing the word "equity" from this section. Golden Spread recommended similar language and proposed reducing the 40 percent capital cost requirement to 20 percent. Vistra recommended adding "at least" before "40 percent" and eliminating "estimated."

TIEC suggested that developers should be allowed to self-fund more than 40 percent and use debt for remaining non-TEF funding requirements, rather than being required to use equity.

Commission Response

The commission modifies the rule to reflect that there is no explicit requirement for 40 percent equity. An applicant may submit its anticipated financing structures, which will be evaluated during due diligence. While proposed structures with various forms of debt for the non-TEF portion of the funding will be considered, priority will be given to applications with equity at the project level. Moreover, projects with higher levels of equity contribution or with financing structures with corporate guarantees of TEF project debt may yield more favorable evaluation results. The commission also modifies the rule to add, at (h)(8), the requirement for applicants who wish to use subordinated debt in place of equity to assume the cost of drafting any required subordination agreements.

The commission agrees with Vistra on deleting "estimated," but will not add "at least," given the lack of an explicit equity requirement. The commission modifies §25.510(h)(1)(C) to remove the explicit requirement of 40 percent equity to align with other provisions related to equity.

Proposed §25.510(h)(1)(D)-Interest

Proposed §25.510(h)(1)(D) states that interest on the loan amounts disbursed under the credit agreement will accrue at a fixed annual rate of three percent.

WattBridge suggested postponing the accrual of interest until the project has been commercially operational for three years as that coincides with the start of loan repayment. WattBridge suggested interest accrual before that third anniversary should be incorporated as additional project cost.

Commission Response

PURA §34.0104(f)(3) states that a loan "must bear an interest rate of three percent." The statute does not provide for postponing the accrual of interest, as recommended by WattBridge. Interest accrues daily during construction and until the third anniversary of the project's estimated COD. This interest may be capitalized in certain circumstances, as determined during the due diligence process. Only the portion of interest capitalized during construction is considered a project cost--see (e)(6)(H), where the commission adds interest accrued and capitalized during construction as an allowable project cost.

Proposed §25.510(h)(1)(E)-Voluntary Prepayment

Proposed §25.510(h)(1)(E) allows the borrower to voluntarily prepay the total loan amount under the credit agreement in whole or in part at any time without premium or penalty.

Vistra pointed out a typographical correction recommending removing the word "total" from this section.

Commission Response

The commission agrees that "total" in §25.510(h)(1)(E) is not applicable and modifies the rule for clarity. Voluntary pre-payments, including partial pre-payments, are allowed without penalty except that the loan agreement may require that applicants cover TEF interest rate breakage costs. Additionally, the TEF administrator will negotiate with a borrower seeking to prepay part or all of the loan other conditions related to prepayment, which may include the continuation of the performance, compliance, or audit covenants for the entirety of the envisioned 20-year loan period.

Proposed §25.510(h)(1)(F) - Collateral

Proposed §25.510(h)(1)(F) states that to secure the indebtedness under the credit agreement, the borrower will grant the commission a first priority security interest in all of its existing and after-acquired real and personal property related to the facility and in all of the outstanding equity interests of the borrower in the facility.

Advanced Power recommended allowing the developer the flexibility to grant shared first priority security interests to other counterparties. NRG also proposed allowing shared first priority security interest with hedge counterparties, enhancing cash flow stability for generation projects, benefiting project lenders. NRG stated the change would comply with the statutory requirement for the loan to be the senior debt secured by the facility, because sharing a senior security interest does not detract from the seniority of the interest. NRG provided redlines consistent with its recommendations.

Calpine suggested specifying how the collateral requirement relates to eligibility for PUNs and industrial generators.

TPPA requested clarification on whether this includes intellectual property, including, for instance, software leased to the facility by OEMs or other contractors.

Vistra stated that any commission remedy other than what is described in SB 2627 is prohibited and the Legislature only allowed appointment of a receiver as the remedy for default. Vistra stated, per SB 2627, the commission is barred from owning the real and personal property of the facility applicant and a security interest facilitates state ownership of private property in a default. Vistra provided redlines consistent with the recommendations.

Commission Response

PURA §34.0104(b)(3) states that TEF loans will be secured by project facilities. The commission disagrees with recommendations from Advanced Power and NRG to permit shared first priority security interest because the TEF loan is to be the senior debt of the project. In keeping with the requirement that any other debt must be subordinate to the TEF loan, the non-TEF debt of facilities associated with industrial load or PUNs must also be subordinate to the TEF loan.

Regarding TPPA's request for clarification, collateral is required for all project assets and equity. If intellectual property is a project asset, that intellectual property needs to be included as collateral. If there is intellectual property, leased or otherwise, the intellectual property itself or the lease to it needs to be included as collateral, though the underlying intellectual property will be governed by the lease.

The commission disagrees with Vistra's assertion that the commission's remedy--appointment of a receiver--conflicts with the commission requiring a security interest. The commission can hold the lien and exercise its interests via a receiver without taking ownership of the underlying assets.

Proposed §25.510(h)(1)(G)-Change of Ownership and Control

Proposed §25.510(h)(1)(G) states that a change of ownership and control occurs if greater than 50 percent of the equity interest in the project is sold to a third party. The borrower and third party must apply for change of ownership approval from the commission.

Advanced Power stated that it would be atypical for a lender to have control over these types of decisions and suggested that commission approval for a sale of equity interests above the borrower's direct parent should not be required. Advanced Power suggested limiting change of control to direct ownership of the asset securing the loan, not ownership above direct control.

Calpine recommended eliminating §25.510(h)(1)(G), suggesting change of ownership and control should not need commission approval as this sort of approval would not otherwise be required for a generating facility's change in ownership outside of the TEF loan context. Calpine further stated that it is not administratively necessary, because, as a registered PGC, the generating facility would be required to apply to amend its PGC registration should a change of control result in a change of corporate parent. Calpine recommended that if the commission deems this additional approval necessary, the commission should establish an administrative approval process for such an application, including the use of a commission-approved form with a specified timeline for approval.

WattBridge proposed a 60-day review period for change of ownership and control. For non-rate regulated assets that generally do not require commission approval, the purchase and sale of an existing GR can be completed in 30 days between the signing of the agreement and actual transfer, subject to the Hart-Scott-Rodino Act. WattBridge stated that a lengthy regulatory review process will dampen investor interest and diminish the value of a plant with a TEF loan.

TIEC suggested using the standard for change of ownership and control from sale, transfer, and merger (STM) regulations. TIEC

stated that PURA §39.915 requires approval for any transaction where 50 percent of stock is sold or where a controlling or operational control will be transferred. TIEC noted that the higher, more robust standard in §25.510(h)(1)(G) is appropriate and should be used for this program because the program is taxpayer support for subsidized loans.

NRG suggested adding language that consent will not be unreasonably withheld and allowing 90 days for commission approval.

Commission Response

Given the use of public funds for a TEF loan, the commission determines that review and approval of an application to change ownership and control for TEF loan recipients is appropriate to ensure that a TEF-funded facility continues to meet TEF objectives after acquisition. Therefore, the commission disagrees with Advanced Power and Calpine that there should be no review or approval of such changes. The commission modifies (h)(1)(H) to require a third party acquiring a TEF-funded facility to meet the performance covenant of the facility and the audit and compliance covenants for the remainder of the borrower's loan term. In addition, the commission adds a sentence to (h)(1)(H) to signify that the commission's determination on a change of ownership and control does not affect any person's obligations under PURA §39.158.

The commission does not seek to place an undue burden on potential changes in ownership and control, agrees with NRG's suggestion to clarify the rule to note that consent will not be unreasonably withheld, and modifies the rule to reflect this clarification. However, the commission declines the suggestions by WattBridge, TIEC, and NRG to impose specific timelines associated with change of ownership and control approval because some transactions may involve complex arrangements that necessitate extensive review. Additionally, the commission declines TIEC's proposal to adopt the standards in PURA §39.915 to govern a change of control evaluation because the public interest concerns in a transaction involving the sale of a TEF-funded facility are not the same as the sale of electric utility assets. PURA §39.915 protects retail customers when there is a sale of assets of a rate-regulated entity. But in this rule, the commission's primary concern is that a TEF facility continues to serve ERCOT in the manner described in the borrower's application and loan commitments.

Proposed §25.510(h)(1)(H)-Compliance and Audit Covenants

Proposed §25.510(h)(1)(H) states that credit agreements include covenants requiring borrowers to meet loan eligibility and submit annual audits. If serving an industrial load or PUN, borrowers must show that the majority of electric facility output served the ERCOT power system.

Calpine recommended including a confidentiality clause. Calpine recommended that annual financial audits, credit assessments, and electric generating performance assessments, as well as the annual accounting showing output of the electric generating facility, are confidential and not subject to disclosure under Chapter 552, Government Code.

Vistra recommended the commission prioritize facilities that will participate fully in the market. Vistra further suggests that if the PUNs are funded, then only a prorated percentage of the generator's cost should receive funding. Vistra recommended that the proration should account for the amount of generation participating in the market.

TPPA recommended strengthening the "primarily" language to support ERCOT more than PUNs. Vistra recommended modifying the language to clarify that if the borrower also serves an industrial load or PUN, the borrower must also submit an annual accounting showing that the output of the electric generating facility primarily served the ERCOT bulk power system during the performance year. Vistra provided specific redline language.

Drax Group also suggested aligning the audit requirement with definition of "primarily." Drax Group proposed a definition for "primarily" that excludes any facility that contributes no less than 100 MW of capacity to ERCOT, regardless of whether the facility is serving load behind the meter.

Commission Response

The commission agrees with Calpine that certain aspects of the information required for loan performance monitoring may be commercially sensitive and confidential. Therefore, the commission modifies the rule to maintain the confidentiality of financial audits, credit assessments, and electric generating facility performance assessments.

In response to Vistra's recommendation that only a prorated amount of a PUN generator's costs should be eligible for a TEF loan, the commission modifies (g)(1) to allow only those costs related to the percentage of a PUN generator's capacity dedicated to ERCOT to be eligible for a TEF loan. However, the commission declines to modify the rule to prioritize facilities that will participate fully in the market because the universe of applicants is not known at this time, and the commission will fully evaluate all applicants based on the strength of their applications.

In response to TPPA's comment, the commission modifies (c)(1)(C) to define the requirements that an electric generating facility serving an industrial load or PUN must meet. Regarding Vistra's recommendation for an annual accounting, the commission modifies the rule to add subsection (h)(1)(I), which requires an electric generating facility serving an industrial load or PUN to submit an annual accounting showing its net capacity made available to ERCOT in the prior year, as compared to its nameplate capacity and the NCP demand of the associated industrial load or PUN.

The commission agrees with the Drax Group that the annual audit should align with the definition of "primarily." The commission adds the annual accounting requirement so that it may confirm that an electric generating facility associated with a PUN or an industrial load continues to reserve the primary portion of its capacity for ERCOT. However, the commission disagrees with the Drax Group's suggested definition of "primarily" because this suggested definition ignores the comparison between capacity dedicated to an industrial load or PUN and capacity dedicated to ERCOT. This comparison is essential for the commission's interpretation of "primarily."

Proposed §25.510(h)(1) and (h)(2)-Definitions for Credit Agreement and Depository Agreement

Proposed §25.510(h)(1) and (h)(2) define the following loan terms: credit agreement and depository agreement.

CPS Energy recommended recognizing that, according to §1208.002 of the Texas Government Code, any security interest connected to public debt obligations of a municipal utility system is statutorily perfected.

Vistra contended that the requirements of §25.510(h)(2) are inconsistent with the SB 2627 and should, therefore, be removed or modified.

Commission Response

The commission acknowledges CPS Energy's comment that any security interest related to public debt obligations of a municipal utility system is statutorily perfected. Accordingly, the commission adds new paragraph (h)(9) to allow an MOU or river authority to provide substitute documentation customarily associated with the issuance of a public security to meet all preceding requirements of subsection (h), including any obligations of the MOU or river authority under other applicable statutes. Any such substitute documentation must be prepared by an MOU or river authority at that entity's expense and must be on terms satisfactory to the commission.

The commission declines Vistra's proposed modification to the rule. While PURA §34.0108 specifies certain remedies in the event of default, it does not prohibit the inclusion of additional loan requirements. The requirements of §25.510(h)(2) are appropriate.

Proposed §25.510(h)(3) and (h)(4)-Definitions for Security Agreement and Pledge Agreement

Proposed §25.510(h)(3) and (h)(4) define the following loan terms: security agreement and pledge agreement.

CPS Energy asserted that certain agreements are not applicable to MOUs applying to the TEF loan. CPS Energy recommended additional language which would state that the remedy to the debtholder, in the event of default by an MOU, would reside in a rate covenant to compel the borrower to impose a rate sufficient to satisfy the debt obligations.

Commission Response

The commission acknowledges CPS's position that a public power entity is not able to consent to certain activities described in PURA §34.0108. Accordingly, the commission adds new paragraph (h)(9) to allow an MOU or river authority to provide substitute documentation customarily associated with the issuance of a public security to meet all preceding requirements of subsection (h), including appropriate remedies upon borrower default. Any such substitute documentation must be prepared by an MOU or river authority at that entity's expense and must be on terms satisfactory to the commission.

Proposed §25.510(h)(3), (h)(4), and (h)(5)-Definitions for Security Agreement, Pledge Agreement, and Deposit Agreement

Proposed §25.510(h)(3), (h)(4), and (h)(5) define the following loan terms: security agreement, pledge agreement, and deposit agreement.

Vistra recommended using only a security agreement that recognizes PURA §34.0108(c) as the remedy for default. Vistra argued that the mandate for each borrower to execute a security agreement, pledge agreement, and depository agreement conflicts with SB 2627.

Shell Energy proposed expanding the security lien on the project to use project assets as collateral for hedge agreements, either through a capped lien amount or on a pari passu basis, ensuring stable cash flow. Shell recommended that if a hedge agreement is not required, any monthly gross margin above 125 percent of the project's pro forma should go into the Debt Service Reserve Fund. If the project is delayed by nine months or exceeds the budget by 40 percent, the commission should have step-in rights, including auctioning the project to other Market Participants.

Commission Response

The commission disagrees with Vistra that the commission's remedies for a default should be limited only to PURA §34.0108. While PURA §34.0108 specifies certain remedies in the event of default, it does not prohibit the inclusion of additional loan requirements. The requirements of §25.510(h)(2) are appropriate.

The commission disagrees with Shell Energy's proposed amendments. The existing protections in §25.510(h)(3) are sufficient to safeguard public funds consistent with the restrictions of PURA §34.0108 and the purpose of TEF.

Proposed §25.510(h)(6) and (h)(7)-Events of Default & Remedies

Proposed §25.510(h)(6) outlines the events of default to which the borrower must agree. Proposed §25.510(h)(7) requires the borrower to agree to the remedies described in PURA §34.0108 following an event of default.

TPPA recommended detailing the procedures for determining when an event of default has occurred, how a borrower can respond, and what process the borrower must follow in a default. TPPA commented that program participants need to be able to understand what constitutes default, who will make decisions on whether default has occurred, and what the process is. TPPA further recommended confirming that any defaults not sufficiently covered by collateral would result in a loss to the fund itself.

NRG proposed the inclusion of standard provisions related to potential default, such as notice and opportunity to cure, materiality thresholds, and force majeure provisions. NRG argued that the legislature did not prohibit these provisions and the provisions are necessary to safeguard against default. NRG provided redlines consistent with its recommendations.

TCPA advised using standard contract provisions to determine if a default has occurred. TCPA noted it is not beneficial for the state to seek receivership for all breaches. To prevent default, TCPA recommended including reasonable notice and cure provisions in the final rule.

Calpine proposed that events in §25.510(h)(6)(B) through §25.510(h)(6)(E) should only be considered a default if the events pose a material adverse effect to the project or its finances. Calpine also suggested that the commission should have the discretion to waive a breach or default without penalty to the borrower. If a default is declared, Calpine recommended mandatory arbitration with a third-party expert. Calpine argued that not all breaches that do not result in a material adverse effect should be considered a default. Calpine provided redlines consistent with its recommendations.

Vistra recommended revising the language in §25.510(h)(6)(B) to include "Material breach."

Commission Response

The commission declines to further detail the procedures determining an event of default. Subsection (h)(1) provides for a credit agreement, and (h)(6) identifies specific events of default. The rules have sufficient general guidance which, combined with the credit agreement executed between the borrower and the commission, will govern specific procedures.

The commission confirms that a default not covered by collateral or other credit support would result in a loss for the fund. PURA §34.0108 does not prescribe any other mechanisms to recover losses.

The commission declines the rule modifications proposed by NRG, TCPA, Calpine, and Vistra. PURA §34.0106(c) requires performance standards to be included in a debt covenant, and a recipient's failure to adhere to such requirements will constitute a breach of the covenant. The commission will develop appropriate cure periods along industry norms as part of the standard loan documentation.

Proposed §25.510(h)(6)-Events of Default

Proposed §25.510(h)(6) outlines the specified events of default to which the borrower must agree.

Shell Energy proposed that a delay of 12 months in reaching the projected COD should be considered a default event. In such a case, the commission should have the right to auction the project to other Market Participants. This comment also applies to §25.510(h)(7).

LSP recommended removing breach of performance covenant from the events of default and instead proposes to require the project sponsor to develop a plan acceptable to the commission to cure the performance breach.

Commission Response

The commission declines Shell Energy's proposed modification to the rule. Per PURA §34.0104(h) and (i), the failure to timely construct or upgrade a project facility may result in the borrower forfeiting the three percent deposit of its project costs. The commission declines to further penalize any such failure as an independent default event.

The commission declines LSP's proposed modification to the rule. PURA §34.0106(c) requires performance standards to be included in a debt covenant, and a recipient's failure to adhere to such requirements will constitute a breach of the covenant. The commission will develop appropriate cure periods along industry norms as part of the standard loan documentation.

Proposed §25.510(h)(7)-Remedies for Events of Default

Proposed §25.510(h)(7) requires the borrower to agree to the remedies described in PURA §34.0108 following an event of default.

LCRA commented that the proposed default remedies in PURA §34.0108 are not applicable to certain potential borrowers under state law. LCRA argued that certain legal constraints may prevent the commission from appointing a receiver, as PURA §34.0108 suggests. LCRA commented that borrowers should only comply with the default remedy if the default remedy does not contradict existing law.

Sierra Club suggested the commission clarify that the commission will not own defaulted projects but will instead transfer the defaulted projects to a court-established receivership.

Commission Response

The commission acknowledges LCRA's position that a public power entity is not able to consent to certain activities described in PURA §34.0108. Accordingly, the commission adds new paragraph (h)(9) to allow an MOU or river authority to provide substitute documentation customarily associated with the issuance of a public security to meet all preceding requirements of subsection (h), including appropriate remedies upon borrower default. Any such substitute documentation must be prepared by an MOU or river authority at that entity's expense and must be on terms satisfactory to the commission.

PURA §34.0108(b) prohibits the state, including the commission, from owning projects or facilities, and §34.0108(c), (d), (e), and (f) clearly establish the receivership process, authorities, and requirements. The commission declines Sierra Club's suggestion to revise the rule.

Proposed §25.510(i)(1)-Escrow Deposit Requirement for Loan Disbursement

Proposed §25.510(i)(1) requires the borrower to deposit three percent of the project's estimated cost in a Texas Comptroller-held escrow account before the initial loan disbursement.

WattBridge recommended using letters of credit as an alternative for cash deposits for commercial efficiency. WattBridge notes that letters of credit are regularly used in lieu of cash and are a more commercially efficient use of capital.

Commission Response

The commission agrees that it is suitable for a borrower to provide a standby letter of credit in lieu of a cash deposit. However, to protect the commission's interest in advancing TEF projects, the letter of credit must be supported by a financial institution acceptable to the commission. Accordingly, the commission revises §25.510(i)(1) to allow for a standby letter of credit, but also adds standards for the types of institutions that are acceptable to support a letter of credit.

Proposed §25.510(i)(2)-Requirements for Withdrawal of Escrow Deposit

Proposed §25.510(i)(2) outlines the requirements for escrow deposit withdrawal.

TPPA asked what would happen if a borrower failed to timely request the return of its deposit. TPPA also asked what happens if the commission does not provide authorization to withdraw a borrower's deposit.

Commission Response

PURA §34.0104 describes the requirements applicable to borrower deposits. Under that section, if the commission does not authorize withdrawal of a deposit, then the comptroller must deposit any escrow funds to the credit of the Texas Energy Fund. Accordingly, sections 25.510(i)(2) and 25.510(i)(3) describe how borrowers may withdraw deposit funds, and §25.510(i)(4) directs the commission to instruct the comptroller to transfer the deposit to the Texas Energy Fund if a withdrawal is not authorized. Failure of the borrower to meet withdrawal conditions including a timely request would result in the commission determining a withdrawal is not authorized. In response to TPPA, the commission modifies §25.510(i)(4) to reflect that failure to notify the commission of project completion will result in a return of the deposit to the Texas Energy Fund.

Proposed §25.510(i)(2)(C)-Definition of Interconnection in ERCOT Region

Proposed §25.510(i)(2)(C) explains that for the purpose of this subsection, interconnection occurs when the electric generating facility is physically connected and able to inject energy into the ERCOT region.

WattBridge proposed linking escrow funds' withdrawal to ERCOT's Part 2 approval during commissioning, which occurs when resources are able to enter the real-time market. WattBridge recommended adding "as outlined under the Part 2 process" to this proposed section.

Commission Response

The commission declines WattBridge's suggestion to use Part 2 in determining interconnection. For the purpose of this subsection, interconnection occurs on the resource commissioning date, as established in the ERCOT Nodal Protocols, of the last GR that is part of an electric generating facility financed by a loan under this rule. The commission modifies §25.510(i)(2)(C) to reflect this change.

Proposed §25.510(i)(4)-Evaluation & Decision Process for Deposit Withdrawals

Proposed §25.510(i)(4) states that the commission will evaluate each notice of satisfaction to determine whether the borrower is entitled to withdraw its deposit. If requirements are met, the deposit is returned. If not, the deposit is transferred to the TEF.

TPPA requested more details about the approval process for a withdrawal request.

Commission Response

The commission declines to modify the rule to provide further details of a withdrawal request because §25.510(i)(3) describes the process for filing a notice of satisfaction upon the occurrence of an event that entitles a borrower to a return of its deposit. Borrowers seeking authorization for withdrawal must file a notice with the commission that includes information required in (i)(3). The commission declines to make any changes in response to TPPA's request for clarification.

Proposed §25.510(j)-No Contested Case or Appeal

Proposed §25.510(j) states that neither an application for a loan nor a request for withdrawal of a deposit is a contested case. Commission decisions on a loan application or request for withdrawal of deposit are not subject to motions for rehearing or appeal.

Vistra suggested proceedings under this rule should be contested cases subject to judicial review. Vistra asserted that all commission actions are either contested cases or rulemakings governed by the Texas Administrative Procedure Act (APA). Accordingly, Vistra recommended delegating authority to the commission's administrative law judge under 16 TAC §22.32, and processing applications under 16 TAC §22.35. Vistra offered a proposal for streamlined contested cases, where intervention would be limited to the applicant and commission staff.

TPPA requested clarification on whether the rule would prohibit all forms of appeal, including judicial review.

Calpine suggested applicants should be allowed to supplement or refile denied or deficient loan applications without prejudice, avoiding the need for a contested case proceeding. Calpine added that if the commission does process applications through contested case procedures, the only parties should be the applicant and commission staff.

NRG opposed a contested case process for making determinations on applications. NRG commented that contested case procedures were not workable given the statutory timelines for application determinations and loan disbursements. NRG recommended that if the rule were to be revised to include a contested case process, the rule should be clear that the proceeding would only include the applicant and staff, and the contested case would be processed in an informal manner without hearing.

Commission Response

The commission declines Vistra's recommendation to modify the rule relating to contested case procedures. A contested case is a proceeding in which a state agency determines the legal rights, duties, or privileges of a party after an opportunity for an adjudicative hearing. No part of Chapter 34 of PURA provides an applicant the opportunity for an adjudicative hearing relating to a request for TEF funding. The commission interprets the absence of an opportunity for hearing to signify that contested case rights under the Texas APA do not apply to any application for a loan, change of ownership request, or request for withdrawal under this rule. Consequently, applicants do not have the opportunity to move for rehearing or seek judicial review under the Texas APA because those rights are exclusively associated with contested cases.

Commission determinations on loan applications are final. The limitation of an appeal mechanism reflects that the commission will not develop an internal appeal process. The commission is unable to provide further clarification in response to TPPA because it does not have the power to define the jurisdiction of Texas courts with respect to the various challenges that applicants may present in relation to this rule.

The commission agrees with Calpine, TPPA, and NRG that the absence of Texas APA contested case procedures does not prevent an applicant from supplementing or revising an application upon the request of the commission after initial application submission.

This new rule is adopted under the provisions of PURA §§14.002, which provides the commission with the authority to adopt and enforce rules reasonably required in the exercise of its powers and jurisdiction; 34.0104, which provides the framework to establish procedures for applying for a loan for construction of dispatchable electric generation facilities within the ERCOT region, evaluation criteria, and terms for repayment; 34.0106, which establishes restrictions on loans and requires the commission by rule to adopt performance standards based on reliability metrics appropriate for the types of facilities for which loans may be provided; and 34.0108, which establishes procedures in the event of a default.

Cross reference to statutes: Public Utility Regulatory Act §§14.002 and 34.0104, 34.0106, and 34.0108.

§25.510. Texas Energy Fund In-ERCOT Generation Loan Program.

(a) Purpose. The purpose of this section is to implement Public Utility Regulatory Act (PURA) §§34.0104, 34.0106, and 34.0108, which establish requirements and terms for loans to finance dispatchable electric generating facilities within the ERCOT region.

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

(1) Borrower--An applicant to the Texas Energy Fund who is successfully awarded a loan under this section and executes a loan agreement with the commission.

(2) Commercial operations date--The resource commissioning date, as defined in the ERCOT protocols, for the last generation resource that is part of an electric generating facility financed by a loan under this section.

(3) Generation resource--Has the same meaning as defined in the ERCOT protocols.

(4) 12-Month performance availability factor (PAF) --A metric calculated with ERCOT availability and real time (RT) telemetered data for each generation resource in an electric generating facility financed by a loan under this section. The PAF is computed as the average ratio of each generation resource's RT high sustainable limit (HSL) and its obligated capacity over a 12-month measurement period, expressed as a percentage. Intervals that occurred during an approved planned outage of a generation resource are excluded. The PAF is calculated as follows:
Figure: 16 TAC §25.510(b)(4)

(5) 12-Month planned outage factor (POF)--A metric calculated with ERCOT data for each generation resource in an electric generating facility financed by a loan under this section. The POF is computed as the percentage of time each generation resource spent in planned outages over a 12-month measurement period. The POF is calculated as follows:
Figure: 16 TAC §25.510(b)(5)

(c) Eligibility.

(1) A power generation company, municipally owned utility (MOU), electric cooperative, or river authority is eligible for a loan under this section. An electric utility other than a river authority is not eligible for a loan under this section.

(2) The following are eligible for a loan under this section:

(A) New construction of an electric generating facility having at least 100 megawatts (MW) of nameplate capacity with an output that can be controlled primarily by forces under human control. For purposes of this section, new construction of an electric generating facility means that the facility site has no existing point of interconnection to the ERCOT power region.

(B) An upgrade to an existing electric generating facility that results in a net increase of at least 100 MW of nameplate capacity for the facility with an output that can be controlled primarily by forces under human control. For purposes of this section, an existing electric generating facility already has a point of interconnection to the ERCOT power region, and the upgrade does not require an additional point of interconnection to enable delivery of energy from the increased capacity.

(C) A new or upgraded electric generating facility that is serving or will serve an industrial load or PUN, provided that the electric generating facility meets the following conditions: the portion of new nameplate capacity that will serve the industrial load or PUN must be less than 50 percent of the facility's total new nameplate capacity, and the remainder of new capacity serving the ERCOT market must be greater than 100 MW.

(3) In addition, to be eligible for a loan under this section, a proposed electric generating facility must:

(A) be designed to interconnect and provide power to the ERCOT region;

(B) be designed to participate in the ERCOT wholesale market;

(C) consist of one or more generation resources that interconnect to the ERCOT region through a single point of interconnection; and

(D) be eligible to interconnect to the ERCOT region based on the attributes of the owners of the facility, according to the requirements in the Lone Star Infrastructure Protection Act (codified at Texas Business and Commerce Code §117.002).

(4) The following activities are not eligible for a loan under this section:

(A) Construction or operation of an electric energy storage facility.

(B) Construction or operation of a natural gas transmission pipeline. For the purposes of this section, only the infrastructure necessary to connect an electric generating facility to a natural gas supply system may be considered part of the cost of the facility and eligible for a loan. Only those costs in support of new or upgraded capacity that is exclusively provided to the ERCOT region are eligible.

(C) Construction of an electric generating facility that met the planning model requirements necessary to be included in the capacity, demand, and reserves report issued by ERCOT before June 1, 2023.

(D) Construction or upgrade of an electric generating facility that will provide more than 50 percent of its nameplate capacity to an industrial load or PUN.

(E) Construction or upgrade of an electric generating facility that is capable of switching service at its point of interconnection between ERCOT and another power region.

(d) Notice of intent to apply.

(1) No earlier than May 1, 2024 and no later than May 31, 2024, an applicant must submit a notice of intent to apply in the manner prescribed by the commission. A corporate sponsor or parent may submit the notice of intent on behalf of a subsidiary applicant. Except as provided in paragraph (2) of this subsection, information submitted to the commission as part of the notice of intent to apply is confidential and not subject to disclosure under Chapter 552, Government Code. The notice of intent to apply must include:

(A) The applicant's legal name and the proposed name of the electric generating facility for which it seeks a loan;

(B) The anticipated nameplate capacity of each generation resource in an electric generating facility proposed to be financed with a loan under this section, and if the proposed facility will serve an industrial load or PUN, the net nameplate capacity of each generation resource that will be dedicated to ERCOT;

(C) The anticipated commercial operations date of each generation resource in the electric generating facility;

(D) The amount of the loan requested; and

(E) For each electric generating facility, if an applicant anticipates contributing equity in its application, a non-binding attestation demonstrating that the applicant, or a corporate sponsor or parent on the applicant's behalf, is capable of financing project-related costs not financed by a loan under this section.

(2) Concurrent with the notice of intent to apply, the applicant, or a corporate sponsor or parent of the applicant, must separately file a letter with the commission stating the applicant's legal name and the MW capacity that the requested loan amount will finance.

(e) Application requirements and process. A loan application must be submitted in the form and in the manner prescribed by the commission. The application portal will be open for an eight-week window, beginning on June 1, 2024, at 12:00 a.m., and closing on July 27, 2024, at 11:59 p.m. The executive director may extend the application window by providing public notice of the extension at least 30 days prior to the previously announced closing date. The executive director may

also open additional application windows if necessary to achieve the objectives of this section. A corporate sponsor or parent may submit an application on behalf of a subsidiary applicant. Information submitted to the commission as part of the loan application process is confidential and not subject to disclosure under Chapter 552, Government Code. An application must include each of the requirements detailed in this subsection. An applicant may withdraw an application at any time while under commission review.

(1) The applicant's legal name and the proposed name of the electric generating facility for which it requests a loan.

(2) Amount of the loan requested.

(3) The anticipated nameplate capacity of each generation resource in an electric generating facility proposed to be financed with a loan under this section, and in the case of an electric generating facility that will serve an industrial load or PUN, the nameplate capacity of each generation resource that is proposed to be dedicated to ERCOT and the anticipated maximum non-coincident peak demand of the industrial load or PUN.

(4) Applicant information.

(A) A copy of any information submitted to ERCOT regarding the applicant's attestation of market participant citizenship, ownership, or headquarters, if submitted, or a direct attestation of market participant citizenship, ownership, or headquarters, if such information has not yet been submitted to ERCOT;

(B) Evidence of the applicant's experience with siting, permitting, financing, constructing, commissioning, operating, and maintaining electric generating facilities to provide reliable electric service in competitive energy markets;

(C) Evidence of the applicant's creditworthiness, including:

(i) A binding equity commitment letter, if the applicant proposes to fund any project costs using equity, or a binding letter with information regarding the applicant's other funding sources, demonstrating the ability to fund the balance of project costs separate from the loan under this section plus the required three percent construction escrow deposit amount; and

(ii) Audited financial statements for each of the previous five fiscal years of the applicant's operations, or if not available, audited financial statements of the applicant's corporate sponsor or parent company. Statements must include total assets, total liabilities, and net worth; and, if available for the applicant, its corporate sponsor or parent, or both, credit ratings issued by major credit rating agencies.

(5) Project information.

(A) A narrative explanation that details how the facility will contribute to reliably meeting peak winter and summer load in the ERCOT region, including the project's plans for ensuring adequate fuel supplies and preparations for compliance with §25.55 of this title (relating to Weather Emergency Preparedness);

(B) Demonstration of the project's eligibility under subsection (c) of this section, including a statement indicating whether any generation resource in the electric generating facility will serve an industrial load or PUN;

(C) Project-specific information that will allow the TEF administrator to evaluate the viability and attributes of the electric generating facility, and each individual generation resource, including:

(i) A table with the resource operation attributes, including nameplate capacity, heat rate, seasonal net maximum sustainable ratings during winter and summer, cold and hot temperature start times, resource ramp rate, and the original equipment manufacturer's estimated equivalent availability factor (EAF) calculation.

(ii) If any generation resource in the electric generating facility will serve an industrial load or PUN, an attestation of the net nameplate capacity of each generation resource that will be dedicated to ERCOT and nameplate capacity that will serve the industrial load or PUN, a description of how the electric generating facility will primarily serve and benefit the ERCOT bulk power system given its relationship to an industrial load or PUN, including details of all obligations or commitments of the electric generating facility to provide energy or capacity to the industrial load or PUN, and whether the proposed electric generating facility's generation capacity would be available to the ERCOT bulk power system during any Energy Emergency Alert, and a copy of any information submitted to ERCOT regarding PUN net generation capacity availability;

(iii) One-line diagrams of the proposed project for both transmission planning and the facility;

(iv) Evidence of site control, consistent with applicable ERCOT planning guide requirements;

(v) An up-to-date phase I environmental site assessment, conducted in accordance with standards identified in 40 C.F.R. Part 312;

(vi) A description of the electrical interconnection plan, including evidence that the proposed project is in the interconnection queue with ERCOT; a copy of the ERCOT screening study, if completed; and a copy of the full interconnection study with the interconnecting transmission service provider, if completed;

(vii) A description of the fuel and water supply arrangements, including copies of applicable fuel and water supply agreements, if available, and evidence of receipt of necessary water rights and applicable permits;

(viii) A description of the operations and maintenance staffing plan, organizational structure, and operating programs and procedures for the proposed project, including copies of operations and maintenance agreements, if available, and organizational charts;

(ix) A list of all required environmental, construction, and operating permits with current approval status;

(x) A description of the air emissions compliance plan, including evidence of receipt of any required air emissions credits;

(xi) A detailed financial forecast of cash available for debt service, covering a period equal to the repayment period of the loan, including sources of revenue, capital, and an annual operating and maintenance budget; and

(xii) A proposed project schedule with anticipated dates for major project milestones, such as the start date for project engineering, construction start date, submission of available interconnection documents with ERCOT, completion date of the ERCOT screening study, completion date of the full interconnection study, execution of the standard generation interconnection agreement, if applicable, submission of applicable registration documents with ERCOT and the commission, and commercial operations date.

(6) Estimated costs. A description of estimated project costs, which includes:

(A) Development, construction, and capital commitments required for the project to reach completion;

(B) Permitting-related costs;

(C) Development fees;

(D) Land acquisition and lease costs;

(E) Legal fees;

(F) Up-front fees;

(G) Commitment fees;

(H) Interest accrued and capitalized during construction;

(I) Ancillary credit facility fees, if applicable;

(J) Title insurance; and

(K) Interconnection costs.

(f) Evaluation Criteria. The commission will approve or deny an application based on the criteria and TEF administrator evaluations outlined in this subsection. Evaluations and other recommendations provided by the TEF administrator are advisory only. All final decisions on whether to approve or deny each application will be made by the commission.

(1) The TEF administrator will evaluate an application under this section based on:

(A) The applicant's or its corporate sponsor or parent's:

(i) Quality of services and management and proposed organizational structure for the project for which the applicant seeks a loan;

(ii) Efficiency of operations, as shown by the applicant's existing generation resources and asset management practices;

(iii) History of electricity generation operations in this state and this country;

(iv) Resource operation attributes, including fuel type and heat rate, seasonal net maximum sustainable ratings for winter and summer, cold and hot temperature start times, resource ramp rate, and the original equipment manufacturer's estimated EAF;

(v) Ability to address regional and reliability needs;

(vi) Access to resources essential for operating the facility for which the loan is requested, such as land, water, and reliable infrastructure, as applicable;

(vii) Evidence of creditworthiness and ability to repay the loan on the terms established in the loan agreement, including the applicant's total assets, total liabilities, net worth, and credit ratings issued by major credit rating agencies;

(B) The nameplate capacity, total forecasted revenues, and total estimated costs of the facility for which the loan is requested; and

(C) The completeness of the application.

(2) The TEF administrator may also consider the following criteria:

(A) The suitability of the facility site to support the construction, operation, and maintenance of the proposed facility and to provide sufficient access to utilities;

(B) The sufficiency of the various construction and equipment supply contracts necessary to construct the facility;

(C) Whether and to what extent the proposed facility will serve an industrial load or PUN;

(D) The commercial feasibility of the facility's construction schedule, including the projected commercial operations date;

(E) The facility's proposed environmental permits and commitments;

(F) The reasonableness of the applicant's forecast of non-fuel operating and maintenance costs;

(G) The methodology used to construct the facility's financial forecast of projected net revenues, expenses, and cash flows;

(H) The sufficiency of the applicant's proposed sources of equity or other funding sources to cover the costs of the facility not funded through a loan provided under this section;

(I) Whether the facility can achieve the applicant's EAF and capacity projections over the life of the loan agreement; and

(J) The basis for the total projected construction costs, including project contingencies.

(3) The TEF administrator will conduct due diligence on each application to gauge the feasibility of the project. Each applicant must submit an independent engineer's report, signed and sealed by a professional engineer licensed in the state of Texas, at the applicant's own expense, that assesses the feasibility of the project, its location, and all supporting commercial agreements relating to fuel, water, site control, and interconnection. The TEF administrator may request that an applicant provide additional information it determines necessary to conduct a complete evaluation of the project proposal.

(g) Loan Structure. An approved loan will have the following characteristics:

(1) Consist of no more than 60 percent of the estimated cost of the electric generating facility to be completed, or in the case of an electric generating facility that serves an industrial load or PUN, consist of no more than 60 percent of a percentage of total estimated facility costs equal to the percentage of the total capacity of the facility that is dedicated to ERCOT;

(2) Be the senior debt secured by:

(A) the electric generating facility to be completed; or

(B) with regard to an MOU or river authority, the revenues of the applicant's utility system into which the electric generating facility will be incorporated and made a part of;

(3) Have a term of 20 years;

(4) Be payable starting on the third anniversary of the estimated commercial operations date of the electric generating facility as stated in the application;

(5) Be payable ratably on terms on which the TEF administrator and the applicant have agreed, based on the applicant's expectation of cash flows from the project and the TEF administrator's assessment of the applicant's cash flows; and

(6) With respect to a borrower other than an MOU or river authority, be structured as senior debt secured by a first lien security interest in the assets and revenues of the project.

(7) Notwithstanding paragraph (1) through (6) of this subsection, a loan accepted by a borrower that is an MOU or river authority may be in the form of a public security, as defined in Chapter 1201, Government Code, issued under Texas laws governing MOU or river authority financing, provided that the MOU or river authority, at its own expense, presents documentation of indebtedness satisfactory to the commission.

(h) Loan Terms and Agreements. A borrower must enter into one or more agreements with the commission that include the terms of this section.

(1) Credit agreement--the primary agreement between the borrower and the commission that will govern the terms and conditions under which the commission will loan funds to the borrower. The credit agreement will include the following key terms:

(A) Performance covenant--each generation resource in an electric generating facility that is financed by a loan under this section must maintain a PAF of at least 85 percent and a POF no greater than 15 percent, evaluated monthly, over the trailing 12-month period, throughout the term of the loan.

(B) Loan facility--a senior secured first lien loan facility will be advanced to the borrower in one or more drawdowns after the closing date of the credit agreement and upon satisfaction of any conditions precedent, and may continue until the project achieves commercial operation. Amortization schedules for the loan facilities will be determined during due diligence and specified in the credit agreement.

(i) Upon initial closing of the credit agreement and after the borrower has met the conditions precedent outlined in the loan agreement, the borrower may request an initial loan disbursement for up to 60 percent of qualifying and documented incurred expenses that are part of the total estimated cost of construction for the project, as verified by the TEF administrator. Equity may be funded pro rata with TEF debt or may be required in its entirety prior to funding of TEF debt, based on the credit quality of the application and discretion of the commission and as outlined in the loan agreement.

(ii) During the period of construction, the borrower may request loan disbursements for up to 60 percent of the documented project construction and commissioning costs.

(iii) For all loan disbursements, the borrower must submit a construction drawdown certificate in the form specified by the commission. The TEF administrator will review the construction drawdown certificate and, upon the TEF administrator's approval, will instruct the Texas Treasury Safekeeping Trust Company to disburse funds.

(C) Other capital contributions. The TEF administrator will verify the borrower's ability, or the ability of the borrower's corporate sponsor, to fund the required commitment of the balance of no less than 40 percent of the construction and commissioning costs.

(D) Interest on the loan amounts disbursed under the credit agreement will accrue daily at a fixed annual rate of three percent, starting at initial disbursement and continuing throughout the term of the loan.

(E) Voluntary prepayment--the borrower may voluntarily prepay the loan amount under the credit agreement in whole or in part at any time without premium or penalty, except that the loan agreement may require that borrowers pay any breakage costs associated with the loan, and the borrower must agree to adhere to the terms of the performance covenant for the duration of the 20-year term.

(F) Collateral--to secure the indebtedness under the credit agreement, the borrower, other than an MOU or river authority, will grant the commission a first priority security interest in all of its existing and after-acquired real and personal property related to the facility and in all of the outstanding equity interests of the borrower in the facility.

(G) Registration--prior to the initial loan disbursement, the borrower must register with the commission as a power generation company, unless the borrower is an MOU, electric cooperative, or river authority. The borrower must also agree to register each generation resource in the electric generating facility with ERCOT, according to ERCOT's registration requirements in its protocols for generation resources.

(H) A change of ownership and control occurs if greater than 50 percent of the equity interest in the project is sold to a third party. The borrower and the third party must submit an application for change of ownership and control commission, that meets the eligibility requirements of subsections (c) and (e) of this section. The acquiring third party must agree to adhere to the terms of the performance covenant in paragraph (1)(A) of this subsection and compliance and audit covenant in paragraph (1)(I) of this subsection for the remainder of the 20-year term of the borrower's loan. A change of ownership and control will require the commission's approval, and such approval will not be unreasonably withheld. Upon approval of a change of ownership and control, the acquiring third party must update the power generation company registration and the generation resource registration to reflect the change of ownership and control. The commission's determination on a change of ownership does not impact any person's obligations under PURA §39.158.

(I) Compliance and audit covenants--the credit agreement will include debt covenants requiring the borrower to meet all statutory requirements for loan application eligibility and a debt covenant requiring that the borrower submit annual financial audits and credit assessments throughout the term of the loan. If the borrower's electric generating facility serves an industrial load or PUN, the borrower must also submit an annual accounting, at the generation resource level, showing the capacity made available exclusively to the ERCOT bulk power system during the performance year. The annual accounting must consist of a comparison between the sum of the nameplate capacity of each generation resource in the electric generating facility and the maximum non-coincident peak demand of the associated industrial load or PUN. Annual financial audits, credit assessments, and electric generating facility performance assessments submitted under this section are confidential and not subject to disclosure under Chapter 552, Government Code.

(2) Depositary agreement--an agreement between the borrower and commission that will give the commission, as lender, control over the borrower's deposit accounts and securities accounts to perfect the commission's security interest in those accounts.

(3) Security agreement--an agreement between the borrower and the commission that will authorize the commission, as lender, to take control of and transfer all material project assets in the event of a default on the credit agreement, subject to the applicable procedures and approvals identified in PURA §34.0108.

(4) Pledge agreement--an agreement between the borrower and the commission that will create a security interest in the equity interests of the project in favor of the commission as the senior secured party.

(5) Deposit agreement--an agreement between the borrower and the commission in which the borrower will agree to a deposit described in subsection (i) of this section.

(6) Events of default--the borrower must agree to specified events of default, which include:

(A) Failure to pay principal, interest, or other amounts due;

(B) Breach of a covenant in any agreement that has not been remedied within the time prescribed by the loan agreement;

(C) Inaccuracy of representations in any agreement;

(D) Bankruptcy or insolvency of the borrower; and

(E) Abandonment.

(7) Remedies for events of default--the borrower must agree to the remedies described in PURA §34.0108 following an event of default.

(8) Subordination and other agreements--to the extent that the project is to be financed by debt other than a loan under this section, each other creditor must agree that a loan under this section will be the senior debt secured by the facility. The borrower will be responsible for the preparation and costs associated with any agreement necessary to maintain the senior position of the loan under this section.

(9) With respect to a borrower that is an MOU or river authority, the forms by which the requirements of paragraph (1) through (8) of this subsection are accomplished can be substituted by documentation satisfactory to the commission that is customarily used in connection with the issuance of public securities that are subject to approval by the Office of the Texas Attorney General or satisfied by reference to applicable Texas law. An MOU or river authority that presents documentation in accordance with this paragraph will be responsible for the preparation and costs of that documentation.

(i) Deposits.

(1) The borrower must deposit in an escrow account held by the Texas Comptroller of Public Accounts or provide in a standby letter of credit an amount equal to three percent of the estimated cost of the project for which the loan is provided. The terms of a standby letter of credit must permit a draw in full upon a commission determination that withdrawal of a borrower's deposit is not authorized under paragraph (4) of this subsection. The borrower must deposit the required funds or provide the standby letter of credit before the initial loan amount is disbursed.

(A) Standby letters of credit provided under paragraph (1) of this subsection must use the standard form standby letter of credit template approved by the commission. The original document of the standby letter of credit must be provided in a manner established by the commission.

(B) The standby letter of credit must be issued by a financial institution that is supervised by the Board of Governors of the Federal Reserve system, the Office of the Comptroller of the Currency, or a state banking department and is a:

(i) U.S. domestic bank with an investment-grade credit rating; or

(ii) U.S. domestic office of a foreign bank with an investment-grade credit rating.

(2) The borrower may not withdraw the deposit from the escrow account or terminate its standby letter of credit unless authorized by the commission.

(A) For deposits related to the construction of new facilities, the commission will authorize the borrower's withdrawal of its deposit funds or the release of the borrower's standby letter of credit, as applicable, if the facility for which the loan was provided is interconnected in the ERCOT region:

(i) before the fourth anniversary of the date the initial loan funds were disbursed; or

(ii) after the fourth anniversary but before the fifth anniversary of the date the initial loan funds were disbursed, if the commission finds that extenuating circumstances caused the delay.

(B) For deposits related to upgrades to existing facilities, the commission will authorize the borrower's withdrawal of its deposit funds or the release of the borrower's standby letter of credit, as applicable, if the facility for which the loan was provided is completed:

(i) before the third anniversary of the date the initial loan funds were disbursed; or

(ii) after the third anniversary but before the fourth anniversary of the date the initial loan funds were disbursed, if the commission finds that extenuating circumstances caused a delay in the completion of the project.

(C) For the purpose of this subsection, interconnection occurs when the last generation resource that is part of an electric generating facility financed by a loan under this section is issued a resource commissioning date, as defined in the ERCOT protocols.

(3) Upon the occurrence of an event that entitles the borrower to withdraw its deposit or request termination of its standby letter of credit--interconnection or completion of its project--the borrower will file a notice of satisfaction with the commission stating that the borrower requests the return of the deposit. The notice must state:

(A) A description of the event that the borrower asserts as justification for withdrawal of the deposit or termination of the standby letter of credit, including the date on which the event occurred and any relevant evidence required to support the assertion;

(B) The date of initial loan disbursement; and

(C) A detailed statement of extenuating circumstances, if any, that support the borrower's request for a late withdrawal of the deposit resulting from a delayed interconnection or completion of the project, as described in paragraph (2)(A)(ii) or (B)(ii) of this subsection.

(4) The commission will evaluate each notice of satisfaction to determine whether the borrower is entitled to withdrawal of its deposit or release of its standby letter of credit. If the borrower demonstrates that it has satisfied the requirements for withdrawal, then the commission will instruct the comptroller to return the deposit to the borrower or will release the borrower's standby letter of credit. If the commission determines that withdrawal is not authorized, including if the borrower fails to file a timely notice of satisfaction, then it will instruct the comptroller to transfer the deposit to the Texas Energy Fund or will direct a draw on the borrower's standby letter of credit and deposit the funds in the Texas Energy Fund.

(j) No Contested Case or Appeal. None of an application for a loan, a request for withdrawal of a deposit, or a request for approval of a change of ownership is a contested case. Commission decisions on a loan application or request for withdrawal of deposit are not subject to motions for rehearing or appeal under the commission's procedural rules.

(k) Expiration. This section expires September 1, 2050.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

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

The commissioner of insurance adopts amendments to 28 TAC §§3.3038, 3.3702 - 3.3705, 3.3707 - 3.3711, 3.3720, 3,3722, and 3.3723; new §3.3712; and the repeal of §3.3725. Proposed §3.3713 is not adopted. The commissioner also adopts amendments to the title of Division 2 of 28 TAC Chapter 3, Subchapter X. These sections concern preferred and exclusive provider benefit plans. The amendments and new section are adopted with changes to the proposed text published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7129). These sections, specified subsequently, will be republished. The commissioner adopts §§3.3038, 3.3710, and 3.3720 and the repeal of §3.3725 without changes to the proposed text. These sections will not be republished. The commissioner adopts §§3.3702 - 3.3705, 3.3707 - 3.3709, 3.3711, 3.3712, 3.3722, and 3.3723 with nonsubstantive changes to the proposed text. Sections 3.3703 - 3.3705, 3.3707 - 3709, 3.3712, 3.3722, and 3.3723 were revised in response to public comments. Section 3.3702 and §3.3711 are adopted with nonsubstantive changes to update punctuation and grammar and to reflect current agency drafting style and plain language references.

REASONED JUSTIFICATION. The repeal, amendments, and new sections are necessary to implement House Bill 711, 88th Legislature, 2023, which prohibits anticompetitive contract provisions; House Bill 1647, 88th Legislature, 2023, which provides protections for certain clinician-administered drugs; House Bill 1696, 88th Legislature, 2023, which expands protections for optometrists and therapeutic optometrists in contracts with managed care plans; House Bill 2002, 88th Legislature, 2023, which requires insurers to credit certain out-of-network payments to the enrollee's deductible and maximum out-of-pocket amounts; House Bill 3359, 88th Legislature, 2023, which provides network adequacy standards and requirements; Senate Bill 1003, 88th Legislature, 2023, which expands facility-based provider types that must be listed in provider directories; and Senate Bill 2476, 88th Legislature, 2023, which creates new payment standards and balance billing protections for emergency medical services.

The adopted text also makes additional amendments in Subchapter S and throughout Subchapter X. The amendments remove payment rules that were invalidated by court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020) (TAHP Order); provide new payment requirements and protections for preferred and exclusive provider plans consistent with Senate Bill 1264, 86th Legislature, 2019; expand exceptions to guaranteed renewability requirements; affirm the Texas Department of Insurance's (TDI's) prohibition on referral requirements; prohibit penalties on insureds for failure to obtain a preauthorization; restrict misrepresentation of cost-sharing incentives in advertisements; streamline disclosure requirements for policy terms; require that certain filings be submitted to TDI via the National Association of Insurance Commissioners (NAIC) System for Electronic Rates & Forms Filing (SERFF) instead of email; remove references to a repealed section; and revise sections as necessary to conform to changes in other sections. In addition, an amendment revises the title of Subchapter X, Division 2, to reflect that the division addresses application, examination, and plan requirements and applies to both preferred and exclusive provider benefit plans.

The adopted repeal, amendments, and new section are described in the following paragraphs, organized by subchapter.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions. The amendments to §3.3038 expand the exceptions related to guaranteed renewability to permit coverage under a preferred or exclusive provider benefit plan to be discontinued or nonrenewed if the insured no longer resides, lives, or works in the service area of the issuer by removing a reference to subsection (c) in subsection (a), amending subsection (c)(4) to include Insurance Code Chapter 1301, and adding references to the insurer's service area to subsections (c), (e), and (f). These changes implement Insurance Code §1202.051, which addresses guaranteed renewability, and §1301.0056, which addresses qualifying examinations for preferred and exclusive provider benefit plans. As amended by HB 3359, Insurance Code §1301.0056 provides that an insurer may not offer a preferred or exclusive provider benefit plan before the commissioner determines that the network meets the quality-of-care and network adequacy standards in Insurance Code Chapter 1301 or the insurer receives a waiver.

Amendments to subsection (d) require insurers to notify the commissioner of a discontinuance and revise subsection (h) to clarify requirements for uniform modifications. They also add a definition of "uniform modification" in new subsection (i); clarify notice requirements by adding new subsection (j), which states that a notice provided to the commissioner under §3.3038 must be submitted as an informational filing consistent with the procedures specified in 28 TAC Chapter 3, Subchapter A; and clarify network filing requirements by adding new subsection (k).

In addition, an amendment to the section title adds a comma, and another amendment adds a reference to the title of Insurance Code Chapter 842 in a citation to the chapter in subsection (c)(4).

Subchapter X. Preferred and Exclusive Provider Plans

Division 1. General Requirements

28 TAC §§3.3702 - 3.3705, 3.3707 - 3.3711, and new §3.3712

Section 3.3702. Definitions. The amendments to §3.3702 expand the definition of "facility-based physician" in subsection (b)(8) by changing the defined term to "facility-based physician or provider," thereby including non-physician providers, and by deleting the reference to specific specialists listed in the current definition, consistent with SB 1003. For greater rule precision and to capture any future changes in the statutory definition, the definition of "facility-based physician or provider" as proposed has been changed to reference the statutory definition in Insur-

ance Code Chapter 1451 rather than reproducing the same text in the rule.

An amendment also revises subsection (b)(17) to remove the definition of "rural area," which is no longer needed due to the county classification guidance in Insurance Code §1301.00553(b), and replace it with a definition for SERFF. The definition of SERFF as proposed has been updated with a few stylistic changes to more closely conform with the official name.

Amendments also add the titles of a cited Insurance Code chapter and cited Insurance Code sections in subsections (a) and (b)(1), (7), and (10).

Section 3.3703. Contracting Requirements. Amendments to §3.3703 implement HB 711 by adding requirements in new paragraph (29) of subsection (a) that a contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning contract requirements, including the prohibitions on contractual anti-steering, anti-tiering, most favored nation, and gag clauses. Similarly, amendments implement HB 1696 by adding requirements in new subsection (a)(30) that contracts comply with Insurance Code Chapter 1451, Subchapter D, concerning access to optometrists used under managed care plans, including protections for optometrists and therapeutic optometrists in managed care plans that cover vision or medical eye care. Amendments also update a reference to "facility-based physician group" in subsection (a)(26) by adding the words "or provider" to conform with an amended definition in §3.3702.

Amendments also clarify language in the section by changing "assure" to "ensure" in subsection (a); "shall" to "must" in subsection (a)(4); "x-ray" to "X-ray" in subsection (a)(5); "therein" to "in the contract" in subsection (a)(13); "such immunizations or vaccinations" to "they" and "rules promulgated thereunder" to "implementing rules" in subsection (a)(17); "e-mail" to "email," "pursuant to" to "in accordance with," and "in accordance with" to "under" in subsection (a)(20); "methodologies" to "methods" in subsection (a)(20)(A); "pursuant to" to "in accordance with" in subsection (a)(20)(G)(iii); and "utilized insofar as" to "employed to the extent" in subsection (b). In addition, amendments add an apostrophe following the word "days" in subsection (a)(20)(D) and quotation marks around the words "batch submission" in subsection (a)(20)(D); remove parenthetical information following a citation to Insurance Code §1661.005; add the titles of cited Insurance Code sections in paragraphs (13), (14), (15), (18), (25), and (27) of subsection (a) and subsections (b) and (c); and delete an unnecessary use of the word "the" in a citation to Insurance Code §1661.005 in subsection (a)(25). Also, a citation to Insurance Code §1301.0053 is added to subsection (a)(28).

The following changes to the text of subsection (a) as proposed have been made in response to comments. The word "assures" in §3.3703(a) as proposed has been changed to "ensures" for consistency. Paragraph (20) as proposed has been changed to add subparagraph (J) to prohibit certain adverse material changes to provider contracts; in addition, a reference to new subparagraph (J) has been added to the text of paragraph (20) that appears before the subparagraphs. Paragraph (29) as proposed has been changed to clarify that compliance with Insurance Code §1458.101 is required "to the extent applicable." Paragraph (30) as proposed has been changed to clarify its applicability to contracts with optometrists and therapeutic optometrists.

Section 3.3704. Freedom of Choice; Availability of Preferred Providers. The amendments to §3.3704 remove references to repealed §3.3725 and add the titles of cited Insurance Code sections in subsection (a), including in paragraphs (1), (4), (5), (9), and (12). Citations in subsections (a) and (b) to specific Insurance Code sections are replaced with broader chapter and subchapter citations. The citation to §3.3708 in subsection (a)(5) is changed to reflect the amendment to the section title, and the citation to 28 TAC Chapter 19, Subchapter R, in subsection (a)(9) is updated to reflect the current name of that subchapter. References in subsection (a) to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Amendments in subsection (a)(7) affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and amendments in subsection (a)(9) prohibit an insurer from penalizing an insured based solely on a failure to obtain a preauthorization, as TDI views such practices as unjust under Insurance Code §1701.055(a)(2). An amendment in subsection (a)(12) removes a citation to 28 TAC §3.3725 to reflect the repeal of that section. In addition, amendments clarify language in subsection (a) by changing "pursuant to" to "in accordance with" in subsection (a)(1), "50 percent" to "50%" in subsection (a)(6), "is taken pursuant to the" to "are taken under" in subsection(a)(9), and "accord" to "accordance" in subsection (a)(12).

The amendments implement Insurance Code §1458.101(i), as added by HB 711, by replacing the current subsection (e) with a new subsection (e) that contains provisions restricting the use of steering or a tiered network to encourage an insured to obtain services from a particular provider. New subsection (e) restricts the use of steering or a tiered network to encourage an insured to obtain services from a particular provider only to situations in which the insurer engages in such conduct for the primary benefit of the insured. In response to comment, subsection (e) as proposed has been revised and paragraph (3) has been added to the subsection to provide more clarity on compliance with Insurance Code §1458.101 and an insurer's fiduciary duty as applied to steering activities or a tiered network.

Amendments implement HB 3359 by amending subsection (f) to add requirements that preferred provider plans comply with new network adequacy standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Subsection (f) is also amended to delete the previous network adequacy standards and reference to local market adequacy requirements, consistent with the statutory changes in HB 3359. Paragraph (1)(C) of subsection (f) as proposed has been revised to reflect the withdrawal of proposed §3.3713. In response to comment, paragraphs (2) and (3) of subsection (f) as proposed have been revised to clarify network adequacy requirements, and new paragraph (4) has been added to clarify network adequacy requirements for specialty care and specialty hospitals for which time and distance standards are not specified in Insurance Code §1301.00553.

Subsection (g) is amended to address requirements if a material deviation from network adequacy standards occurs. In response to comment, subsection (g) as proposed has been changed to clarify network monitoring and corrective action requirements.

Amendments to subsection (h) also implement Insurance Code §1301.005(d), as added by HB 3359, by requiring a service area to be defined in terms of one or more Texas counties, removing options to define a service area by ZIP codes or 11 Texas

geographic regions, and specifying that a plan may not divide a county into multiple service areas.

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. Amendments to subsections (l) and (n) in §3.3705 implement SB 1003 by updating references to "facility-based physician" and by deleting the related listing of included specialist categories. Amendments to subsection (l) also clarify that the applicability of paragraphs (10) and (11) is consistent with Insurance Code Chapter 1451, Subchapter K.

The amendments modernize and streamline the disclosure requirements, including by shortening the name of the written description to a plan disclosure in subsections (b), (c), and (f); requiring insurers to provide the plan disclosure in any plan promotion and link to the plan disclosure from the federally required summary of benefits and coverage in subsection (b); removing the requirement that a plan disclosure follow a specified order and permitting the insurer to use its policy or certificate to provide the disclosure in subsection (b); requiring availability via a website address instead of a mailing address in subsection (b)(2); requiring an explanation relating to preauthorization requirements in subsection (b)(9); conforming to the waiver disclosure requirements in HB 3359 in subsections (b)(14) and (m)(1); conforming prescription drug coverage disclosures requirements to §21.3030 in subsection (b)(4); streamlining network disclosure requirements in in subsection (b)(12); replacing service area disclosures with county disclosures to conform with HB 3359 in subsections (b)(13) and (e)(2); and conforming disclosure requirements concerning reimbursements of out-of-network claims to adopted changes in other sections, such as removing disclosure requirements for preauthorization penalties, consistent with the proposed amendment in §3.3704(a)(9).

In response to comment, subsection (b) as proposed has been revised to require provision of plan disclosures "on request" rather than in any promotion, advertisement, or enrollment opportunity. Also in response to comment, beginning at subsection (b)(14)(B) and continuing throughout the adopted rules, the words "preferred" or "physician or" have been inserted before the word "provider" for clarity.

Amendments to subsection (c) remove filing requirements for listings of preferred providers, consistent with the changes in subsection (b).

A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage. In response to comment, subsection (d) as proposed has been revised to add paragraph (2) to clarify requirements for promotions and advertisements.

Amendments to subsection (f) replace the preferred and exclusive provider benefit plan notices to reflect balance billing protections contained in SB 1264 from 2019, to remove outdated references and to limit the notice requirements to apply only to major medical insurance plans. In response to comment, both notices as proposed have been revised for clarity.

Amendments also add the titles of cited Insurance Code sections and update citations in subsection (k) to §3.3708 and §3.3725 to conform with the adopted amendments and repeal.

Subsection (m)(1) as proposed has been changed in response to comment to make clearer what information must be contained in the annual policyholder notice concerning use of an access plan.

In recognition of the network adequacy requirements contained in HB 3359, amendments remove requirements in subsection (n) to notify TDI of provider terminations that do not impact network compliance and requirements in subsections (p) and (q) to designate a plan network as an approved or limited hospital care network. In response to comment, subsection (n)(2) as proposed has been changed to clarify that, for purposes of determining whether the insurer must disclose a substantial decrease in the availability of certain preferred providers, decreases in numbers of physicians and other providers must be assessed separately. For example, if an insurer is assessing whether a decrease in the availability of anesthesiologists is substantial, the insurer should not include the count of nurse anesthetists in the assessment.

Amendments to subsection (o) update disclosure of payment standards for out-of-network services, consistent with the adopted changes in §3.3708.

In addition, amendments clarify language in the section by changing "chapter" to "title" in subsection (a), "address" to "website address" in subsection (b)(2), and "pursuant to" to "under" in subsections (b)(14)(B) and (m)(1). Amendments to subsections (e), (i), (j), (l), and (n)(5) make changes to simplify the text addressing information on an insurer's website by removing the words "internet" and "internet-based" and adding language using the term "website."

Section 3.3707. Waiver Due to Failure to Contract in Local Markets. Amendments to §3.3707 implement HB 3359 by updating the requirements for a finding of good cause for granting a waiver from network adequacy standards, subject to statutory limits referenced in subsection (a); requiring that a waiver request include certain information, including information demonstrating a good faith effort to contract (if providers are available) and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract in subsections (b) and (c); and clarifying the commissioner's consideration of an access plan for waiver requests in subsection (c).

In response to public comment, subsection (a) as proposed has been changed to remove the listed criteria for finding good cause.

Amendments in subsections (b) and (c) specify that an insurer must use the process and electronic form specified in §3.3712 to file a waiver request and access plan, which will enable TDI to publish data on waivers as required by statute.

Additional amendments in subsections (b) and (d) require an insurer to use TDI's electronic forms to submit the evidence supporting the waiver request and mark the document as confidential if it contains proprietary information. Required documents must be submitted in SERFF, which makes filed information publicly available, unless the insurer marks a document as confidential.

The text of subsection (b)(1) as proposed has been changed in response to comment. As adopted, subsection (b)(1)(B) expressly references the definition of "good faith effort" in Insurance Code §1301.00565(a). Subsection (b)(1)(C), which would have required a description of the best offer of reimbursement rates made by the issuer, is not adopted. Because proposed subsection (b)(1)(C) is not adopted, the subparagraphs that follow it have been redesignated. The text of adopted subsection (b)(1)(C) (which was proposed as subsection (b)(1)(D)) has been modified to change the word "refusing" to "declining" and to clarify that insurers should submit a description of any reason each

provider or physician gave for declining to contract, such as their participation in any exclusivity arrangement.

In response to comment, the text of subsection (b)(2) as proposed has been changed to require insurers to state if there are no providers or physicians available with whom a contract would allow the insurer to meet a network adequacy standard.

The form requirements in subsection (b) include the requirement for insurers to submit information on the new attempt to contract template. A draft template was posted on TDI's website along with the proposal. In response to comment, TDI has changed the template available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized template will be made available on TDI's website at www.tdi.texas.gov. Some of the changes include the following:

- Reformatting the template's cover page.

- Relabeling the "Compliance Access Plan & Waiver Request" heading on filer's information box in the Cover Page as "Filing Information."

- Adding the SERFF tracking number information to the cover page. When the insurer fills in the SERFF tracking numbers on the cover page, using the tracking number assigned by the SERFF system upon the filing of a waiver request, the information will auto-populate in other parts of the template.

- Relabeling the "Waiver Request ID" column in the data worksheet as "SERFF tracking No."

- Adding a "County type" column in the data worksheet to enable TDI to track county types associated with each attempt to contract.

- Removing the "Actions to eliminate network adequacy gaps included in waiver request and access plan" column in the data worksheet. Similar information is already requested in the cover sheet.

- Removing the two columns seeking rate information in the data worksheet.

- Adding a "Deficient county waiver is being requested for" column in the data worksheet to enable TDI to identify the applicable waiver associated with each attempt to contract.

- Relabeling the "Associated hospital name, if applicable" column to replace "hospital" with "facility."

- Adding columns in the data worksheet for the description of the contact method used by the insurer.

- Relabeling the "Comments (as applicable)" column in the data worksheet as "Additional information demonstrating that the insurer made a good faith effort to contract, as defined in Insurance Code 1301.00565(a)." This change clarifies TDI's expectation that insurers provide sufficient detail to allow the agency to evaluate whether the insurer's contracting attempts satisfy the good faith efforts standard.

- Adding new "NA Standards" and "County Designation" reference worksheets that illustrate the applicable time and distance standards for each specialty type and county classification; the classification of each Texas county, consistent with Insurance Code §1301.00553; and the public health region that each county is assigned to, consistent with §3.3711.

In response to comment, subsection (c)(2) and subsection (m) as proposed have been changed to provide an updated citation to access plan requirements in §3.3712(c)(2)(C)(iv).

Amendments in subsection (d) also remove the requirement for insurers to send notices of waiver requests to physicians and providers; instead, TDI will send notices to those providers in advance of a waiver hearing. Amendments to subsection (e) clarify the process for providers to respond to a waiver request.

An amendment to subsection (h) clarifies that TDI will specify the one-year period for which the waiver will apply and will post information relating to the waiver on its website, and an amendment to subsection (g) clarifies that an insurer may request to renew a waiver in conjunction with filing the annual report as required in §3.3709.

Existing subsections (i)(1) and (2) and (j) are deleted to conform with the amended access plan requirements of §3.3707 and filing requirements in §3.3712; references in this section to "local market access plan" are changed to remove references to local markets to conform with the changes in HB 3359.

In response to comment, subsection (j)(2) as proposed has been changed to require insurers to make at least two physicians or providers (rather than at least one) available to insureds when no preferred provider is available.

Amendments in the text of existing subsection (k) (which is redesignated as subsection (j)) and the text of new subsection (k) update the required processes that an insurer must develop to facilitate access to covered services, provide insureds with an option to obtain care without being subject to balance billing, and ensure that insureds understand what options they have when no in-network provider is reasonably available.

New subsection (m) replaces previous access plan requirements with the requirement that insurers submit a general access plan that will apply in any unforeseen circumstance where an insured is unable to access in-network care within the network adequacy standards.

Subsection (n) is deleted, as it is outdated in view of the changes relating to network waivers in this section.

Also, an amendment to subsection (a) corrects an Insurance Code citation and adds the name of the cited section. In addition, amendments clarify language in the section by changing "in accord with" to "consistent with" in subsection (a) and "pursuant to" to "in accordance with" in subsections (g)(2) and (i).

Section 3.3708. Payment of Certain Out-of-Network Claims. Amendments to §3.3708 change the section title to replace "Basic Benefit" with "Out-of-Network" and to delete "and Related Disclosures." Amendments also replace previous subsections (a) and (b), which contained provisions invalidated by the TAHP Order, with new subsections (a) and (b). New subsection (a) provides payment standards for certain out-of-network claims and to reflect balance billing protections, consistent with SB 2476 and SB 1264. New subsection (b) provides consumer protections for network gaps. Subsection (b)(2)(B) as proposed has been corrected to end with a period rather than a semicolon.

Amendments consolidate the requirements for preferred and exclusive provider benefit plans by moving some provisions from §3.3725 to §3.3708. The adopted repeal of §3.3725 is discussed in a subsequent paragraph of this adoption order. Section 3.3708(d) is amended to clarify that exclusive provider benefit plans are exempt from certain payment requirements for

out-of-network services, and references to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Previous subsection (e) is deleted, as it is no longer in effect. It is replaced by a new subsection (e), which implements HB 2002 by clarifying that an insurer must credit certain direct payments to nonpreferred providers toward the insured's in-network cost-sharing maximums. To address a discrepancy raised by a comment and for closer alignment with Insurance Code §1301.140, the text of new subsection (e) as proposed has been changed to remove references to nonpreferred providers. This removal will clarify that insureds may claim a credit regardless of whether they obtain services from a preferred or nonpreferred provider.

Previous subsection (f) is deleted because, with the other adopted amendments, application of the section should no longer be limited to exclusive provider plans. The subsection is replaced by a new subsection (f), which implements HB 1647 by clarifying that insurers must cover certain clinician-administered drugs at the in-network benefit level. In response to a comment, subsection (f) as proposed has been modified to more closely reference the requirements of coverage under Insurance Code Chapter 1369, Subchapter Q.

Section 3.3709. Annual Network Adequacy Report. Amendments to subsection (a) restructure the language of the section for clarification. Amendments to subsections (b) and (c) revise the text of the subsections to expand the content to be included in the annual network adequacy report, including requirements for insurer identifying information and information relating to network configuration, facility access, waiver requests and access plans, enrollee demographics, complaints, and actuarial data. An amendment to subsection (c)(4) also updates a reference to "basic benefits" to clarify that the term refers to out-of-network benefits. In response to a comment, subsection (c) as proposed has been changed to move the phrase "the number of" to subsection (c)(1) for clarity.

Amendments to subsection (d) require that annual network adequacy reports be submitted to TDI via the SERFF system using the electronic template provided by TDI and remove the option to file the report via email. A draft of the annual network adequacy report template was posted on TDI's website along with the proposal. In response to comments, TDI has changed the template available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized template will be made available on TDI's website at www.tdi.texas.gov. Some of the changes include the following:

- Removing the word "Annual" from the "Network Adequacy Report (LHL706)" form name.

- Updating the formatting of the "Network Info and Checklist" worksheet.

- Adding "preferred provider benefit plan" and "exclusive provider benefit plan" checkboxes to the cover page for the filer to identify the network type.

- Adding "SERFF tracking No. of last approved waiver(s) for this network" and "Network ID" fields to the cover page.

- Updating citations to the Administrative Code.

- Relabeling the "Number of providers in network as submitted" and Number of preferred providers" columns in the claims data worksheet as "Number of preferred providers in network as submitted in current filing" and "Number of preferred providers in the network submitted in the previous year," respectively.

- Expanding the specialty types listed in the claims data worksheet to include all applicable specialty types reviewed on the network compliance and waiver request form.

- Adding a new "County Designation" reference worksheet that illustrates the classification of each Texas county, consistent with Insurance Code §1301.00553, and the public health region that each county is assigned to, consistent with §3.3711.

Section 3.3710. Failure to Provide an Adequate Network. Amendments to subsection (a) clarify the scope of the commissioner's sanction authority. Additional amendments to subsection (a) add the titles of cited Insurance Code sections; remove references to the term "local market"; and change "and/or" to "and"; and amendments to subsections (a) and (b) change "pursuant to" to "under."

Section 3.3711. Geographic Regions. Amendments to §3.3711 proposed to replace the ZIP code listing with a county listing, based on the regional map available at www.hhs.texas.gov and consistent with the requirement in HB 3359 that service areas may not divide a county.

TDI has modified the proposed text of §3.3711 to remove the county listing and instead refer to the public health regions designated under Health and Safety Code §121.007 and listed in the annual network adequacy report form, for increased flexibility and to accommodate future updates to region designations. TDI has also modified the proposed text to correct a punctuational error by adding a closing parenthesis to the first sentence.

Section 3.3712. Network Configuration Filings. New §3.3712 implements HB 3359 by requiring submission of network configuration information. This information was addressed in §3.3722. Subsections (a) and (b) clarify that network configuration filings must be submitted in SERFF and are required in connection with a waiver request under §3.3707, an annual report under §3.3709, or an application or modification under §3.3722. Subsection (c) specifies that insurers must use TDI's electronic templates when making network configuration filings and lists the information that must be included within the templates.

The purposes of these electronic templates are to assist the insurer in demonstrating compliance with the network adequacy requirements contained in HB 3359 and to allow TDI to aggregate and publish information concerning networks and waivers consistent with Insurance Code §§1301.0055(a)(3), 1301.00565(g), and 1301.009.

Drafts of the new network compliance and waiver request template and provider listings template were posted on TDI's website along with the proposal. In response to comment, TDI has modified the templates available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized templates will be made available on TDI's website at www.tdi.texas.gov.

Some of the changes to the network compliance and waiver request template include the following:

- Relabeling the "Compliance Access Plan & Waiver Request" heading on filer's information box in the Cover Page as "Filing Information."

- Relabeling the "Waiver request ID" column on the network report worksheets as "SERFF tracking No."

- Adding the SERFF tracking No. information to the template's cover page. When the insurer fills in the SERFF tracking numbers on the cover page, using the tracking number assigned by the SERFF system upon the filing of a waiver request, the information will auto-populate in other parts of the template.

- Repositioning the county list on the cover page to allow filers to more easily select the counties in a service area.

- Revising the county list and the county designations to correct typographic errors identified by a commenter.

- Relabeling the "Specialty" column in the network report worksheet to "Specialty type" for consistency.

- Relabeling the "Number of preferred providers" column in the network report worksheets to add "within the county."

- Relabeling the "Access Plan Required" column in the network report worksheets to "Are network adequacy standards met? (Yes: Adequate; No: Waiver requested)."

- Relabeling the "Years a waiver for this deficiency has been requested (starting 2024)" column in the network report worksheets as "Years a waiver for this deficiency has been granted." Instructions were added to clarify that insurers must specify each year and separate with commas. This will first be reported in 2025, as 2024 is the first year a waiver will be granted under the new rules.

- Relabeling the "Reason Network Providers Not Available" column as "Reason preferred providers not available" for clarity.

- Adding a column for insurers to indicate, "Is waiver needed because there are no physicians or providers available to contract within the service area and applicable time and distance standards?" This information is needed to identify waiver requests that meet the criteria under Insurance Code §1301.0055(a)(6).

- Relabeling the "Number of providers available" column in the network report worksheets to "Number of non-contracted physicians and providers available within the service area and applicable time and distance standards," for major medical and vision providers, and "Number of non-contracted physicians and providers available within the facility" for facility-based physicians and providers.

- Relabeling the "Source System" column as "Source for available physicians and providers."

- Relabeling the "General Plan for Access" column in the network report worksheets as "Access plan."

- Removing the "Percentage of insureds with access to only one provider," "Compliant with at least one (yes/no)," and "Compliant with at least two (yes/no)" columns in the network report worksheet to align with changes to §3.3704(f)(2).

- Removing the "Actions to eliminate network adequacy gaps included in waiver request and access plan" column in the network report worksheet in response to comment, since similar information is collected in the cover page of the attempt to contract form.

- Expanding the "FB Physician or Provider" worksheet, which was inadvertently truncated in the version available at the time of proposal, to separately collect compliance information and waiver requests relating to facility-based physicians and providers.

- Amending the "NA Standards" worksheet, which summarizes network adequacy time and distance standards that apply to various types of physicians and providers, to include the following additional specialty types: durable medical equipment, home health, pharmacy, optometrists, and therapeutic optometrists. This updated worksheet is added as a reference to the attempt to contract and provider listing forms.

- Updating the "NA Standards" worksheet to list the applicable facility types and specialty types for evaluating facility-based physicians and providers, consistent with Insurance Code §1301.0055(b)(4).

- Making available a separate network compliance and waiver request template for vision networks so that vision insurers can more easily provide information specific to vision provider types.

Some of the modifications to the Provider Listing template include the following:

- Adding a "Cover Page" worksheet to capture the insurer name, NAIC number, Network name, Network ID, and SERFF tracking number.

- Adding "SERFF tracking No." column for consistency.

- Refining formatting, including splitting the "Provider's Last and First Name" column into two separate columns.

- Converting open text fields into dropdown menus.

- Relabeling the "Does this provider offer telehealth?" column in the Individual worksheet as "Does this provider offer telehealth/telemedicine?"

- Adding "FB Physician or Provider" and "Facility" worksheets, which were inadvertently omitted in the version available at the time of proposal, to separately collect physician and provider listing information relating to facilities and facility-based physicians and providers.

- Adding in the Individual worksheet an "if available" notation to the column label for the name of the facility at which the provider has privileges.

- Adding new "NA Standards" and "County Designation" reference worksheets that illustrate the applicable time and distance standards for each specialty type and county classification; the classification of each Texas county, consistent with Insurance Code §1301.00553; and the public health region that each county is assigned to, consistent with §3.3711.

The text of subsection (c)(1)(B) as proposed has been changed to clarify that network configuration filings must include information about the licenses of preferred providers and whether they offer telemedicine. The text of subsection (c)(2)(C)(i) as proposed has been changed to better align with Insurance Code §1301.0055(a) and conform to changes made to §3.3707(b)(2), by replacing the reference to "of an insufficient number of physicians or providers available within the network adequacy standards" with "there are no physicians or providers available with whom a contract would allow the insurer to meet the network adequacy standards." The text of subsection (c)(2)(C) as proposed has also been changed to remove clause (v), because similar information is required in §3.3707(b)(1(D) and collected on the cover page of the attempt to contract form template.

Subsection (d) clarifies that information submitted under §3.3712 is considered public information and will be subject to publication by TDI.

In response to comment, new subsection (e) has been added to clarify that, upon request by TDI, an insurer must provide access to any additional information needed to evaluate and make

a determination of compliance with quality-of-care and network adequacy standards.

Section 3.3713. County Classifications for Maximum Time and Distance Standards. The commissioner declines to adopt proposed §3.3713. To capture any future changes in the statutory classification of counties, proposed §3.3713 has been withdrawn. Instead, TDI has listed the county classifications consistent with Insurance Code §1301.00553(b) within the network compliance and waiver request form. That form lists each Texas county and identifies whether it is classified as large metro, metro, micro, rural, or a county with extreme access considerations.

Division 2. Application, Examination, and Plan Requirements

28 TAC §§3.3720, 3.3722, 3.3723, and 3.3725

Section 3.3720. Preferred and Exclusive Provider Benefit Plan Requirements. The amendments to §3.3720 update the titles of administrative code sections referenced in the section; revise an incorrect citation in the section; remove a reference to repealed §3.3725; add the title to a citation to the Insurance Code; and change "pursuant to" to "under."

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The amendments to §3.3722 implement HB 3359 by updating network configuration filing requirements and cross-references to conform to changes made in §§3.3038, 3.3707, 3.3708, and 3.3712, and the repeal of §3.3725. Requirements for network modifications are clarified to align with current practices.

Amendments to subsection (a) clarify that insurers must use the specified form to file an application for approval of a plan.

An amendment to subsection (b)(4) clarifies the rule text by changing passive voice to active voice.

Amendments to subsection (c) update references to service areas to refer to counties, consistent with HB 3359; update a reference to "medical peer review" to conform to statute; replace the listing of required network configuration information with a reference to new §3.3712; replace citations to §3.3725, which has been repealed; change "pursuant to" to "under"; and add titles to citations to the Insurance Code. In response to comment, paragraph (c)(10) as proposed has been changed to clarify the reference to §3.3707.

Amendments to subsection (d) clarify that the documents required for a qualifying examination must include network configuration information described in new §3.3712 that demonstrates network adequacy compliance. Amendments to subsection (d) also change "pursuant to" to "in accordance with" and "under."

Amendments to subsection (e) add a reference to new §3.3712; require that for nonrenewals resulting from a service area reduction, insurers must comply with §3.3038, as adopted; and remove the requirement that insurers must comply with §3.3724 to receive approval of a service area expansion or reduction application for certain exclusive provider benefit plans.

Section 3.3723. Examinations. Amendments to §3.3723 change "pursuant to" to "under" or "in accordance with," as appropriate, and also change "in accord with" to "in accordance with"; add the titles of cited Insurance Code, Administrative Code, and Occupations Code provisions; and add a citation to new §3.3712. Section 3.3723 as proposed has been changed to make the term "Commissioner" lowercase and to remove an erroneous use of "the," to reflect current agency drafting style.

In response to comment, paragraph (f)(7) as proposed has been changed to make clear that the documents an insurer must make available to TDI include the most recent demographic data provided by the insurer under §3.3709.

Section 3.3725. Payment of Certain Out-of-Network Claims. Section 3.3725 is repealed to conform with the amendments to §3.3708 and to remove sections invalidated by the TAHP Order.

In addition, amendments to the sections as previously described include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include adding headings to cited statutes and rules; removing references to repealed §3.3725; updating cross-references to other rules; updating terminology, including references to access plans, out-of-network level of coverage, and service areas; nonsubstantive text edits, including removing extraneous words such as "the" from statutory citations; and grammatical, punctuational, and format changes to reflect current agency drafting style and plain language preferences.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI provided an opportunity for public comment on the rule proposal for a period that ended on January 22, 2024. TDI received comments from 27 commenters during the comment period. A public hearing on the proposal was held on January 10, 2024; the hearing notice was published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7129) with a corrected notice published in the January 5, 2024, issue (49 TexReg 85). One commenter spoke at the public hearing. Commenters in support of the proposal were the Office of Public Insurance Counsel and the Texas Academy of Anesthesiologist Assistants. One commenter, the National Association of Vision Care Plans, was against the proposal.

Commenters in support of the proposal with changes were the American Association of Payers, Administrators and Networks; MultiPlan, Inc.; Superior Health Plan; Texas 2036; Texas Allergy, Asthma and Immunology Society; Texas Association of Health Plans; Texas Association of Neurological Surgeons; Texas Chapter of the American College of Physicians; Texas College of Emergency Physicians; Texas Dermatological Society; Texas Hospital Association; Texas Medical Association; Texas Oncology; Texas Ophthalmological Association; Texas Orthopaedic Association; Texas Osteopathic Medical Association; Texas Pediatric Society; Texas Radiological Society; Texas Society for Gastroenterology and Endoscopy; Texas Society of Anesthesiologists; Texas Society of Pathologists; State Representative Greg Bonnen; State Representative Tom Oliverson; and State Senator Charles Schwertner.

General Comments

Comment. A commenter states that they appreciate TDI's codifying internal policies, as this reduces confusion as to how to navigate agency processes. The commenter also appreciates TDI streamlining and updating Subchapters S and X.

Agency Response. TDI appreciates the commenter's support.

Comment. A commenter states that, as it pertains to TDI's deferment to Centers for Medicare & Medicaid Services (CMS) regulations for HMOs to reduce their administrative burdens given new regulations for exclusive provider benefit plans, they are in support of this recommendation.

Agency Response. TDI appreciates the commenter's support but notes that while HMO plans are not affected by this rulemaking, TDI continues to review HMO networks for compliance with Texas requirements.

Comment. Several commenters express concern that the required implementation timeline is too short. Several commenters suggest extending the April 1, 2024, submission deadline for annual network adequacy reports to September 1, 2024. Another commenter notes that the annual filing is a snapshot of the network as it currently stands, and the April 1, 2024, due date essentially moves the effective date of HB 3359 up from September 1, 2024, to April 1, 2024. That commenter suggests that TDI can maintain the April filing date but allow plans to continue good faith negotiations, and provide an opportunity to submit a second filing to demonstrate compliance as late as August 2024. Several other commenters collectively express support for the proposed timeline and questioned whether TDI needs to amend language in §3.3701 that addresses the effective date of previous rule changes.

Agency Response. To provide adequate time for insurers to submit filings after the rule is adopted, TDI will allow insurers until May 1, 2024, to submit their annual report filings for 2024. The due date will remain April 1 for future years.

While TDI agrees that network adequacy submissions reflect a snapshot in time, HB 3359 was signed by the governor in June 2023. HB 3359 applies to policies delivered, issued for delivery, or renewed on or after September 1, 2024. Insurance Code §1301.0056 requires TDI to examine network adequacy before a plan is offered, and Insurance Code §1301.00565 requires TDI to hold a public hearing before approving a waiver request. TDI will need sufficient time to review the network adequacy filings, hold public hearings, and make determinations of whether there is good cause to grant a waiver. TDI anticipates a high volume of hearings, as there were over 140 separate network waiver requests in 2023.

TDI does not believe that amendment of §3.3701 is necessary to clarify the effective date of these rule amendments because nothing in that section prevents these amendments from becoming effective. In addition, amending §3.3701 is outside the scope of this rulemaking because it was not included in the proposal.

Comment. Several commenters collectively seek clarification that the amendments and new sections will apply to both preferred provider benefit plans and exclusive provider benefit plans.

Agency Response. The provision at 28 TAC §3.3701(f) states that a provision of Title 28 applicable to a preferred provider benefit plan is also applicable to an exclusive provider benefit plan unless specified otherwise. Under §3.3701(f), the amendments and new sections that are applicable to preferred provider benefit plans also apply to exclusive provider benefit plans unless specified otherwise. This provision is consistent with Insurance Code §1301.0041.

Comments on §3.3703 - Contracting Requirements.

Comment. Several commenters collectively note that Insurance Code §1301.0642 prohibits certain adverse material preferred provider contract changes and state that these protections are essential in ensuring that insured patients' networks remain strong; however, the protections are not contemplated by the proposed rules. These commenters state that TDI must reference the new definition of an "adverse material change" to make clear what is and is not allowed and that explicit rules are necessary to direct the process. The commenters also recommend that TDI develop a process for reviewing and enforcing contract amendments to ensure compliance with the statute.

Several other commenters similarly note that TDI did not appear to implement Insurance Code §1301.0642 and recommend adding appropriate language to §3.3703(a)(20) and a new subparagraph (J), stating that "no adverse material change to a preferred provider contract will be effective as to the preferred provider unless the adverse material change is made in accordance with Insurance Code §1301.0642, concerning Contract Provisions Allowing Certain Adverse Material Changes Prohibited." These commenters would also like TDI to clarify that Insurance Code §1301.0642 supplements the existing requirements, so the existence of an adverse material change does not alter the existing requirements of §3.3703(a)(20).

Agency Response. TDI believes the requirements in Insurance Code §1301.0642 are enforceable without repeating it in the Administrative Code. Nevertheless, the text of §3.3703(a)(20) as proposed has been changed to add a reference to Insurance Code §1301.0642. TDI declines to make additional changes at this time but encourages providers to file complaints with TDI when appropriate so that the agency can take appropriate action if any carriers violate the requirements of Insurance Code §1301.0642. At this time, TDI declines to require that every contract change be filed for review but will continue to monitor complaints that are received to see whether additional processes and agency action are necessary. TDI agrees that the provisions of §3.3703(a)(20) continue to apply, so the existence of an adverse material change does not alter the existing requirements.

Comment. Several commenters collectively note that in the introductory clause to §3.3703(a), TDI changes the word "assure" to "ensure" in one instance. However, the commenters note that the introductory clause has two references to "assure" that should be "ensure."

Agency Response. TDI agrees and has made the suggested changes.

Comment. Several commenters collectively recommend that TDI clarify the reference in §3.3703(a)(29) to Insurance Code §1458.101 because the applicability of the statutory provisions depends on whether an entity meets the definition of a "contracting entity," a "general contracting entity," or both.

Agency Response. TDI agrees and has added "to the extent applicable" to the end of §3.3703(a)(29).

Comment. Several commenters collectively suggest TDI clarify that §3.3703(a)(30) applies only to a contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist. One commenter states that the relevant provisions are limited to Insurance Code §1451.155, rather than the entire subchapter. Another commenter expresses concern with the provisions enacted by HB 1696.

Agency Response. TDI agrees with the first comment and has added the words "that is an optometrist or therapeutic optometrist" to §3.3703(a)(30), as suggested. TDI disagrees that the only provisions in Insurance Code Chapter 1451, Subchapter D, that could affect contracts are limited to §1451.155. TDI is involved in active litigation challenging HB 1696 and its implementation.

Comments on §3.3704 - Freedom of Choice; Availability of Preferred Providers.

Comment. A commenter notes that TDI's amendment to §3.3704(a)(7) affirms TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and TDI's amendment to §3.3704(a)(9) prohibits an insurer from penalizing an insured solely on the basis of a failure to obtain a preauthorization. The commenter agrees that such practices are unjust under Insurance Code §1701.055(a)(2) and strongly supports these amendments. The commenter adds that the amendment to §3.3701(a)(9) is especially beneficial to Texas consumers "because insurers and providers are best equipped to navigate the sometimes-bewildering preauthorization process" and will help prevent insureds from unintentionally subjecting themselves to penalties for failure to complete a process they might not have been aware of. Several other commenters collectively agree that preferred and exclusive provider benefit plans cannot engage in these kinds of practices and support the intent of TDI's proposed amendment.

Agency Response. TDI appreciates the commenters' support.

Comment. A commenter seeks clarification of §3.3704(a)(9), asking, "If members can go in- and out-of-network at will, what is the purpose of network adequacy standards?"

The commenter states that allowing members to go out-of-network with no primary care physician (PCP), referral, or prior authorization circumvents an insurer's ability to ensure quality of care. The commenter notes that there are providers that refuse to work with insurers, resulting in members being unknowingly treated and then billed for all services. The commenter states that the purpose of a PCP is to take care of general services and assist the member in obtaining care and directing care for more complex services. The commenter notes that many specialists will not make an appointment or see members with another physician's referral. The commenter notes that PCPs typically have a network of specialists they work with, providing the member with coordinated medical care, and without this, members will need to navigate a complex medical system. The commenter states that this may lead to members being noncompliant with medical recommendations, physicians under risk arrangements could be responsible for members who seek care out-of-network, and members may end up paying additional out-of-pocket costs that could be avoided. The commenter notes that members electively going out-of-network are more likely to pay higher out-of-pocket costs for non-emergent care, as the nonparticipating providers most often will not agree to the health plan's fee schedule. The commenter notes that prior authorization requirements ensure that elective services are medically necessary and are covered benefits; without this, members might later find that they are obligated to pay an unexpected bill. The commenter notes that HEDIS/CAHPS/Provider Survey data collection will be difficult, as nonparticipating providers are not obligated to supply any information. This makes it more difficult for members to make informed decisions when choosing a health plan.

Agency Response. TDI declines to make a change. TDI agrees that PCPs provide a valuable role in coordinating care and making referrals. The rule does not prevent insurers from encouraging insureds to select a PCP; insurers just cannot require insureds to do so. While some insureds prefer to let their PCP refer them to a specialist, others prefer to self-direct their care and use a specialist of their own choosing. A key difference between insurance plans and HMOs is the insured's right to use any provider without a PCP acting as a gatekeeper to specialty care. This has been TDI's long-standing position, evidenced, for example, by TDI's response to a comment on this issue in 1999 that "nothing in the statute or rules authorizes the use of a 'gatekeeper' in a preferred provider plan." 24 Tex. Reg. 5204, 5207. TDI also notes that the definition of a preferred provider benefit plan in Insurance Code §1301.001(9) is a plan that provides "for the payment of a level of coverage that is different from the basic level of coverage . . . if the insured person uses a preferred provider." This indicates that the out-of-network coverage is not secondary or incidental--it is the basic level. That the basic level of coverage must be accessible is made clear in Insurance Code §1301.005, which provides that an insurer offering such a plan "shall ensure that both preferred provider benefits and basic level benefits . . . are reasonably available to all insureds. . . ." The rule also does not prohibit preauthorization requirements; it prevents penalizing the insured, since insureds cannot navigate those requirements independently from physicians and providers.

Insureds who choose to use out-of-network care generally understand that they will be responsible for substantially more out-of-pocket expenses, and depending on their chosen physician's or provider's policies, may also be responsible for seeking reimbursement from their insurer. Given this increased responsibility on the part of the insureds, they have plenty of incentive to work with their out-of-network provider to pursue verification and prior authorization before obtaining care. The Texas Legislature has empowered TDI via Insurance Code §1701.055 to disapprove insurance policy forms that violate TDI rules or contain unjust provisions. The prohibitions on these PCP, referral, and prior authorization requirements are based on TDI's assessment that it would be unjust to apply them to an insured in the context of a preferred provider benefit plan, particularly considering the structure of such plans under current law.

Comment. Several commenters collectively note that TDI states it is proposing language to prohibit an insurer from penalizing an insured solely on the basis of failure to obtain a preauthorization. The commenters state that, "given TDI's very vague and limited explanation of this proposal, we do not have sufficient information to meaningfully comment on this proposal." The commenters request more information on the penalties TDI references and the impetus for this amendment and its impact, and they request another opportunity to comment after additional information is made available to stakeholders.

Agency Response. TDI disagrees that its explanation of the proposal is vague and limited. Both the plain language of the rule text and the explanation clearly state that the amendments prohibit an insurer from penalizing an insured based solely on a failure to obtain preauthorization. TDI notes that the preamble on this issue contains an error. Specifically, TDI stated in the proposal, "This does not impact contractual requirements with preferred providers related to preauthorization requirements and does prevent an insurer from retrospectively reviewing a claim for a service that was not preauthorized and denying a claim if it fails to meet medical necessity standards." 48 TexReg 7134. The phrase "does prevent" should have been "does not prevent." TDI apologizes for the confusion.

Comment. Several commenters request clarification in §3.3704(e) on what limits to steering and tiering apply beyond those in HB 711. One of the commenters specifically asks for clarification on the reference to "full freedom of choice under this section." A commenter asks that TDI clarify whether there are any further rules that would limit a health benefit plan from developing a tiered network--specifically, any rules that require separate network tiers to meet network adequacy standards

independently. Two of the commenters support giving insurers broad authority to steer and tier, citing a study proving that tiered network designs saved 5% in health spending. Several commenters collectively oppose TDI's proposed language because it could be misconstrued as "granting blanket permission to steer and use a tiered network provided that the insurer meets only one requirement--i.e., engages in that conduct for the primary benefit of the insured or policyholder." The commenters note that HB 711 does not supersede other applicable laws, including Insurance Code §1251.006, §1301.068, and Chapter 1460.

Agency Response. TDI agrees that proposed §3.3704(e) could lead to a misinterpretation that steering and the use of a tiered network was governed exclusively by Insurance Code §1458.101(i) and §3.3704. TDI also agrees that HB 711 did not supersede other applicable law and notes that some steering approaches and tiered network designs meet the definition of a provider ranking system that is subject to additional requirements under Insurance Code Chapter 1460. To clarify the rule, TDI has changed §3.3704(e) as proposed to remove the "freedom of choice" reference and to reference the requirement under Insurance Code §1458.101(i). TDI has also changed the proposed text to provide additional guidance for insurers in new §3.3704(e)(3). TDI is not adopting rules that would strictly require separate network tiers to meet network adequacy standards independently. However, TDI will monitor this issue to ensure that network and benefit designs provide fair and reasonable access and that advertised cost-sharing levels are not illusory due to a lack of physicians and providers being reasonably available at preferred cost-sharing tiers.

Comment. A commenter notes that §3.3704 creates anti-steering provisions and restricts the use of a tiered network designed to encourage an insured to obtain services from a particular provider to only situations in which the insurer uses steering or a tiered network for the primary benefit of the insured. The commenter states their concern that this section does not specify the provider types it is applicable to, and this concern is applicable throughout the rule's network adequacy provisions wherever providers are referenced. The commenter seeks clarity with respect to a list of providers in the rule or an explicit cross-reference to an applicable Administrative Code section.

Agency Response. TDI agrees to change the rule text as proposed to clarify its applicability to various provider types. Accordingly, TDI has changed §3.3704(e) to add "as defined under Insurance Code Chapter 1458," following the reference to a "provider" under §3.3704(e). References to provider in other parts of the rule have the meaning as defined in Insurance Code §1301.001(1-a), as stated in §3.3702(b)(9). TDI has also made similar clarifying edits in the rule text to change provider references to a "preferred provider" or a "physician or provider," as appropriate.

Comment. A commenter welcomes that §3.3704(e) explicitly states that steering and tiering in compliance with Insurance Code §1458.101 do not run afoul of the insured's "freedom of choice" but notes that it is unclear what "full freedom of choice" means and wonders how it could have been construed to prohibit steering or tiered networks. The commenter suggests that TDI should clarify the meaning of §3.3704(a)(7) by explaining the statutory basis for the rule and providing a more explicit definition of "freedom of choice."

Agency Response. TDI agrees that the reference to "freedom of choice" in §3.3704(e) is unnecessary and has changed the subsection's proposed text to remove it. Regarding the statutory basis for the phrase "full freedom of choice" in §3.3704(a)(7), that phrase has existed in the preferred provider benefit plan rules since they were first adopted in 1986. The phrase is consistent with the subsequent requirement in Insurance Code §1301.0055 that TDI adopt rules that ensure the "availability of, and accessibility to" providers and ensure "choice, access, and quality of care. . . ." Similarly, Insurance Code §1301.006 requires that insurers contract with providers "in a manner ensuring availability and accessibility. . . ." Finally, Insurance Code §1301.007 requires that TDI adopt rules to "ensure reasonable accessibility and availability of preferred provider services to residents of this state."

The Legislature is aware of TDI's interpretation that preferred provider benefit plans may not require the use of a "gatekeeper" to manage an insured's care. For instance, in adopting amendments to §3.3704 in 1999, TDI responded to a comment on this issue by stating that "nothing in the statute or rules authorizes the use of a 'gatekeeper' in a preferred provider plan" 24 TexReg 5204, 5207. In light of TDI's long-standing interpretation and the legislative language consistent with that position, TDI declines to make a change to §3.3704(a)(7). While carriers have been able to comply with the "freedom of choice" requirement for many years, TDI is providing additional guidance in the meaning of the phrase through its amendment to §3.3704(a)(7) and does not believe additional changes are needed at this time.

Comment. Multiple commenters note that Insurance Code §1458.101(i) imposes a fiduciary duty on an insurer to its enrollees when it engages in steering or modifies a tiered network, but TDI's proposal fails to reference this fiduciary duty.

One commenter asks that TDI consider the following revision to §3.3704 so that the rule follows the statute: "(e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section *but only if by doing so such conduct allows the insurer to meet its fiduciary duty to the insured or policyholder that such conduct is for the primary benefit of the insured or policyholder,* consistent with Insurance Code §1458.101(i), concerning Contract Requirements." The commenter cites *Orbison v. Ma-Tex Rope Company Inc.*, 553 S.W.3d 17, 21 (Tex. App. Texarkana, 2018) for the proposition that "the term fiduciary 'applies to any person who occupies a position of peculiar confidence towards another' and 'contemplates fair dealing and good faith.'" The commenter asserts that, left unchecked, insurers could begin steering patients toward providers that accept the cheapest reimbursement rate without considering the quality of care provided. The commenter adds that imposing a fiduciary relationship ensures that insurers engage in steering or modify tiered networks only if patients will receive high-quality health care at an affordable cost--not to increase insurers' profit margins.

Another commenter also requests that TDI include information and guidance on how it will evaluate steering or tiered benefits in the context of the fiduciary duty. The commenter suggests that TDI clarify practices that might result in enhanced scrutiny, such as situations where the potential for self-dealing could occur. The commenter notes as an example an insurer steering enrollees toward a practice group in which the insurer has a financial interest and suggests that this might require the presentation of evidence as to why the provider represents the best value to the insured, taking into account both the price and quality of the provider.

Several commenters collectively note that the Legislature created this fiduciary duty as a matter of law and that otherwise there is no general fiduciary duty between an insurer and an insured, and thus suggest that TDI add an explicit set of fiduciary duties in the rule to ensure that insurers are aware of their duties. The commenters suggest that TDI explain the penalties for violating the fiduciary duty as well as the remedies available to insureds for a violation. Finally, the commenters request that TDI require insurers to provide notice of steering or a tiered network in its plan disclosures, and state that this is part of an insurer's fiduciary duty.

Agency Response. TDI agrees that it would be appropriate to incorporate "fiduciary duty" into §3.3704(e) and has changed the text to both expressly reference the statutory requirement and provide additional guidance to insurers. Specifically, §3.3704(e)(3) has been added to include examples of acts that are presumed to violate an insurer's fiduciary duty, such as using a tiered network as an inducement to limit medically necessary services. However, the fiduciary duty is a new statutory requirement, so TDI encourages consumers and providers to file complaints as appropriate on this issue so that TDI can be better informed of compliance issues. TDI will continue to monitor complaints that are received to ascertain whether additional guidance and agency action are necessary. Further, when a form filing indicates that a tiered network is involved, TDI may request additional information that demonstrates the insurer's compliance with the fiduciary duty requirements. TDI welcomes discussions with insurers who have questions about compliance. Regarding explaining the penalties and remedies for violating the fiduciary duty, TDI believes that existing law provides sufficient guidance but will continue to monitor the issue. Regarding plan disclosures, TDI declines to require by rule that insurers provide notice of steering or a tiered network and believes that carriers will provide information to consumers regarding these aspects of plan design but is not ready at this time to find that every failure to do so would be a violation of fiduciary duties.

Comment. A commenter notes that TDI proposed to delete the old §3.3704(e) and requests that TDI confirm that insurers will still be required to include access to institutional providers and facilities.

Agency Response. TDI agrees that insurers will still be required to include access to institutional providers and facilities under §3.3704(f), which incorporates the requirements as to institutional providers found in Insurance Code §1301.0055.

Comment. One commenter opposes the minimum standards in §3.3704(f)(2) that require at least 90% of insureds to have access to a choice of at least two preferred providers within the statutory time and distance standards, arguing that stakeholders negotiated to codify federal requirements into state law, and the federal standard for qualified health plans offered on the exchange requires 90% of insureds to have access to at least one provider of each type. The commenter notes that while TDI network reviews have historically required access to at least two providers, the distance standard applied was 75 miles for most specialty providers; the effect of coupling the more stringent federal distance standards with the state requirement of "at least two" has a compounding effect that exceeds the law's intent. Several other commenters oppose the 90% minimum standard on the ground that it would leave 10% of insureds without the choice required by Insurance Code §1301.0055(b)(3).

Other commenters collectively note that there are significant differences between Texas and federal standards and encourage TDI to apply the plain language of the Texas statutes.

Another commenter offers support for the standards as proposed, which ensure a sufficient number of providers and reasonable choice to insureds.

Agency Response. TDI appreciates the commenter's support. TDI agrees that Insurance Code §1301.0055(b)(12) provides that TDI's rules "require sufficient numbers and classes of preferred providers to ensure choice. . . ." Accordingly, TDI has changed the text to require that all insureds have access to a choice of at least two preferred providers within the statutory time and distance standards. This approach provides more equal treatment for all insureds, guarantees choice, and leverages the distance standards specified in Insurance Code §1301.00553. TDI declines to apply or adopt federal standards. TDI is implementing state statutes that, as one commenter notes, are in variance from federal standards; for example, federal network adequacy standards do not include a "sufficient choice" requirement.

Comment. Several commenters collectively request clarification in §3.3704(f)(2) that the time and distance standards must be met for each physician specialty and class of health care providers identified in Insurance Code §1301.00553 and §1301.00554.

Agency Response. TDI agrees to provide clarification and has changed the proposed text of §3.3704(f)(2) accordingly. TDI notes that the comment also indirectly raises the question of which network adequacy requirements apply to specialty care and specialty hospitals that are not specifically addressed in Insurance Code §1301.00553. TDI had proposed deletion of §3.3704(f)(8), which provided a general rule of a 75-mile requirement for specialty care and specialty hospitals but has determined that it is necessary to maintain that general requirement for situations not otherwise addressed so that insurers are not left without any network adequacy requirements in those circumstances. Accordingly, TDI has changed the text of §3.3704(f) as proposed to require in new paragraph (4) that insureds be able to access at least two preferred providers within 75 miles for specialty care and specialty hospitals for which time and distance standards are not otherwise specified in Insurance Code §1301.00553.

Comment. Several commenters collectively express a concern that §3.3704(f)(2) fails to address the interactions among time and distance, appointment wait time, and other access standards.

Agency Response. Section 3.3704(f)(1), including §3.3704(f)(1)(E), requires compliance with the new maximum appointment wait time standards and other access standards. TDI agrees that for insurance policies delivered, issued for delivery, or renewed on or after September 1, 2025, a network must simultaneously comply with both the appointment wait time standards and the time and distance standards for each type of health care service the plan covers. That is, a network is not adequate if an insured is unable to access preferred providers within a given physician specialty or provider class within the appointment wait time standards in Insurance Code §1301.0055(b) and §1301.00555 and the time and distance standards applicable to that specialty or class. TDI declines to change the rule text, as it does not imply that an insurer can comply by meeting only one of the applicable network

adequacy standards. The network compliance and waiver request form has separate columns in which an insurer must report compliance with the "at least two" and "appointment wait time" standards. Unless all requirements are met, the insurer must request a waiver.

Comment. Several commenters collectively request that §3.3704(f)(3) be modified to strictly conform with Insurance Code §1301.0055(b)(4), which includes both "radiology and laboratory services" in addition to preferred providers, by amending it as follows: "(3) To provide a sufficient number of the specified types of preferred providers with the specialty types *and diagnostic services, including radiology and laboratory services* listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility*, including diagnostic services*" (new text is indicated by italics).

Agency Response. TDI agrees that it is appropriate to modify §3.3704(f)(3) to expressly include a reference to the "diagnostic" providers listed in Insurance Code §1304.0055(b)(4) and has changed the text as proposed to reflect this. TDI notes that the network compliance and waiver request form already includes diagnostic radiology under specialty types, and radiology and pathology under facility-based provider types.

Comment. Several commenters collectively oppose the proposed language in §3.3704(f)(3) because they say it improperly implements Insurance Code §1301.0055(b)(4) by arbitrarily determining that the sufficient number of preferred physicians for each applicable specialty at each preferred hospital, ambulatory surgical center, or freestanding emergency center is always two. The commenters add that this ignores the fact-specific nature of the statutory requirement to "ensure all insureds are able to receive covered benefits, at that preferred location." The commenters note, for example, that two in-network physicians may be enough at a small ambulatory surgery center but "woefully inadequate" at a large urban hospital. The commenters also assert that the rule conflicts with Insurance Code §1301.00565(e), which prohibits considering a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards. The commenters also provide draft rule text for TDI's consideration.

Agency Response. TDI disagrees and declines to make a change. Section 3.3704(f)(3), as modified in response to other comments, sets a clear-cut minimum baseline by specifying that the network must include at least two preferred physicians for each applicable specialty and diagnostic type at each preferred hospital, ambulatory surgical center, or freestanding medical care facility that credentials the particular specialty. The text states "at least" two, and §3.3704(f)(1)(B) incorporates the requirements of Insurance Code §1301.0055, including its requirement in subsection (a)(2) to ensure accessibility to contracted physicians and providers, its requirement in subsection (b)(3) that there be sufficient access to be capable of providing the health care services covered by the plan from preferred providers, and its requirement in subsection (b)(11) to ensure an adequate number of preferred providers. It is also important to factor in the impact of appointment wait time standards, which would likely be violated by a carrier that failed to provide an adequate number of preferred providers. Between the rules and the statutes, insurers will be required to show at least two preferred physicians and then also show that the number of preferred physicians in any particular situation is adequate to provide access.

Comment. A commenter notes that Insurance Code §1301.0055 requires an insurer to report any material deviation from the network adequacy standards to TDI within 30 days of the date the material deviation occurred and, unless there are no available providers or unless a waiver is requested, the insurer must take corrective action to ensure that the network is compliant not later than the 90th day. The commenter requests guidance on what constitutes a material deviation, what format or template should be used to notify TDI of a material deviation, and how the insurer should indicate that the issue has been remedied by the 90-day deadline.

Agency Response. The text of Insurance Code §1301.0055(a)(1) is clear: any violation of the network adequacy standards and requirements would be a material deviation that must be reported to TDI and promptly addressed through a corrective action or a request for a waiver. An insurer would notify TDI of a material deviation by submitting a network configuration filing in the SERFF system for a network modification, consistent with §3.3712 and §3.3722(e). TDI has changed the text of §3.3704(g) as proposed to clarify that the filing requirements in §3.3712 apply to a notification of a material deviation. Such a submission should include an access plan and description of corrective action taken by the insurer. If the insurer is unable to ensure that the network is compliant by the 90-day deadline, it should request a waiver, consistent with §1301.0055(a)(1)(B)(ii). If, after reporting a material deviation, the insurer has remedied the issue, the insurer can update its network configuration filing in SERFF.

Comment. Several commenters collectively recommend changing §3.3704(g) to require that an insurer must "promptly" take corrective action required to ensure a compliant network by no later than the 90th day after the occurrence of the material deviation.

Agency Response. TDI agrees and has changed the text of §3.3704(g) as proposed to include the word "promptly" in conformance with Insurance Code §1301.0055(a)(1)(B).

Comment. Several commenters collectively recommend changing §3.3704(g) to replace the word "area" with "county" to better conform with the underlying statute.

Agency Response. TDI agrees that clarification is appropriate but disagrees that the use of the term "county" in this context is the best way to conform the rule to HB 3359. The recommended change could be interpreted inconsistently with Insurance Code §1301.0055(a)(6), which references "no uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area." TDI has changed the text of §3.3704(g) as proposed to align with this reference.

Comment. A commenter asks whether insurers are able to measure network adequacy using physician or provider distance to insureds versus the CMS beneficiary file.

Agency Response. Section 3.3704(f)(2) provides that "an adequate network must, for each insured residing in the service area, ensure that all insureds can access a choice of at least two preferred providers for each physician specialty and each class of health care providers within the time and distance standards. . . ." Carriers must be able to demonstrate compliance with this requirement whether they are an established insurer or a new entrant to the market with no insureds. TDI does not currently

prescribe the method that carriers must use to demonstrate compliance, but TDI may evaluate the method used to ensure that it provides a reasonable estimation of where current and future insureds reside.

Comment. Regarding the network compliance and waiver request form, a commenter asks for clarification of the statement in §3.3704(f)(3) that "a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility." Specifically, the commenter asks, given the "or" statement, whether the expectation is to report on just one of these types or all three.

Agency Response. TDI agrees that additional clarifying language would be helpful to confirm that the requirement applies to all applicable facilities. TDI has revised the proposed text to add the phrase "that credentials the particular specialty" to §3.3704(f)(3), consistent with Insurance Code §1301.0055(b)(4).

Comment. A commenter requests clarification regarding whether compliance with appointment wait time requirements starts in 2025, with insurers submitting this detail in network adequacy reports beginning April 1, 2025. The commenter also asks whether a waiver is required if an insurer meets the time and distance requirements but not the appointment wait time requirements.

Agency Response. Section 3.3704(f)(1)(E) provides that Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards, will be effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025, and thus data on wait times is not required in the network compliance and waiver request form in 2024. However, TDI is requiring the data beginning April 1, 2025, to ensure that policies sold after September 1, 2025, will be compliant with this requirement. As the appointment wait times and the time and distance requirements are separate and independent requirements under Insurance Code §1301.0055, an insurer meeting time and distance requirements would also have to meet the appointment wait time requirements to be compliant. An insurer that does not meet the appointment wait time standards would be required to request a waiver, even if the insurer's network meets the time and distance standards.

Comments on §3.3705 - Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

Comment. Two commenters express concern that the inclusion of the phrase "in any promotion, advertisement, or enrollment opportunity" in §3.3705(b) is overly broad and goes beyond statute. These commenters request clarification that the disclosure requirements apply only to waiver-related disclosures in promotional materials for a specific insurance plan. These commenters also request flexibility for insurers to satisfy the disclosure requirements via a website link. Other commenters collectively argue that, by statute, the waiver-related disclosures must be in the actual promotion or advertisement. These commenters request limitations on an insurer's ability to use its policy, certificate, or handbook to satisfy disclosure requirements and also request reinstatement of the "upon request" provision to expressly permit insureds to request a description of policy terms and conditions. These commenters oppose removal of the requirement that policy disclosures be made in a prescribed order.

Agency Response. TDI has changed the text of §3.3705 as proposed to separately address waiver-related advertisement disclosures in subsection (d) and to reinstate the "upon request" language in subsection (b). TDI disagrees that the phrase "promotion, advertisement" goes beyond statute, as this language aligns with Insurance Code §1301.0055(a)(4).

TDI has changed the text of §3.3705(d) as proposed to clarify that the requirement applies to advertisements for a specific plan. A general advertisement at the company level encouraging consumers to shop for plans would not be subject to the requirement. TDI agrees that an insurer can fulfill this requirement by providing a statement that the plan received a network adequacy waiver and an electronic link from advertising materials for a particular plan to the plan disclosure required under §3.3705(d), which contains detailed information on any network waivers.

TDI declines to revert to the prescribed order requirement, as the federal summary of benefits and coverage disclosure requirements already allows for a meaningful comparison between plans, using a format that went through consumer testing. Allowing companies to include plan disclosures within policies and certificates helps both insurers and consumers by reducing the number of separate documents that insurers must develop and that consumers must review. In addition, policies and certificates are subject to plain language requirements under Insurance Code §1301.157.

Comment. Multiple commenters suggest that TDI make bold or more conspicuous the following sentence in each consumer notice in §3.3705(f): "If you don't think the network is adequate, file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439." A commenter notes that this will ensure that consumers are aware that they have the right to file complaints with TDI if they believe their plan is not providing an adequate network of health care providers and physicians to meet their needs.

Agency Response. TDI agrees this language should be made more conspicuous and has put the sentence in bold in both consumer notices.

Comment. Regarding the consumer notices in §3.3705(f), several commenters collectively state a concern that the notices fail to clearly inform insureds that a preferred provider is the same as an in-network provider or that preferred providers make up the plan's network. The commenters also state that the description of network adequacy does not mention or indicate network adequacy requirements. The commenters also state that the notice does not reference that an insured might be protected from balance billing when they relied on the plan's directory to pick an in-network provider. The commenters state their concern that the phrase "and you didn't pick the doctor or facility" is confusing since it is referring to care received at an in-network facility. The commenters also note their concern that the exclusive provider benefit plan notice implies that the plan does not have to pay for medically necessary covered services that are not available in the network. The commenters also provide a draft of the consumer notices that reflects specific editing suggestions.

Agency Response. TDI agrees with the commenters and has changed the proposed text of the consumer notices in §3.3705(f)(1) and (2) to address their points. TDI has based its changes on wording suggested by the commenters but has adapted the suggested language for additional clarity and consistency with agency rule drafting style.

Comment. A commenter notes that TDI's proposed amendments to §3.3705(l)(10) and (11) faithfully reflect the changes in law found in SB 1003 from the 88th Legislative Session. SB 1003 expanded the specialty and licensure types that must be organized by facility in provider directories.

Agency Response. TDI appreciates the commenter's support.

Comment. Several commenters collectively note that §3.3705(m)(1) requires an insurer to provide a link in its annual policyholder notice concerning the use of an access plan to a webpage listing of information on network waivers and access plans "made available under subsection (e)(2)" of §3.3705. The commenters note, however, that §3.3705(e)(2) would only require an insurer to link to a limited set of information regarding each county's network adequacy and would not require providing a link to a webpage listing of information regarding network waivers and access plans. Thus, the commenters suggest changing §3.3705(m)(1) to add a reference to subsection (b)(14)(B) and strike paragraph (2) from the reference to subsection (e)(2).

Agency Response. TDI agrees with the comment and has changed the proposed text to reference subsection (d)(2) rather than (b)(14)(B) (as suggested by the commenters) to align with other changes related to the waiver disclosure requirements.

Comment. Several commenters collectively assert that §3.3705(n) equates physician specialists and non-physician specialties when calculating and defining a substantial decrease in the availability of preferred facility-based physicians, and equating physicians with non-physicians artificially increases the number of available network physicians if a plan terminates a contract. These commenters suggest that because physicians and non-physicians provide different services and are trained to provide different levels of care, especially in a facility-based setting, TDI should not equate the two when calculating a substantial decrease in availability of a provider type. Several other commenters similarly note that, because "specialty" is undefined, inserting "or provider" could be interpreted as including non-physicians within a physician specialty. The commenters recommend TDI add language to clarify that facility-based physicians are separate from non-physician facility-based providers for purposes of calculating a substantial decrease.

Agency Response. TDI agrees that decreases in physician availability and other provider availability should be assessed separately. Accordingly, TDI has changed the text as proposed to add a clarifying clause to §3.3705(n)(2).

Comment. Several commenters collectively oppose TDI's removal of a requirement in §3.3705(n) for an insurer to certify to TDI that the termination of a provider contract will not cause their provider network to be noncompliant with network adequacy standards because enforcement of network adequacy standards is best upheld when TDI is informed of any substantial decrease of preferred providers at a preferred facility. The commenters state that the removal would allow an insurer to unilaterally determine that the termination will not cause its network to be noncompliant.

Agency Response. TDI disagrees and declines to make a change. TDI believes the new network adequacy requirements contained in statute and rule are sufficient to provide for compliance, and notes that a requirement for such a certification is not a common regulatory practice. While an insurer's determination that its network is compliant is to some extent unilateral, so is the decision by the insurer on whether to seek a waiver of network adequacy standards. TDI has found limited benefit in the prior requirement for insurers to send numerous certifications to TDI. Instead, TDI has found, for example, that complaints from consumers are effective sources of information for TDI to identify a network issue.

Comment. A commenter supports streamlining disclosure requirements for policy terms and believes that the proposed amendments to §3.3705, especially in new subsection (o)(2), will result in more transparent and understandable disclosures to Texas insurance consumers, as well as enabling them to determine how to obtain assistance in accessing care.

Agency Response. TDI appreciates the commenter's support.

Comment. Several commenters collectively oppose the deletion of approved and limited hospital care network designations and other disclosures and requirements in §3.3705(p) and (q) because these have been important consumer protections and will continue to be. The commenters assert that TDI may not consider balance billing protections in making the decision to delete these requirements.

Agency Response. TDI disagrees and declines to make a change. The labels of "approved" and "limited" hospital care networks were essentially shorthand to inform consumers whether an insurer had an adequate network. Under new Insurance Code §1301.0055(a)(3), insurers are now required to disclose in all promotions and advertisements that they are operating under a waiver. This renders the prior rule language duplicative and unnecessary.

Comments on §3.3707 - Waiver Due to Failure to Contract in Local Markets.

Comment. A number of commenters express concern that the rules do not allow providers to submit information for TDI's evaluation in determining whether a waiver from network adequacy standards should be granted. These commenters request that the rules require TDI to consider all pertinent information submitted in connection with a waiver request. Several commenters collectively request that TDI add language expressly stating that the commissioner may not consider a prohibition on balance billing, as required under Insurance Code §1301.00565(e).

Agency Response. TDI declines to make a change because the amendments to §3.3707(a) already state that the commissioner will determine whether to grant a waiver "after considering all pertinent evidence in a public hearing under Insurance Code §1301.00565. . . ." TDI will provide opportunities for providers and the public to submit information pertinent to a waiver request, consistent with the requirements of HB 3359, and the commissioner will make a determination on each waiver request in accordance with statutory guidelines. TDI will comply with its statutory obligations and declines to restate those statutory provisions in agency rules applicable to regulated entities.

Comment. A number of commenters suggest that insurers be required to provide, as part of a waiver request, substantive information about the insurer's efforts to contract and negotiate with uncontracted providers. Some of these commenters note that the determination of good faith efforts to contract requires a "highly fact-specific analysis" and that the rules do not explain how the information required in the attempt to contract form will demonstrate a good faith effort. Several other commenters request that the waiver rules should not limit the information to be provided regarding the insurer's good faith efforts to contract but

should instead allow the insurer and providers to offer proof of such efforts.

Agency Response. TDI agrees that it is appropriate to require an insurer to provide substantive information about its attempts to contract. The attempt to contract form requires the number of attempts made, the dates of the attempts, the method of contact used, and the reason for the provider declining to contract--information pertinent to the assessment of whether the insurer engaged in good faith efforts. TDI has changed the form to clarify TDI's expectations that the insurer provide additional information showing that the insurer made a good faith effort to contract, as defined in Insurance Code §1301.00565(a). In addition, TDI plans to provide public notice of each waiver hearing, and all interested stakeholders and the general public will be given the opportunity to provide TDI with evidence relating to the waiver request.

As several commenters note, the analysis of good faith efforts is highly fact-specific, and TDI declines to strictly define what will or will not constitute a good faith effort, beyond the framework provided in the statute. As part of its good faith analysis, TDI will consider all information pertinent to the waiver request, including the information provided in the request and associated forms, as well as all information submitted by insurers, providers, and members of the public, to determine whether the insurer's efforts reflect the requirements under Insurance Code §1301.00565. The information requirements in the attempt to contract form are not intended to constitute the entirety of the information considered by TDI, nor will such information be automatically included in TDI's consideration if it is not pertinent to the waiver request.

Comment. One commenter notes that the associated facility information required in §3.3707(b)(1)(A) is not always known to the insurer. The commenter requests clarification on whether the insurer may mark this information as unknown or unavailable.

Agency Response. If an uncontracted provider's facility association is not known by the insurer filing a waiver request, the insurer may mark such information as "N/A" (not available) for non-facility-based providers.

Comment. A commenter suggests that disclosure of the steps that an insurer will take to improve its network, as required in §3.3707(b)(1)(E), is not necessary because the attempt to contract form requires a description of recruitment efforts.

Agency Response. TDI disagrees that recruitment efforts provide the same information as the steps the insurer will take to improve its network. However, because the cover page of the attempt to contract form requests information on the steps the insurer will take to improve its network, TDI has modified the attempt to contract form and the network compliance and waiver request form as available when the text of §3.3707 was proposed to remove the table column labeled "Actions to eliminate network adequacy gaps included in waiver request and access plan."

Comment. Several commenters collectively argue that the criteria for good cause for a waiver as specified in §3.3707(a)(1) and (2) and TDI's reliance on the waiver request templates are not authorized by statute and are contrary to legislative intent because Insurance Code §1301.0055(a)(3) requires the commissioner to consider good faith efforts and all pertinent evidence received. These commenters express concern that the rule will allow the commissioner to ignore an insurer's failure to engage in good faith efforts with any uncontracted provider.

Agency Response. TDI agrees that it is appropriate to remove the criteria for good cause and adopts §3.3707(a) without paragraphs (1) and (2). As previously discussed, TDI will consider all pertinent evidence in determining whether good cause exists to grant a waiver. TDI notes that the information that the commissioner will consider in determining good cause is not limited to the specific items included in the attempt to contract template. Both insurers and providers are encouraged to present any relevant evidence.

Comment. Several commenters collectively oppose the reference to "insufficient number" of providers in §3.3707(a)(1) and §3.3707(b)(2) as contrary to statute. These commenters cite HB 3359 as requiring the commissioner to consider whether there are "no" uncontracted providers to meet a network adequacy standard, and they argue that the "insufficient number" reference provides for a much lower threshold for granting a waiver, thereby encouraging insurers not to contract with providers and allowing the commissioner to disregard whether the insurer made good faith efforts.

Agency Response. TDI notes that the "insufficient number" phrase was used to reflect the practical realities that some network standards require more than one physician or provider and, for network gaps in more distant parts of a county, there could be additional uncontracted providers in the county that are located in areas that would not address the network gap. TDI has changed the proposed text of §3.3707(a)(1) and §3.3707(b)(2) to reflect a "no providers" threshold. TDI has made a conforming change to §3.3712(c)(2)(C)(i). Under the adopted text, for a waiver from the §3.3704(f)(2) standard that all insureds must have access to at least two preferred providers, the threshold is met if there are no additional uncontracted providers available that would fill the network gap. For a waiver from maximum appointment wait time standards, the threshold is met if there are no additional providers available to contract that would fill the network gap.

Comment. One commenter requests that the statutory definition of "good faith effort" be added to §3.3707 and that insurers be required to attest that "they did not offer reimbursement rates designed to disincentivize providers from entering into contracts" with the insurers.

Agency Response. TDI has modified §3.3707(b)(1)(B) to include a reference to the statutory definition of "good faith effort." TDI declines to require the proposed attestation because it is unlikely to be helpful to TDI's assessment of the insurer's efforts.

Comment. Multiple commenters oppose the §3.3707(b)(1)(C) requirement for a description of the best offer of reimbursement rates made by the insurer, including computations based on Medicare rates and the insurer's average contracted rates. These commenters argue that (1) HB 3359 does not authorize TDI to collect this information, (2) Medicare rates do not reflect a fair market rate, and (3) the use of average contracted rates would allow the low and high ends of contract rates to distort rate computations. One commenter suggests that TDI instead require reporting consistent with CMS recruiting activity reporting and requests clarification on the disclosure requirements. Another commenter notes that the current industry standard is to use median rates. Several commenters suggest that, instead of rates information, TDI consider the insurer's ongoing efforts to bring providers in network and all circumstances surrounding contract negotiations and outcomes.

Agency Response. In consideration of the concerns raised by commenters, TDI has modified §3.3707(b)(1) as proposed to remove subparagraph (C). TDI will provide insurers, providers, and the public with opportunities to provide relevant information in connection with a waiver request. TDI will consider all relevant information.

Comment. Several commenters collectively object to the use of the terms "refusing" and "refused" in §3.3707 to refer to a physician's decision not to enter into a contract with an insurer on terms unacceptable to the physician. Several commenters oppose the requirement in §3.3707(b)(1)(D) that the waiver request include information on any exclusivity arrangement because HB 3359 does not expressly include this requirement and the information concerns private contract matters.

Agency Response. TDI has deleted the term "refused to contract" in §3.3707(a)(2) as proposed in response to another comment. TDI has changed §3.3707(b)(1)(D), now renumbered as §3.3707(b)(1)(C), to replace the term "refusing" with "declining" and to clarify that the requirements apply to information about the provider's participation in an exclusivity arrangement, rather than information about the exclusivity arrangement itself.

The amendments require insurers to describe any reason a provider or physician gave for declining to contract, including if the reason includes an exclusivity arrangement or other external factors. These factors that are outside the insurer's control are relevant in determining whether (1) the insurer made a good faith effort to contract, (2) an issue may be remedied through good faith efforts, and (3) there is good cause to grant a waiver. For example, if Hospital A has an exclusive contract with Physician Group B, which prevents any physicians outside Physician Group B from practicing at the hospital, the existence of the exclusivity arrangement is relevant in understanding the insurer's efforts to contract with a sufficient number of facility-based physicians at Hospital A to comply with the network adequacy standards applicable to Hospital A. TDI requires the insurer to report the total number of available physicians, the number of contracted physicians, and each physician with whom they attempted to contract. For each attempt to contract with a given physician or provider, the insurer must also report, if applicable, the group name and the associated facility name.

The existence of an exclusivity arrangement helps TDI understand why an insurer may focus its contracting efforts on Physician Group B, even if several other physicians appear to be available. TDI is authorized to seek this information under Insurance Code §1301.0055(a), requiring TDI to assess good cause for a waiver and good faith efforts; §1301.00565(c), requiring TDI to consider all information pertinent to a waiver request; and §1301.0056(e), authorizing TDI to require information necessary to evaluate compliance with network adequacy standards or to ensure the use of the plan in the most efficient and effective manner possible.

Comment. A commenter opposes TDI's consideration of whether a provider has refused to contract with the insurer on reasonable terms, as set forth in §3.3707(a)(2). The commenter asserts that this standard is highly subjective and recommends that TDI instead require reporting that aligns with CMS recruiting activity reporting.

Agency Response. TDI has deleted §3.3707(a)(2) in response to a different comment. With respect to the reporting requirements, TDI's attempt to contract form does align closely with the CMS spreadsheet on which qualified health plans report recruitment activity. For example, the CMS column "Status of Recruitment Efforts" provides information that is similar to the column in TDI's attempt to contract form labeled "The reason given for declining to contract." While TDI does not constrain the insurer's description in this field, the insurer could report information similar to the options within the CMS form, which include the following: Good faith offer rejected; Provider has entered into an exclusivity contract with another organization prohibiting the provider from contracting with us; Not licensed, accredited, or certified by the state; Moved/retired or facility closed; Does not contract with any commercial insurance organizations; and Contract negotiations being conducted.

Comment. A commenter supports TDI's proposed clarification of expectations for access plans and the proposed updates to the waiver process in §3.3707, especially in the proposed amendments in redesignated subsection (j), new subsection (k), and new subsection (m). The commenter adds that these rule updates represent important improvements to Texas insurance consumers' ability to obtain the proper services at a reasonable cost, without being blindsided by unexpected billing for services they believed were covered.

Agency Response. TDI appreciates the commenter's support.

Comment. A commenter notes that the rule proposal updates requirements and processes relating to the filing and consideration of requests for waivers from network adequacy standards and access plans. The commenter seeks clarification regarding adjudication of an insurer's waiver request, including the process for waiver hearings, and states that proper process is needed to ensure fairness.

Another commenter similarly states that insurers need more information surrounding the waiver and public hearing processes, particularly considering that network adequacy reports are due April 1, 2024.

In addition, a commenter proposes adding a provision requiring that waivers be granted for any county in a service area in which the counties do not meet standards. This would bring counties into compliance and simplify the waiver process. The commenter also asserts that waivers for partial county service areas, consistent with CMS, would also simplify the process, be in the best interest of the insured, and promote targeted recruitment. The commenter also suggests that there should be a mechanism for appeal to provide parties with administrative recourse in the event of an adverse ruling that they believe is defective.

Agency Response. Regarding waiver procedures, detailed procedural information is not required to be adopted by rule. However, TDI plans to post additional process information on its website. Regarding county-level waivers, §3.3707 of the rule addresses waiver requests at the county level, as contemplated by the Insurance Code. Section 1301.0055(a)(3) of the Insurance Code provides that when waivers are granted, TDI must post the "affected county" and other information on its website. Insurance Code §1301.0055(a)(5) places limits on waivers from being granted multiple times "in the same county" or in "each county in a service area" under certain circumstances. These provisions are consistent with Insurance Code §1301.005, which provides that service areas may not divide counties; thus, TDI will similarly not permit waiver requests that divide counties.

Regarding administrative recourse in the event of an adverse ruling on a waiver, TDI notes that, unlike some other TDI functions, network adequacy review decisions have not been delegated within TDI as a "routine matter" under Insurance Code

§36.102. Instead, TDI's denial of a waiver request is a final action that is subject to direct judicial review under Insurance Code Chapter 36, Subchapter D.

Comment. A commenter asks under what circumstances average rates and contract offer rates will be published.

Agency Response. In response to other comments, TDI has changed the forms as available when the rule text was proposed to delete the columns regarding rates in the attempt to contract form, and has deleted the corresponding requirement in §3.3707(b)(1)(C) to provide rate information, making this comment moot. If carriers believe that the information they choose to submit to TDI is confidential, they should mark it as such.

Comment. Several commenters collectively note that §3.3707(c)(2) includes an erroneous citation to "§3.3712(c)(2)(E)(iii)."

Agency Response. TDI has changed the proposed text of §3.3707(c)(2) and §3.3707(m) to correct the citation and apologizes for any confusion. The correct citation is §3.3712(c)(2)(C)(iv).

Comment. Multiple commenters object to the provision in §3.3707(d) stating that TDI will specifically notify providers named in a waiver request of the public hearing on that request. These commenters recommend that TDI be required to notify all providers in the affected county or counties of the waiver request and hearing and provide all providers with the opportunity to respond to the request and submit evidence, as required by statute. One commenter recommends that the rule describe the specific process for when, how, and to whom TDI will provide notice and seek consent in connection with the waiver hearings; the commenter criticizes the rule as placing the burden on providers to notify TDI of their consent to be named at the hearing.

Agency Response. TDI disagrees that Insurance Code §1301.00565(c) requires TDI to notify all providers, rather than "affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer. . . ." Similarly, the consent requirement does not apply to all providers. In addition, even if it were possible for TDI to specifically contact and notify each and every provider in all affected counties, these efforts would be cost prohibitive and would require significant agency resources. TDI plans to provide public notice of waiver hearings, which will allow all providers the opportunity to attend the hearings and submit evidence for TDI's consideration. All providers attending waiver hearings will have the opportunity to consent to be identified, consistent with Insurance Code §1301.00565(c), which provides that out-of-network providers may not be identified at the hearing unless they consent. TDI declines to adopt rules specifically describing agency procedures relating to waiver requests and hearings; TDI will comply with its statutory obligations and declines to restate those statutory provisions in rules applicable to regulated entities. However, TDI plans to provide additional process information on its website.

Comment. Multiple commenters assert that the 15-day period in §3.3707(e) for certain providers to respond to a waiver request is insufficient. One commenter suggests that TDI be required by rule to provide 60-day notice of the waiver hearing, and several commenters collectively suggest that the 15-day response period be extended to 30 days to give providers ample time to gather evidence and determine whether to give consent.

Agency Response. TDI declines to make a change to the notice period. Because of the anticipated volume of waiver hearings and the need for TDI to provide timely decisions on waiver requests before applicable statutory deadlines, TDI will need to promptly schedule and hold waiver hearings. To implement HB 3359 by September 1, 2024, TDI will not be able to provide 60-day notice and a 30-day response period. Evidence will be accepted from all providers and the public following the expiration of the 15-day period and up to one week after the hearing date, but prompt submission of evidence will allow TDI to be better informed of all pertinent evidence before a hearing.

Comment. Several commenters collectively recommend reinstating the requirement that an access plan include maps identifying the geographic areas in which a sufficient number of providers are available. These commenters claim that the maps would be an important and useful tool to TDI to monitor and verify compliance with network adequacy standards.

Agency Response. TDI declines to require the inclusion of maps in an access plan. Because it is not practical to measure driving distances via maps, TDI does not view maps as a helpful tool to verify compliance. While maps were useful under the prior network requirements, TDI does not believe they are necessary in the context of driving distance requirements. Under the prior network requirements, TDI measured distance standards based on radius, which could be easily illustrated using maps. In contrast, specialized software is needed to measure compliance with the driving distance requirements. Also, there is no reference in Insurance Code Chapter 1301 to requiring the submission of maps by insurers.

Comment. Several commenters collectively assert that the requirement in §3.3707(j)(2) for the insurer to recommend at least one provider to address a network gap does not provide sufficient choice consistent with HB 3359. These commenters suggest instead requiring the insurer to recommend at least three physicians or providers.

Agency Response. TDI agrees that consumers should have a choice of providers when there is a network gap, consistent with HB 3359. Accordingly, §3.3707(j)(2) has been modified to require the insurer to recommend a choice of at least two physicians or providers, consistent with other network adequacy choice requirements in §3.3704(f).

Comments on §3.3708 - Payment of Certain Out-of-Network Claims.

Comment. A commenter strongly supports TDI's proposal in §3.3708 providing payment standards for certain out-of-network claims and reflecting balance billing protections, to implement SB 2476 and SB 1264, and providing consumer protections for network gaps. The commenter notes that the rules protect insureds who do not have the ability to reasonably obtain in-network care, which has been a consistent problem for insureds, and the amendments provide important improvements to the existing rules. The commenter concludes that the amendments, especially those in subsection (b) and new subsection (e), will help ensure Texas insurance consumers' ability to obtain the proper services at a reasonable cost without being blindsided by unexpected billing for services they believed were covered.

Agency Response. TDI appreciates the commenter's support.

Comment. A commenter requests that TDI consider changing the maximum number of days in which an exclusive provider plan must process a referral to a nonpreferred provider from five

business days to, at most, three calendar days. The commenter notes that businesses often adopt different definitions for what constitutes a business day, and delays in the processing of referrals and transfers for care have a negative effect on the health and well-being of patients. The commenter continues, saying that waiting five business days can easily compound to nine or more days when including weekends and holidays, which can lead to irreversible consequences for patients who need timely care.

Agency Response. TDI notes that the language added in §3.3708(b)(2) is not new, but duplicates language previously included in repealed §3.3725. The old and new language provides that if services are not available through a preferred provider, the exclusive provider plan issuer must "process a referral to a nonpreferred provider *within the time appropriate* to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. . . ." TDI has not received a significant number of specific complaints that this language has had a negative impact on patient care and declines to change the minimum number of days at this time.

Regarding the reference to "business days," TDI notes that the Legislature has used that phrase many times in the Insurance Code. More specifically, regarding the time to process a referral, the Legislature in Insurance Code §1272.301, concerning Access to Out-of-Network Services, has provided that a contract between an HMO and a limited provider network or delegated entity must require that, if medically necessary services are not available in-network, the network or entity "shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day. . . ." TDI declines to adopt a more restrictive standard than the Legislature at this time.

Comment. Several commenters collectively oppose the deletion of §3.3708(c)(1), which provides a standard for calculating usual, reasonable, or customary charges. These commenters note that the paragraph was not invalidated by the court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020).

Agency Response. TDI declines to restore deleted §3.3708(c)(1). Because the TAHP lawsuit challenged rules providing for the calculation of usual and customary rates based on provider billed charges, deletion of the paragraph providing for calculations based on billed charges is consistent with the court order.

Comment. A commenter requests that TDI revise §3.3708(e) to align with the text of the statute in Insurance Code §1301.140 because the proposed rule places the burden on insureds to identify the discounted average rate paid by an insurer in order to claim the credit, which is not consistent with the statute. The commenter adds that HB 2002 imposed a duty on the applicable insurers to provide credits toward an insured's deductible and out-of-pocket maximum expenses if certain conditions are met and did not place the duty on the insured to undertake another administrative burden.

Agency Response. TDI disagrees with the comment and declines to make a change. Insurance Code §1301.140 requires that the insurer establish the "procedure by which an insured may claim a credit" and "identify documentation necessary to support a claim. . . ." The insurer must make information about the procedure readily accessible on its website, and TDI's rule clarifies that this includes identifying the average discounted rate. However, instead of merely requiring the insurer to give the credit any time the insured pays a claim out of pocket or otherwise placing the burden on the insurer to proactively identify when the insured has saved money over what the insurer would have paid, the statute is intended to reward consumers that shop for lower-priced care. As the May 13, 2023, Bill Analysis for HB 2002 states, the author's intent was to provide incentive for patients to seek out deals and encourage cost-saving behavior. Under the statute, the insured is provided the necessary information to shop for care and then make a claim for the credit. Only the insured will know what they have ultimately paid out of pocket to a particular provider.

Comment. A commenter welcomes rules regarding implementation of HB 2002 and expresses support for the clarification that credit to the deductible and out-of-pocket maximum must be provided at the preferred level of coverage (§3.3708(e)(3)), as this specification most naturally follows the legislative purpose to reward patients who find good value outside of the network. The commenter adds that applying the credit toward any other level of coverage would already be required under existing law, so the regulatory interpretation here gives effect and meaning to the statutory language of HB 2002.

Agency Response. TDI appreciates the commenter's support. TDI notes that the comment indirectly raises a discrepancy between the proposed rule text and the language of the statute. Specifically, the proposed rule text referenced the credit being available in situations where the insured pays a "nonpreferred" provider without a traditional claim being filed with the insurer. However, HB 2002 contains no such reference to nonpreferred, or out-of-network, providers. Because the rule text was inconsistent with statute, TDI has deleted references to nonpreferred providers in §3.3708.

Comment. A commenter suggests that TDI specify at least one procedure that would satisfy §3.3708(e)(1)--specifically, that insurers may satisfy this requirement by providing the "average discounted rate paid by the insurer . . . for a covered service or supply" through the self-service tool that insurers are required to provide enrollees to identify real, negotiated, provider-specific rates under the federal Truth in Coverage rules (and corresponding state requirements).

Agency Response. TDI agrees that insurers are already required to provide price comparison information for participating providers under 42 USC §300gg-114, and information on negotiated rates and estimated cost-sharing information under 45 CFR §147.211. However, these federal requirements are different from the "average discounted rate," which insurers must disclose under Insurance Code §1301.140. If an insurer wishes to leverage existing price transparency websites to comply with HB 2002, they must update those websites to include information on the insurer's average discounted rate.

Comment. A commenter suggests that TDI consider clarifying that the "average discounted rate paid" under §3.3708(e)(1) must be calculated from actual paid claims, rather than an average of negotiated rates. The commenter states that this can prevent the inclusion rates that are negotiated in contracts, but rarely or never actually used, usually because the rates are included in contracts with providers that do not provide the service on a regular basis. The commenter also suggests specifying a

time period over which the average must be calculated and the frequency of updates in the publication of the calculation.

Agency Response. TDI disagrees that the proposed change is needed. Insurance Code §1301.140 and §3.3708(e) both require that insurers identify the average discounted rate "paid." A carrier disclosing a discounted rate based on average negotiated rates would be noncompliant with this requirement. Regarding specifying data time frames and updates, in TDI's experience, it is important to give insurers some flexibility as they develop their initial compliance procedures, and it is unlikely that carriers would use time frames or update frequencies that would materially affect consumers' ability to obtain the required credit. However, TDI will continue to monitor this issue for complaints in case additional clarification is needed in the future.

Comment. A commenter notes that the rule text in §3.3708(f) accurately reflects the intent of HB 1647 regarding the coverage of certain drugs at the preferred level, even if administered by a nonpreferred provider. However, the commenter recommends the following definition be added: "Preferred level of coverage--the highest level of coverage that an insured receives under the applicable policy with a preferred provider benefit plan for drugs or services administered or provided by a preferred provider, which includes the amount of financial liability allocated to the insured for such drugs or services, including any applicable copayment, coinsurance, and deductible."

Agency Response. TDI declines to make a change at this time. TDI agrees that payment is required at the in-network level of benefits but does not believe that the suggested definition would add any material clarification beyond the detailed language of HB 1647 found in Insurance Code §1369.764(a)(4).

Comment. A commenter notes that proposed §3.3708(f) requires an insurer to cover a clinician-administered drug under the preferred level of coverage if certain criteria are met, even if it is dispensed by a nonpreferred provider. However, the commenter notes that HB 1647 was carefully drafted to apply only to nonpreferred "pharmacies." The commenter notes that not only pharmacists can dispense; for example, §158.003 of the Texas Occupations Code allows physicians to dispense certain drugs in rural areas. The commenter asks that TDI either cite to the relevant Insurance Code section or replace "provider" with "pharmacy." In addition, the commenter notes that Insurance Code §1369.763 contains an exception that the coverage requirements do not apply "to a prescription drug administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center," but the proposed rule does not account for this exemption because it is not part of the criteria in Insurance Code §1369.764. The commenter asks that TDI add this key provision to the rule. Several commenters collectively oppose the first commenter's request to replace "provider" with "pharmacy," and propose suggested language to address the exemptions in Insurance Code §1369.763.

Agency Response. While the applicability of HB 1647 is sufficiently clear and enforceable based on the statutory language, in light of the comments, TDI has revised the proposed text of §3.3708(f) to eliminate any misinterpretation that TDI's rule modifies the scope of Insurance Code Chapter 1369, Subchapter Q, by deleting the phrase "even if it is dispensed by a nonpreferred provider." TDI retains the text otherwise, in order to emphasize insurers' duty to comply with the Insurance Code requirements.

Comments on §3.3709 - Annual Network Adequacy Report.

Comment. Several commenters note that HB 3359 amends Insurance Code §1301.009 to add new reporting requirements for health plans in their annual reports to include any waiver requests made and any waivers granted; any material deviation from network adequacy standards; and any corrective actions, sanctions, or penalties assessed against the insurer by TDI for deficiencies related to the preferred provider benefit plan. The commenters recommend adding "any corrective actions, sanctions, or penalties assessed against the insurer by the department for deficiencies related to the preferred provider benefit plan" to §3.3709(b).

Agency Response. TDI is preparing to implement Insurance Code §1301.009(b)(3)(C), as written, without adopting rules, and continues to view the statute as self-executing. TDI has created www.texashealthplancompare.com to enable consumers to compare health plans. TDI is currently assessing the additional information that it will need to collect to implement Insurance Code §1301.009(b)(3)(C), but believes that it already has, or will have, the information raised by the commenters regarding waivers; material deviations; and corrective actions, sanctions, or penalties.

Comment. Several commenters collectively note that §3.3709(c)(1) requires insurers to provide in their annual network adequacy report the number of insureds in the most recent year and the number projected to be served in the upcoming year, but Insurance Code §1301.0056(e)(2) requires that this information be provided by county. The commenters also state that the projected number of insureds should be provided for the next two years to enable TDI to determine whether a plan is compliant. The commenters also note that §3.3709(c)(7) requires that the annual report include actuarial data but fails to require actuarial data of current and projected utilization of each provider type by county. The commenters also state that the annual report should include information regarding the current and projected utilization of physicians credentialed at each of the institutional providers by specialty (e.g., pain versus anesthesia) to give TDI information that is necessary to ensure the preferred provider benefit plan is used in the most efficient and effective manner possible.

Agency Response. TDI notes that Insurance Code §1301.0056(e) requires that TDI's rules "require insurers to provide access to or submit data or information. . . ." At this time, TDI is not requesting that the very detailed information described by the commenters be provided in advance of TDI's review. For instance, TDI believes that the granularity of county-level data would be less useful than what is currently requested in the annual report. Instead, TDI intends to request this information from insurers when relevant to a determination. In order to make this clear, TDI has changed the proposed text to add new §3.3712(e), which requires that insurers make this information available to TDI upon request.

Comments on §3.3712 - Network Configuration Filings.

Comment. A commenter notes that §3.3712 addresses reporting of network configuration information and seeks clarification of the provider types that must be listed on the provider listing form. The commenter recommends that the provider listing form include the provider types listed in Insurance Code §1301.00553, as included on the draft waiver request form, and facility-based providers as required by Insurance Code §1301.0055(b)(4).

Agency Response. Section 3.3712(c)(2) requires that insurers use the network compliance and waiver request form to provide

data for each county, including "the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form. . . ." Consistent with the commenter's suggestion, the specialty types specified in the form are primarily based on those listed in Insurance Code §1301.00553 and §1301.0055(b)(4). While insurers are required to provide an adequate network of providers for all covered services, TDI does not currently require data on all provider types. Insurers should review the network compliance and waiver request form, as changed from the versions available when these sections were proposed, and contact TDI staff if there are questions.

Comment. Multiple commenters state that HB 3359 added Insurance Code §1301.0056(e), which requires the information provided by the petitioning health plan in a waiver request to include credentialling information of the providers. They note that this information is especially important for facility-based physicians like anesthesiologists because their credentials include medical staff privileges, which distinguishes them from physicians who provide only limited medical treatment, such as clinic-based pain management specialists. One of the commenters asserts that this will ensure the plans are considering practicing anesthesiologists and not using inappropriate providers to create the appearance of an adequate network. The commenter suggests that credentialling information should also be listed in the waiver directories for transparency purposes, and recommends that TDI add language to §3.3712 to require that physician and medical provider specialty and credentialling information be included in the network configuration filings submitted by the health plan in its waiver request and in the waiver directory to ensure physicians are being appropriately considered according to their specific facility privileges or credentialling, in addition to specialty.

Agency Response. TDI notes that "facility-based physician or provider" is defined in §3.3702(b) as a physician or health care provider to whom a facility has granted clinical privileges and who provides services to patients of the facility. TDI's credentialing requirements are found in §3.3706. In addition, the network analysis and waiver request form contains a facility-based provider tab, which is limited to reporting providers who are actually practicing at facilities. TDI agrees that credentialling information could be important in analyzing a carrier's network adequacy but believes that instances of carriers disguising an inadequate network through the use of inappropriately credentialed providers will most often be identified by other providers in the same field of practice. TDI encourages providers to make complaints on this issue and has added new §3.3712(e) to make it clear that this information must be made available to TDI on request.

Comment. A commenter requests that TDI clarify when the first network configuration information must be submitted by an insurer to TDI. The commenter notes that, in the preamble to the proposal, TDI explained that the first annual report would be due April 1, 2024, and asks whether the same will apply to the network configuration filing, or whether a different date will be allowed.

Agency Response. To provide adequate time for insurers to submit filings after the rule is adopted, TDI will allow insurers until May 1, 2024, to submit their annual report filings for 2024. The due date will remain April 1 for future years. As specified in §3.3709(b)(2), the network configuration information must be included in each annual report. The rules as adopted will apply to any network configuration filing that is submitted on or after the day the rule becomes effective.

Comment. A commenter requests that TDI consider a rule that would require insurers to indicate whether the insurer includes particular pediatric specialties in its network configuration to illustrate compliance with the network adequacy standards in §1301.055(b)(4), (6), and (8) of the Insurance Code and in proposed §3.3704(f). The commenter notes that specialists who see only adult patients should not be permitted to meet network adequacy requirements for pediatric patients who need specialty care.

Agency Response. With respect to the standards in Insurance Code §1301.0055(b)(4), TDI has expanded the worksheet in the network compliance and waiver request form on which insurers will list each in-network facility and demonstrate that a sufficient number of applicable types of specialty and diagnostic physicians and providers are available at the facility, consistent with §3.3712(c)(2)(A) - (C). The initial posting of the form included only a truncated version of this worksheet; TDI apologizes for any confusion. With respect to the standards in Insurance Code §1301.0055(b)(6), including pediatric specialties, the cover page of the network compliance and waiver request form requires insurers to explain how they comply, consistent with §3.3712(c)(2)(D). With respect to the standards for hospital services in Insurance Code §1301.0055(b)(8), TDI has a major medical worksheet in the network compliance and waiver request form on which insurers will list each in-network hospital, consistent with the types of institutional providers listed in Insurance Code §1301.00553.

Comment. A commenter requests that TDI create more thorough guidance for plans on how to fill out the new form templates and what certain fields mean, and provide acceptable examples, as this will save time for both plans and TDI because the filed forms will need fewer corrections and amendments. The commenter also provides suggestions for technical corrections: (1) that Deaf Smith County should be FIPS Code 48117, Region 1, Rural; (2) that Delta County should be FIPS Code 48119, Region 4, Metro; and (3) that Denton County should be FIPS Code 48121, Region 3, Metro.

Another commenter asks TDI to confirm that blanks or "N/A" will be accepted, as not all providers have facility privileges. The commenter also asks whether provider types will be reported by separate tabs, asks TDI to specifically list the provider types required on the provider listing, and, if separate tabs are required, asks TDI to clarify what data points will be required on each tab.

Agency Response. Regarding the request for additional guidance on how to fill out forms, TDI has provided additional information within the form, for example, by filling out the first row of data as an example. Regarding the technical corrections, TDI agrees and has made the suggested changes to the County Designation reference worksheets, except for classifying Delta as a metro county. As of March 1, 2023, CMS classifies Delta as a rural county. TDI confirms that "N/A" will be accepted for the reporting of facility privileges within the provider listing form since not all providers have facility privileges. Finally, TDI confirms that the required preferred provider types are included in a drop-down list under the Provider type column.

The attempt to contract and network compliance and waiver request forms include a table listing applicable network adequacy standards and a worksheet illustrating each county's classification, consistent with Insurance Code §1301.00553. The network compliance and waiver request form includes separate worksheets for hospital-based providers and all other major medical providers. TDI also created a separate network compliance and

waiver request form for single service vision filings that has a single worksheet for all applicable vision care providers.

Comment. Several commenters collectively note that the provisions in §3.3712(c) fail to capture all the information specified in Insurance Code §1301.0056(e)(1), which requires TDI to adopt rules that require insurers to provide access to or submit data or information that includes "a searchable and sortable database of network physicians and health care providers by national provider identifier, county, physician specialty, hospital privileges and credentials, and type of health care provider or licensure, as applicable." The commenters add that §3.3712(c)(1)(B)(iii) and the provider listings form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute.

In addition, the commenters note that §3.3712(c)(1)(C) fails to require an insurer to include information related to "hospital privileges and credentials," also in conflict with the underlying statute. The commenters also assert that §3.3712(c)(2) and the network compliance and waiver request form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute. The commenters next oppose §3.3712(c), as it fails to capture all the information specified in Insurance Code §1301.0056(e)(1), contains problematic language concerning telehealth, and ceases to require the submission of maps for each physician specialty demonstrating the location and distribution of each physician and the provider network within the insurer's service area.

Next, the commenters note that §3.3712(c)(1)(B)(iv) and the corresponding spreadsheet in the provider listing form references telehealth but should also reference telemedicine, which is provided by physicians. The commenters also oppose counting physicians or providers that offer only telemedicine or telehealth services toward network adequacy requirements, as this would severely diminish the strength of the networks and undermine the Legislature's intent. The commenters recommend that TDI's forms be updated to instruct insurers that physicians and providers offering solely these services either must not be listed or must be clearly identified as such so that TDI can exclude them from network adequacy calculations. Finally, the commenters recommend that TDI amend §3.3704 to include a new subsection expressly stating that physicians or health care providers who offer only telemedicine or telehealth services, respectively, will not be counted toward network adequacy requirements.

Agency Response. Regarding the comment that §3.3712(c) fails to capture all the information specified in Insurance Code §1301.0056(e)(1), TDI notes that its intent was not to require provision of all the statutory information by insurers in advance of TDI's review, but for TDI to request some of the information as needed for the review. TDI has clarified this by changing the proposed text to add §3.3712(e), requiring that insurers provide access upon request to any necessary information, including information contained in Insurance Code §1301.0056(e). TDI is also capturing relevant information for assessing compliance with §3.3704(f)(3) within the new form templates. The network compliance and waiver request form includes a separate worksheet that includes information on the number of preferred providers of each applicable specialty type that are available within each in-network facility. Insurers will also submit information on facility privileges in the provider listing form and the attempt to contract form.

Regarding the use of the phrases "provider's specialty type" in §3.3712(c)(1)(B)(iii), TDI has changed the proposed text to add clarifying language to the subsection. Based on comment, TDI has also changed the proposed text to clarify other instances throughout the adopted sections where TDI referenced only "provider."

Regarding telehealth, TDI agrees that the reference to telehealth in §3.3712(c) as proposed was too limited and thus, in the adopted text, has added the reference to telemedicine. While TDI will collect data on telehealth (and telemedicine) providers, TDI agrees that a provider that offers services only in this manner would not count toward meeting network adequacy requirements in a particular area of the state. Permitting this would render the mileage requirements in the statute meaningless. However, in light of the language of the statute, TDI does not believe a change in rule text is necessary.

Regarding TDI's decision to discontinue requirements for network maps, TDI notes that, while maps were useful under the prior network requirements, the agency does not believe they are necessary in the context of driving distance requirements. Under the prior network requirements, TDI measured distance standards based on radius, which could be easily illustrated using maps. In contrast, specialized software is needed to measure compliance with the driving distance requirements. Further, there is no reference in Insurance Code Chapter 1301 to requiring the submission of maps by insurers.

Comment. One commenter requests that TDI clarify what responses regarding telehealth data will be acceptable, asking that "Yes, No, or Unknown" be permitted, since this information is self-reported by the provider and not consistently available.

Agency Response. TDI agrees that these responses will be acceptable, as long as the carrier has made good faith efforts to obtain the requested information.

Comment. A commenter requests clarification regarding page 6 of the network compliance and waiver request form, where there is a hospital listing, as to whether this is solely a hospital listing or is a hospital-based form meant to indicate if at least two preferred physicians are available for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility.

Agency Response. The network compliance and waiver request form includes a worksheet on which insurers will report all facility types described in Insurance Code §1301.0055(b)(4), and each specialty type that is applicable to each facility. The worksheet is designed to reflect compliance with the standards for facility-based physicians and providers in §3.3704(f)(3).

Comments on §3.3722 - Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications, and §3.3723 - Examinations.

Comment. Several commenters collectively note that, in §3.3722 and §3.3723, TDI did not add language to implement the provisions of Insurance Code §1301.0056, which requires (1) that an insurer is subject to a qualifying examination and subsequent quality of care and network adequacy examinations, and (2) that insurers must provide access to or submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, including the information described by Insurance Code §1301.0056(e)(1) - (4).

Agency Response. TDI partially agrees and has changed the text of §3.3722(c)(10) as proposed to add a requirement that the applicant provide documentation showing that its plan procedures and documents are compliant with §3.3707(j) - (m). TDI has also changed the text of §3.3723(f)(7) as proposed to require demographic data for an exam. However, TDI disagrees that it is necessary to restate the statutory requirement that TDI conduct an exam.

SUBCHAPTER S. MINIMUM STANDARDS AND BENEFITS AND READABILITY FOR INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES

28 TAC §3.3038

STATUTORY AUTHORITY. The commissioner adopts amendments to §3.3038 under Insurance Code §§1202.051, 1301.0056, and 36.001.

Insurance Code §1202.051 requires the commissioner to adopt rules necessary to implement the section.

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

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Jessica Barta
General Counsel
Texas Department of Insurance
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Proposal publication date: December 8, 2023
For further information, please call: (512) 676-6555

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

28 TAC §§3.3702 - 3.3705, 3.3707 - 3.3712

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.3702 - 3.3705 and 3.3707 - 3.3711 and new §3.3712 under Insurance Code §§541.401, 1301.0055, 1301.0056, 1301.007, 1369.057, 1458.004, 1701.060, and 36.001.

Insurance Code §541.401 authorizes the commissioner to adopt reasonable rules necessary to accomplish the purposes of Chapter 541.

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

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

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

Insurance Code §1369.057 authorizes the commissioner to adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

Insurance Code §1701.060 authorizes the commissioner to adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

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

(1) Adverse determination--As defined in Insurance Code §4201.002(1), concerning Definitions.

(2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(4) Complainant--As defined in §21.2502 of this title (relating to Definitions).

(5) Complaint--As defined in §21.2502 of this title.

(6) Contract holder--An individual who holds an individual health insurance policy, or an organization that holds a group health insurance policy.

(7) Facility--As defined in Health and Safety Code §324.001(7), concerning Definitions.

(8) Facility-based physician or provider--As defined in Insurance Code §1451.501, concerning Definitions.

(9) Health care provider or provider--As defined in Insurance Code §1301.001(1-a).

(10) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14), concerning Definitions.

(11) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

(12) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(13) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(14) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

(15) Pediatric practitioner--A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

(16) Provider network--The collective group of physicians and health care providers available to an insured under a preferred or exclusive provider benefit plan and directly or indirectly contracted with the insurer of a preferred or exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(17) SERFF--The National Association of Insurance Commissioners (NAIC) System for Electronic Rates & Forms Filing.

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

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

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

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

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

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

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

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

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

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

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

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

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

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

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

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

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate

the provider for communicating with any individual listed in Insurance Code §1301.067, concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited, about any of the matters set forth in the contract.

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

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

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

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

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

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

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

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

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

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

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

(ii) all applicable coding methodologies;

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

(iv) all applicable downcoding policies;

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

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

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

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

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

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

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

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

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

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

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

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

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

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

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

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

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

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

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

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

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of Insurance Code §1661.005, concerning Refund of Overpayment.

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician or provider group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care and §1301.155(a), concerning Emergency Care, that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.0053 and §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contract Requirements, to the extent applicable.

(30) A contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist must comply with Insurance Code Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, and the provisions of that subchapter will be employed to the extent practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health

care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

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

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

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

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

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

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

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

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

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

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

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan are taken under Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy) and the insurer does not penalize an insured solely on the basis of a failure to obtain a preauthorization;

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

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

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

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

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

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

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

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

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

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

(2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred providers to tiers within the network that are associated with different levels of cost sharing; and

(3) violations of the fiduciary duty under Insurance Code §1458.101(i) will be determined by TDI based on assessment of the insurer's conduct. Examples of conduct that would violate the insurer's fiduciary duty include, but are not limited to:

(A) using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, to encourage receipt of lower quality medically necessary services, or in violation of state or federal law;

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

(C) failing to implement reasonable processes to ensure that the insurer does not make materially false statements or representations about a physician's or health care provider's quality of care or costs; or

(D) failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection.

(f) Network requirements.

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

(A) Insurance Code §1301.005;

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

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

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

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

(F) Insurance Code §1301.006.

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

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

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

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

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

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements).

(b) Plan disclosure. The insurer is required, on request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy (plan disclosure) that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its policy, certificate, or handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection, including the level of disclosure required. An insurer that is required by federal law to provide a summary of benefits and coverage (SBC) must include in the SBC a link to the plan disclosure required in this subsection. The written plan disclosure must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll-free number, unless exempted by statute or rule, and website address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and, if prescription drug coverage is included, the name of the formulary used by the plan, a link to the online formulary, and an explanation regarding how a nonelectronic copy may be obtained free of charge;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance, or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and an explanation that unless a provider obtains preauthorization, a claim could be denied if a service is not medically necessary or appropriate, or if a service is experimental or investigational;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or 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;

(12) the name of the provider network used by the plan, a link to the online provider listing, and information on how a nonelectronic copy may be obtained free of charge;

(13) the counties included in the plan's service area; and

(14) information that is updated at least annually regarding the following network demographics for each county:

(A) the number of insureds in the service area or region; and

(B) for each preferred provider area of practice and applicable network adequacy standard, the number of preferred providers, as well as an indication of whether an active waiver and access plan under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) applies to the services furnished by that class of provider in the county and how such access plan may be obtained or viewed, if applicable.

(c) Filing required. A copy of the plan disclosure required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section.

(d) Promotional disclosures required.

(1) The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must 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 out-of-network benefits, except in the case of an exclusive provider benefit plan.

(2) All promotion and advertisement of the preferred provider benefit plan for which a waiver has been granted must contain a statement that the plan received a waiver for a departure from network adequacy requirements and a website link where the following information about the waiver may be obtained:

(A) the name of the plan and the insurer offering the plan;

(B) the specific network adequacy standards waived;

(C) each county affected by the waiver; and

(D) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services, consistent with §3.3707(j) of this title.

(e) Website disclosures. Insurers that maintain a website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide on their website a:

(1) preferred provider listing for use by current and prospective insureds and group contract holders;

(2) listing of the counties within the insurer's service area, indicating as appropriate for each county that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that provides major medical insurance and is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan that provides major medical insurance, in all policies, certificates, plan disclosures provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.
Figure: 28 TAC §3.3705(f)(1)

(2) Exclusive provider benefit plan notice.
Figure 28 TAC §3.3705(f)(2)

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available preferred provider listings. The insurer must ensure that it updates its listing of preferred providers on its website at least once a month, as required by Insurance Code §1451.505, concerning Physician and Health Care Provider Directory on Internet Website. The insurer must ensure that it updates all other electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of preferred provider listing required in certain cases. If no preferred provider website listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on preferred provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(a)(5) of this title (relating to Payment of Certain Out-of-Network Claims), and the insurer must take responsibility for any balance bill amount the nonpreferred provider may charge in excess of the insurer's payment if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a preferred provider listing; or

(B) preferred provider information on the insurer's website;

(2) the preferred provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the preferred provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the preferred provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any website postings by the insurer to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (11) of this subsection.

(1) The preferred provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good-faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or provider or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or provider or physician group is a preferred provider.

(2) The preferred provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The preferred provider information must indicate whether each preferred provider is accepting new patients.

(5) The preferred provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The preferred provider information must provide a method by which insureds may identify preferred provider facility-based physicians or providers able to provide services at preferred provider facilities, if applicable.

(7) The preferred provider information must be provided in at least 10-point type.

(8) The preferred provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The preferred provider information must be dated.

(10) Consistent with Insurance Code Chapter 1451, Subchapter K, concerning Health Care Provider Directories, for each health care provider that is a facility included in the listing, the insurer must:

(A) create separate headings under the facility name for radiologists, anesthesiologists, anesthesiologist assistants, nurse anesthetists, nurse midwives, pathologists, emergency department physicians, neonatologists, physical therapists, occupational therapists, speech-language pathologists, and surgical assistants, except that a physician or health care provider who is employed by the facility is not required to be listed;

(B) under each heading described by subparagraph (A) of this paragraph, list each preferred facility-based physician or provider practicing in the specialty corresponding with that heading;

(C) for the facility and each facility-based physician or provider described by subparagraph (B) of this paragraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician or provider, or facility-based physician or provider group;

(D) for each facility-based physician or provider described by subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician or provider group in which the facility-based physician or provider practices; and

(E) include the facility in a listing of all facilities and indicate:

(i) the name of the facility;

(ii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(iii) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.

(11) Consistent with Insurance Code Chapter 1451, Subchapter K, the listing must list each facility-based physician or provider individually and, if a physician or provider belongs to a physician or provider group, also as part of the physician or provider group.

(m) Annual policyholder notice concerning use of an access plan. An insurer operating a preferred provider benefit plan that relies on an access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of information on network waivers and access plans disclosed under subsection (d)(2) of this section and made available under subsection (e) of this section;

(2) information on how to obtain or view any access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians or providers at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician or provider group that comprises 75% or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician or provider group that comprises 75% or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) For purposes of this subsection, decreases in numbers of physicians and other providers must be assessed separately, but no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred providers of the same specialty as the physician or provider group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer determines that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its website preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) An insurer must disclose how the plan will cover out-of-network services received when medically necessary covered services are not reasonably available through a preferred provider, consistent with §3.3708 of this title and how an enrollee can obtain assistance with accessing care in these circumstances, consistent with §3.3707(k) of this title.

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer, unless balance billing protections apply, as specified in §3.3708(a)(1) - (4) of this title;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

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

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

may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the commissioner may grant the waiver if the requestor shows good cause, subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department. For each waiver requested with respect to a type of physician or provider in a given county, the insurer must provide either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

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

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

(B) a description of how and when the insurer last contacted each provider or physician that demonstrates that the insurer made a good faith effort to contract, as defined in Insurance Code §1301.00565(a), including:

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

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

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

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

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

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

(2) If there are no providers or physicians available within the relevant service area with whom a contract would allow the insurer to meet the specific standard for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

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

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

(2) file the access plan as required in §3.3712(c)(2)(C)(iv) of this title.

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

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

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

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

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section and submitted at the time the insurer files its annual report under §3.3709 of this title (relating to Annual Network Adequacy Report).

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

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

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this ti-

tle for a specific county, the insurer must establish an access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver in accordance with subsection (a) of this section requesting that the department approve the continued use of the access plan.

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

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

(2) upon request by an insured or an individual acting on behalf of an insured, and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient but in no event to exceed five business days, approve a network gap exception and facilitate access to care by recommending at least two physicians or providers that:

(A) have expertise in the necessary specialty;

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

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

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

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

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

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

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

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

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

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

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, and includes the information specified in §3.3712(c)(2)(C)(iv) of this title.

§3.3708. Payment of Certain Out-of-Network Claims.

(a) For an out-of-network claim for which the insured is protected from balance billing under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, or when no preferred provider is reasonably available, an insurer must pay the claim at the preferred level of coverage, including with respect to any applicable copay, coinsurance, deductible, or maximum out-of-pocket amount. The insurer must pay the claim according to the following payment standards:

(1) for emergency care and post-emergency stabilization care, the applicable payment standards are under §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care;

(2) for certain care provided in a health care facility, the applicable payment standards are under §1301.164, concerning Out-of-Network Facility-Based Providers;

(3) for certain diagnostic imaging or laboratory services performed in connection with care provided by a preferred provider, the applicable payment standards are under §1301.165, concerning Out-of-Network Diagnostic Imaging Provider or Laboratory Service Provider;

(4) until August 31, 2025, for certain services and transports provided by an emergency medical services provider, other than air ambulance, the applicable payment standards are under §1301.166, concerning Out-of-Network Emergency Medical Services Provider; and

(5) for services provided by a nonpreferred provider when a preferred provider is not available within the network adequacy standards established in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), the applicable payment standards are under Insurance Code §1301.005, concerning Availability of Preferred Providers; Service Area Limitations, and Insurance Code §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services.

(b) If medically necessary covered services are not available through a preferred provider within the network adequacy standards under §3.3704(f) of this title (relating to Network Requirements) and the services are not subject to subsection (a)(1) - (4) of this section, the insurer must:

(1) for a preferred or exclusive provider benefit plan:

(A) facilitate the insured's access to care consistent with the access plan and documented plan procedures specified in §3.3707(j) of this title (relating to Waiver Due to Failure to Contract in Local Markets); and

(B) inform the insured that:

(i) the out-of-network care the insured receives for the identified services will be covered under the preferred level of cov-

erage with respect to any applicable cost-sharing and will not be subject to any service area limitation;

(ii) the insured can choose to use a physician or provider recommended by the insurer without being responsible for an amount in excess of the cost sharing under the plan, or an alternative nonpreferred provider chosen by the insured, with the understanding that the insured will be responsible for any balance bill amount the alternative nonpreferred provider may charge in excess of the insurer's reimbursement rate; and

(iii) the amount the insurer will reimburse for the anticipated services.

(2) for an exclusive provider plan:

(A) process a referral to a nonpreferred provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(B) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of physician or provider to whom a referral is requested under subparagraph (A) of this paragraph before the insurer may deny the referral.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(2) is updated no less than once per year;

(3) does not use data that is more than three years old; and

(4) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) Except for an exclusive provider benefit plan, an insurer is required to pay all covered out-of-network benefits for services obtained from health care providers or physicians at least at the plan's out-of-network benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan must not be a basis for denial of a claim.

(e) Consistent with Insurance Code §1301.140, concerning Out-of-Pocket Expense Credit, an insurer must establish a procedure by which an insured may:

(1) identify the average discounted rate paid by the insurer to a given type of preferred provider for a covered service or supply;

(2) obtain a covered service or supply; and

(3) claim a credit, under the preferred level of coverage, toward the insured's deductible and annual maximum out-of-pocket amount, for the amount paid by the insured, if:

(A) the amount the insured paid is less than the insurer's average discounted rate;

(B) the insurer has not paid a claim for the service or supply; and

(C) the insured submits the documentation identified by the insurer, according to the process set forth on the insurer's website and in the insured's certificate of insurance.

(f) An insurer must cover a clinician-administered drug under the preferred level of coverage if it meets the criteria under Insurance Code Chapter 1369, Subchapter Q, concerning Clinician-Administered Drugs.

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. On or before April 1 of each year and prior to marketing any plan in a new service area, an insurer must submit a network adequacy report for each network to be used with a preferred or exclusive provider benefit plan. The network adequacy report must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(2) the network configuration information specified in §3.3712 of this title (relating to Network Configuration Filings);

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers); and

(4) if applicable, the waiver request and access plan information as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) - (7) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The report must include:

(1) the number of insureds served by the network in the most recent calendar year and the number of insureds projected to be served by the network in the upcoming calendar year;

(2) total complaints;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for out-of-network benefits or concerning balance billing;

(5) complaints relating to the availability of preferred providers;

(6) complaints relating to the accuracy of preferred provider listings; and

(7) actuarial data on the current and projected utilization of each type of physician or provider within each region, including:

(A) the current and projected number of preferred providers of each specialty type;

(B) claims data for the most recent calendar year, including:

(i) the number of preferred provider claims;

(ii) the number of claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(iii) the number of claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(iv) the number of unique enrollees with one or more claims; and

(v) the number of unique physicians or providers with one or more claims.

(d) Filing the report. The annual report required under this section must be submitted electronically in SERFF or another electronic method that is acceptable to the department using the annual network adequacy report form available at www.tdi.texas.gov.

(e) Exceptions. This section does not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3711. Geographic Regions.

For the purposes of this subchapter, the 11 Texas geographic regions that an insurer is required to use for reporting data under §3.3709 of this title (relating to Annual Network Adequacy Report) are defined based on the public health regions designated under Health and Safety Code §121.007, concerning Public Health Regions, and listed in the annual network adequacy report form.

§3.3712. Network Configuration Filings.

(a) An insurer must submit network configuration information as specified in this section in connection with a request for a waiver under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), an annual network adequacy report required under §3.3709 of this title (relating to Annual Network Adequacy Report), or an application for a network modification under §3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications).

(b) A network configuration filing must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(c) A network configuration filing must contain the following items.

(1) Provider listing data. The insurer must use the provider listings form available at www.tdi.texas.gov to provide a comprehensive searchable and sortable listing of physicians and health care providers in the plan's network that includes:

(A) information about the insurer, including the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(B) information about each preferred provider, including:

(i) the preferred provider's name, address of practice location, county, and telephone number;

(ii) the preferred provider's national provider identifier (NPI) number and Texas license number;

(iii) the preferred provider's specialty type, license, or facility type, as applicable, using the categories specified in the form; and

(iv) whether the preferred provider offers telemedicine or telehealth; and

(C) information about a preferred provider that is not a facility, including information on the preferred provider's facility privileges.

(2) Network compliance analysis. The insurer must use the network compliance and waiver request form available at www.tdi.texas.gov to provide a listing of each county in the insurer's service area and data regarding network compliance for each county, including:

(A) the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form;

(B) information indicating whether the network adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) are met with respect to each type of physician or provider, including specifying the nature of the deficiency (such as insufficient providers, insufficient choice, or deficient appointment wait times);

(C) if the network adequacy standards are not met for a given type of physician or provider, a waiver request and an access plan consistent with §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), including an explanation of:

(i) the reason the waiver is needed, including whether the waiver is needed because there are no physicians or providers available with whom a contract would allow the insurer to meet the network adequacy standards, or because of a failure to contract with available providers;

(ii) if the waiver is needed because of a failure to contract with available providers, each year for which the waiver has previously been approved, beginning with 2024;

(iii) the total number of currently practicing physicians or providers that are located within each county and the source of this information; and

(iv) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services when no preferred provider is available within the network adequacy standards, including procedures to coordinate care to limit the likelihood of balance billing, consistent with the procedures established in §3.3707(j) of this title; and

(D) except for a network offered in connection with an exclusive provider benefit plan, an insurer must include a description of how the insurer provides access to different types of facilities, as required by Insurance Code §1301.0055(b)(6), concerning Network Adequacy Standards.

(3) Online provider listing. The insurer must include a link to the online provider listing made available to insureds and a pdf copy of the provider listing that is made available to insureds that request a nonelectronic version.

(4) Access plan for unforeseen network gaps. The insurer must include a copy of the access plan required in §3.3707(m) of this title, which applies to any unforeseen circumstance in which an insured is unable to access covered health care services within the network adequacy standards provided in §3.3704 of this title.

(d) The information submitted as required under this section is considered public information under Government Code Chapter 552, concerning Public Information, and the insurer may not submit the provider listings form or network compliance and waiver request form in a manner that precludes the public release of the information. The department will use the data submitted under this section to publish network data consistent with Insurance Code §§1301.0055(a)(3), concerning Network Adequacy Standards, 1301.00565(g), concerning Public Hearing on Network Adequacy Standards Waivers, and 1301.009, concerning Annual Report.

(e) Upon request by TDI, an insurer must provide access to any information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, including the information set forth in Insurance Code §1301.0056(e), concerning Examinations and Fees.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Jessica Barta
General Counsel
Texas Department of Insurance
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DIVISION 2. APPLICATION, EXAMINATION, AND PLAN REQUIREMENTS

28 TAC §§3.3720, 3.3722, 3.3723

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.3720, 3.3722, and 3.3723 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer a preferred or exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance as specified on the department's website and use the form titled Application for Approval of Provider Benefit Plan, which is available at www.tdi.texas.gov/forms.

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, the applicant must submit a complete new page with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) - (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the preferred or exclusive provider benefit plan.

(5) The applicant must provide a description and a map of the service area, with key and scale, identifying the county or counties to be served. If the map is in color, the original and all copies must also be in color.

(6) The applicant must provide a list of all plan documents and each document's associated form filing ID number or the form number of each plan document that is pending the department's approval or review.

(7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer's corporate president, corporate secretary, or the president's or secretary's authorized representative that the physician and provider contracts applicable to services provided under the preferred or exclusive provider benefit plan comply with the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter.

(8) The applicant, if applying for approval of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in commercial markets, must provide a description of the quality improvement program and work plan that includes a process for physician review required by Insurance Code §1301.0051, concerning Exclusive Provider Benefit Plans: Quality Improvement and Utilization Management, and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

(9) The applicant must provide network configuration information, as specified in §3.3712 of this title (relating to Network Configuration Filings).

(10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3707(j)-(m) of this title (relating to Waiver Due to Failure to Contract in Local Markets) and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims).

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer in accordance with subsection (c)(12) of this section:

(1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program) if the applicant is applying for approval of an exclusive provider benefit plan offered under Insurance Code Chapter 1301, in commercial markets;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

(3) network configuration information as outlined in §3.3712 of this title that demonstrates compliance with network adequacy requirements described in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

(4) credentialing files;

(5) all written materials to be presented to prospective insureds that discuss the provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

(6) the policy and certificate of insurance; and

(7) a complaint log that is categorized and completed in accordance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file a network configuration filing as specified in §3.3712 of this title for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area. If any insured will be nonrenewed as a result of a service area reduction, the insurer must comply with the requirements under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions).

(2) In accordance with paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

(B) forms of contracts, as described in subsection (c) of this section; or

(C) network configuration information, as required by §3.3712 of this title.

(3) An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

(f) Exceptions. Paragraphs (c)(9) and (d)(3) and subsection (e) of this section do not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3723. Examinations.

(a) The commissioner may conduct an examination relating to a preferred or exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every three years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted under Insurance Code Chapter 401, Subchapter B, concerning Examination of Carriers; Insurance Code Chapter 751, concerning Market Conduct Surveillance; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; and §7.83 of this title (relating to Appeal of Examination Reports).

(c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

(d) On request of the commissioner, an insurer must provide to the commissioner a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider. Documentation provided to the commissioner under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056, concerning Examinations and Fees.

(e) The commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under Insurance Code Title 2, Subtitle B, concerning Discipline and Enforcement, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by Occupations Code §151.002, concerning Definitions.

(f) The following documents must be available for review at the physical address designated by the insurer in accordance with §3.3722(c)(12) of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes as required by §3.3724 of this title (relating to Quality Improvement Program) must be available for examinations of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in the commercial market;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and completed in accordance with §21.2504 of this title

(relating to Complaint Record; Required Elements; Explanation and Instructions);

(4) satisfaction surveys--any insured, physician, and provider satisfaction surveys, and any insured disenrollment and termination logs;

(5) network configuration information as required by §3.3712 of this title (relating to Network Configuration Filings) demonstrating adequacy of the provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity, including the most recent demographic data provided by the insurer in accordance with §3.3709 of this title (relating to Annual Network Adequacy Report).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 5, 2024.

TRD-202401413
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 25, 2024
Proposal publication date: December 8, 2023
For further information, please call: (512) 676-6555

28 TAC §3.3725

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.3725 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonably accessibility and availability of preferred provider services.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 5, 2024.

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Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 25, 2024
Proposal publication date: December 8, 2023
For further information, please call: (512) 676-6555

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER H. CANCELLATION, DENIAL, AND NONRENEWAL OF CERTAIN PROPERTY AND CASUALTY INSURANCE COVERAGE

The commissioner of insurance adopts amendments to 28 TAC Chapter 5, Subchapter H, §§5.7005, 5.7007, and 5.7011 - 5.7013, and new §§5.7101 - 5.7110, concerning nonrenewal of automobile insurance. The commissioner adopts §5.7011 and §5.7013 without changes to the proposed text published in the October 6, 2023, issue of the *Texas Register* (48 TexReg 5813). These rules will not be republished.

The following sections are adopted with changes: §§5.7005, 5.7007, 5.7012 and 5.7101 - 5.7110. These rules will be republished. The proposed text was changed in response to comment, to provide clarification, to better conform to agency style, or to align more closely with statutory language.

A notice of hearing was published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 7094), and the public hearing was held on December 14, 2023.

REASONED JUSTIFICATION. The amended and new sections in Subchapter H are necessary to implement:

- Senate Bill 1602, 87th Legislature, 2021, which requires insurers to nonrenew private passenger automobile policies if an insured fails or refuses to cooperate in an insurer's investigation, settlement, or defense of a claim or action;

- House Bill 1900, 88th Legislature, 2023, which updates the timing of notice for nonrenewal and cancellation of certain property and casualty policies; and

- House Bill 2065, 88th Legislature, 2023, which clarifies that insurers may not renew a policy if any insured--not just a named insured--fails or refuses to cooperate with the insurer in an investigation, settlement, or defense of a claim or action and also clarifies that Insurance Code §551.1053 applies only to third-party liability claims or actions.

HB 1900. Amendments to §§5.7005, 5.7007, 5.7011, 5.7012, and 5.7013 implement Insurance Code §551.104(f) and §551.105, as amended by HB 1900. Insurance Code §551.104(f) allows insurers to cancel a personal automobile insurance policy on any 12-month anniversary of the original effective date of the policy. Under the amended section, the insurer must now send that cancellation notice not later than 60 days before the effective date of cancellation, rather than 30 days. Likewise, Insurance Code §551.105 now requires insurers to send notice of nonrenewal of certain property and casualty policies not later than 60 days before the policy expires, rather than 30 days.

SB 1602 and HB 2065. SB 1602 added Insurance Code §551.1053, effective September 1, 2021, and it was amended by HB 2065 effective September 1, 2023. As amended, §551.1053 mandates nonrenewal of a private passenger automobile insurance policy when an insured fails or refuses to cooperate in the investigation, settlement, or defense of a third-party liability claim or action. However, most private passenger automobile insurance policy forms filed soon after that effective date did not initially comply with §551.1053.

The Texas Department of Insurance (TDI) proposed §§5.7101 - 5.7110 to help insurers understand how to comply with §551.1053. These new sections specify requirements to make it easier for insurers and TDI staff to ensure that policy forms,

claims handling, and nonrenewal practices comply with Insurance Code §551.1053. In addition, to assist consumers, the new sections offer sample plain language notices. TDI also amended §5.7005(c) to implement SB 1602 and HB 2065, adding an exception to the requirement to renew personal auto policies written for less than one year, so that they accumulate a minimum of 12 months of continuous coverage.

Insurance Code §551.1053 gives rise to complex situations for insurers when the insurer decides near the end of the policy term that an insured failed or refused to cooperate. Insurers may have already developed methods to deal with these issues, but the new sections clarify expectations for compliance and promote consistency in handling and communications in these situations. For example, the new sections require that insurers give insureds at least 10 days to cooperate from the date the insurer sends the Notice of mandatory nonrenewal and opportunity to cooperate. (When the word "Notice" is capitalized in Division 2 and elsewhere in this order, it means the Notice required by Insurance Code §551.1053.)

Organization. To provide clarity and structure to Subchapter H, TDI divided the subchapter into two divisions. Division 1, now titled General Provisions, includes §§5.7001 - 5.7018. Division 2, Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies, includes new §§5.7101 - 5.7110.

General changes. Amendments to the sections reorganize some text and include nonsubstantive plain language revisions to conform the text to current agency style. The title of Division 1 was changed from Miscellaneous to General Provisions to better inform readers. In response to public comments, the changes to the proposed rule includes capitalizing "Notice" throughout Division 2 to distinguish the Notice under Insurance Code §551.1053 from a notice of nonrenewal under Insurance Code §551.105 and from a notice of cancellation under Insurance Code §551.104.

Effective date. The changes made to Division 1 and new Division 2 will become effective January 1, 2025, to give insurers time to implement any necessary programming or procedural changes.

The adopted new and amended sections are described in the following paragraphs, organized by division.

Division 1. General Provisions.

Amendments to the sections in Division 1 implement HB 1900.

Sections 5.7005 and 5.7007. Amendments to §5.7005 and §5.7007 conform the rule to Insurance Code §551.104(f) and §551.105 by lengthening the amount of time from 30 days to 60 days for the insurer to give notice of cancellation at the one-year policy anniversary or nonrenewal. The amendments also revise text to simplify language and except from §5.7005(c) policies that are mandatorily nonrenewed under Insurance Code §551.1053 and Division 2. The proposal added a reference to Division 2, and the adopted rule added a citation to Insurance Code §551.1053, in both sections to recognize the exception.

Section 5.7011. Amendments to §5.7011 simplify language and change the word "subchapter" to "division" to account for new Division 2. The scope of the section is unchanged.

Section 5.7012. Amendments to §5.7012 remove redundant and outdated statutory references. Section 5.7001 provides the general applicability for Subchapter H. Section 5.7001(c) specifically provides that §5.7012 applies "to all property and casualty policies regulated by the Texas Department of Insurance pursuant to the Texas Insurance Code, Chapter 5." Thus, the list of specific statutes in §5.7012 is unnecessary. "Board of Insurance" was amended to "Texas Department of Insurance" in the proposal, but the proposed text has been changed to "TDI" to align with agency style.

Section 5.7013. Section 5.7013(a) is amended to remove the specific number of days for notice of cancellation because the time period is specified by Insurance Code §551.053. Amendments to §5.7013(b) update the notice requirements for cancellation and nonrenewal to include an exception for mandatory nonrenewal as required by Insurance Code §551.1053. Amendments to §5.7013(b) also remove the specific number of days for notice of nonrenewal and add references to Insurance Code §551.054 and §551.1053.

Adopted §5.7013(c) provides that (1) an insurer may comply by requiring or permitting its agent to notify the policyholder, and (2) it is the insurer's responsibility to give notice to the policyholder if the agent fails to notify the policyholder.

Division 2. Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies.

Division 2 implements SB 1602 and HB 2065.

Section 5.7101. New §5.7101 states the purpose and applicability of new Division 2. This division does not apply to policies written through the Texas Automobile Insurance Plan Association (TAIPA) because Insurance Code §551.102 specifically excludes TAIPA from the applicability of Insurance Code Chapter 551, Subchapter C. As adopted, the proposed text of §5.7101(b) has been changed to address third-party liability claims or actions, as required by HB 2065.

Section 5.7102. New §5.7102 defines "Notice" to mean the notice of mandatory nonrenewal and opportunity to cooperate required by Insurance Code §551.1053(a). This streamlines the rule text and makes it easier to read. Proposed §5.7102 has been changed in response to public comments.

As adopted, the proposed text has been changed to capitalize "Notice," to distinguish the Notice required by Insurance Code §551.1053 from a notice of nonrenewal under Insurance Code §551.105, and from a notice of cancellation under Insurance Code §551.104. This same change has been made in each section where the Notice required by Insurance Code §551.1053 is addressed.

Section 5.7103. New §5.7103 emphasizes the legislative intent behind and implied in Insurance Code §551.1053 that insurers must use reasonable efforts to contact and encourage cooperation from an insured who fails or refuses to cooperate in the investigation, settlement, or defense of a third-party liability claim or action. The section does not define "reasonable efforts" because what constitutes reasonable efforts depends on the facts of each claim or action. As adopted, §5.7103 was changed from the proposal to add the phrase "third-party liability" to describe the claim or action.

Section 5.7104. New §5.7104 requires an insurer to send the Notice to the named insured within seven days after the insurer decides that an insured has failed or refused to cooperate. Specifying this timing requirement not only promotes prompt communication between the parties and consistency in claims handling and nonrenewal practices but also, importantly, keeps the claims process moving.

Proposed §5.7104 has been changed in response to public comments. First, under the adopted rule, the insurer must send the Notice within seven days--instead of five--after the insurer decides that an insured has failed or refused to cooperate. This gives the insurer more time to send the Notice after making its decision. Second, this section has been changed to emphasize that it is the insurer--not TDI--that decides when and how an insured fails or refuses to cooperate. Finally, new subsection (b) has been added to clarify that if an insurer decides during one policy term that an insured failed or refused to cooperate during any prior policy term, the insurer must still send the Notice within seven days of making that decision, and the text of proposed subsection (b) has been redesignated as subsection (c).

Section 5.7105. New §5.7105(a) prohibits nonrenewal under §551.1053 if the insurer decides that an insured cooperates. The title of the section has been changed to reflect this prohibition.

In response to comments, proposed new §5.7105(a) has been changed to remove the specification that an insured may cooperate at any time during the policy term in which Notice was sent or any extended term. That change acknowledges the variety of situations that insurers may encounter.

New §5.7105(b) requires an insurer to provide an insured at least 10 days to cooperate after the insurer sends the Notice, regardless of when the policy term ends. Insurance Code §551.1053(a)(3) creates a prerequisite to mandatory nonrenewal--that the insured continues to fail or refuse to cooperate. This means that the insurer must provide the insured an opportunity to cooperate before the policy is mandatorily nonrenewed.

Section 5.7106. Proposed §5.7106 has been revised to remove the requirement to extend the policy term and to instead specify that one way the insurer can comply with §5.7104 and §5.7105(b) when the insurer makes the decision that the insured failed or refused to cooperate with less than 17 days left in the policy term is to extend the policy term. This extension gives the insurer time to send the Notice to the named insured within seven days of making its decision. The extension also gives the insured at least 10 days to cooperate. New §5.7106 allows the insurer to charge additional premium for the coverage extension.

Section 5.7107. New §5.7107 lists the required contents of the Notice sent by an insurer under Insurance Code §551.1053. Prescribing specific elements for the Notice provides uniformity and transparency and decreases consumer confusion. These required elements ensure that the named insured is informed of:

- information about the claim or action;

- the identity of the insured who failed or refused to cooperate;

- what the insured needs to do to cooperate; and

- the consequences to the named insured if the insured does not cooperate.

Proposed §5.7107 required an insurer to tell the named insured--in the Notice--about its attempts to contact the insured. The proposed text has been changed in response to public comments; under the adopted text, an insurer is required to tell the named insured about its contact attempts only if the insurer has been unable to contact the insured.

To recognize that insurers may use a variety of methods to identify claims, the proposed text of §5.7107(b)(4) has been changed to add "or other identifying number." In response to comments, subsection (b)(7) as proposed has been changed to remove the requirement that the Notice state that the insured must cooperate before the end of the policy term (or any extended term) to stop nonrenewal.

Adopted §5.7107(c) requires insurers to provide the required Notice either (1) in English and in Spanish, or (2) in English with a statement in Spanish stating that the policy will be nonrenewed if the insured continues to fail or refuse to cooperate.

According to the 2020 U.S. Census, over 7 million Texas households speak Spanish as their primary language. Spanish instructions will help consumers whose native language is Spanish understand their contractual obligation to cooperate. Providing the Notice either completely in Spanish or in English with an instructional statement in Spanish and requiring the insurer's phone number is consistent with other rules intended to alert consumers of important rights or information in their policies, such as in the Consumer Bill of Rights in §5.9970 and §5.9971 and the Texas Liability Insurance Card in §5.204(e).

The proposed text of §5.7107 has been changed in response to public comments to clarify that insurers are not required to have a dedicated phone number for communicating with Spanish speakers.

As adopted, the proposed text of §5.7107 has also been changed to reorganize it and add clarifying nonsubstantive revisions. These revisions include removing language about when the insured must cooperate to stop nonrenewal of the policy, clarifying that the insurer decides if the insured has cooperated after sending the Notice, and giving the insurer the option to include language stating that the insurer might nonrenew the policy for other reasons or might send a renewal offer if the insured cooperates.

Section 5.7108. New §5.7108 provides sample Notices. Insurers are not required to use the sample Notices, but providing them encourages clear and consistent communication, saves insurers the time and expense of having to draft Notice language, and helps insurers comply with the law. In addition to English and Spanish Notices, TDI is providing a sample dual-language Notice. That Notice is in English but also contains a statement in Spanish. These sample Notices are consistent with TDI's plain language recommendations and provisions in Insurance Code §2301.053 regarding plain language.

The all-Spanish and dual-language sample Notices in proposed §5.7108 have been changed in response to public comments to remove language that suggested that companies must have a dedicated phone number for Spanish speakers. The Notices are also changed to align with the revisions to §5.7107.

Section 5.7109. New §5.7109 reiterates that if an insured does not cooperate after the insurer provides the Notice, the insurer must nonrenew the policy. However, if the insurer decides that the insured has cooperated at any time before the policy's expiration or before the end of the extended term, §5.7109 prohibits the insurer from nonrenewing the policy under Insurance Code §551.1053.

The proposed text of §5.7109 has been changed in response to public comments to address when the mandatory nonrenewal takes effect. As adopted, subsection (b) is reorganized to expressly state that Insurance Code §551.105 and §551.106 do not apply where they conflict with the requirement to mandatorily nonrenew the policy under Insurance Code §551.1053. After sending the Notice, if the insurer decides that an insured continues to fail or refuse to cooperate, the policy is mandatorily non-

renewed at the end of the policy term in which the insurer initially decided that the insured failed or refused to cooperate or at the end of any extended term. The Insurance Code does not authorize or require an additional or separate notice of nonrenewal to the named insured to comply with Insurance Code §551.1053.

Section 5.7110. New §5.7110 affirms that insurers may nonrenew a policy for reasons other than refusal or failure to cooperate under other applicable statutes, specifically Insurance Code §551.105 and §551.106. The section also clarifies that the insurer must still provide the Notice if the insurer decides an insured fails or refuses to cooperate in a third-party liability claim or action even when the insurer intends to nonrenew the policy under other applicable law. Because the Notice encourages the insured to cooperate in the claim or action, the insurer must send the Notice even in situations where nonrenewal is certain for other reasons. The text of the section as adopted has been changed to replace the words "other rules and statutes" with "laws" and "send" with "provide."

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on December 14, 2023.

TDI received comments from five commenters. Commenters against the proposal were the Association of Fire and Casualty Companies in Texas (AFACT) and the Insurance Council of Texas (ICT), who submitted a joint comment letter, and whose representative spoke at the public hearing on the proposal held December 14, 2023; the American Property Casualty Insurance Association (APCIA); and Burnie Burner of Mitchell, Williams, Selig, Gates & Woodyard, PLLC, on behalf of the firm's clients affected by the proposal. TDI also received comments from Insurance Services Office, Inc. (ISO), who suggested changes, but was neither for nor against the proposal.

Comment on the Applicability of the Rule (§5.7101)

Comment. Several commenters question how a "private passenger policy" could be issued to a governmental entity or political subdivision and ask TDI to remove governmental entities from the applicability of the rule.

Agency Response. TDI declines to remove governmental entities from the applicability of the rule. Section 551.1053 is in Insurance Code Chapter 551, Subchapter C, and §551.102 specifies that Subchapter C applies to certain governmental entities and political subdivisions. SB 1602 did not amend the applicability of Subchapter C in Insurance Code §551.102 and it did not except those entities from its applicability.

Comment on the Definition of "Notice" (§5.7102)

Comment. Several commenters state that the definition of "Notice" is confusing and vague, and they say that the definition incorrectly suggests that the Notice is the equivalent of a notice of nonrenewal. The commenters state that the definition of Notice should be changed to distinguish between the Notice required under Insurance Code §551.1053 and a nonrenewal notice sent for other reasons.

Agency Response. TDI agrees with the comment in part on the necessity to distinguish the types of notices, but disagrees that the definition is confusing, vague, or is equivalent to a notice of nonrenewal. TDI has capitalized Notice to distinguish the Notice under Insurance Code §551.1053 from a notice of nonrenewal sent to comply with Insurance Code §551.105. The definition is changed to further clarify that distinction by inserting the word "mandatory" before the word "nonrenewal." As adopted, the definition of Notice states that it is the Notice of mandatory nonrenewal and opportunity to cooperate, which distinguishes the Notice from a notice of nonrenewal sent for other reasons under Insurance Code §551.105. The circumstances and timing of the Insurance Code §551.1053 Notice are entirely different from those under which an insurer might send a notice of nonrenewal under Insurance Code §551.105.

Comment on the Breadth of Reasonable Efforts (§5.7103)

Comment. Several commenters state that the rule appears to impose a broader duty for "reasonable efforts" than Insurance Code §551.1053 requires. The commenters state that Insurance Code §551.1053 contemplates only requiring the insurer to make reasonable efforts to contact or find the insured, and they believe it does not extend to encouraging cooperation. They express that this imposes a vague standard on what would be reasonable in encouraging cooperation, and could result in materially different interpretations, particularly by TDI Market Conduct or Enforcement staff, that would not be known until after the fact.

Agency Response. TDI disagrees and declines to make a change. The condition for providing Notice in Insurance Code §551.1053(a) states in part, "If an insured...fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a third-party liability claim or action or the insurer is unable to contact the insured using reasonable efforts *for those purposes*...." (emphasis added). The phrase "for those purposes" refers to the purposes described in the first clause of the condition, "If an insured...fails or refuses to cooperate...." The purposes are not limited to efforts to contact the insured. TDI revised the rule to make it clear that the insurer--and not TDI--decides whether the insured failed or refused to cooperate in the claim or action.

Comment on Deciding Noncooperation (§5.7104)

Comment. One commenter asks how TDI would find that insurers have determined noncooperation if the insurer has not sent the notice. The commenter asks whether TDI would review claims files to make different determinations based on the facts.

Agency Response. TDI has a duty to ensure that the Insurance Code and other laws regarding insurance and insurers are executed under Insurance Code §31.002. As part of those duties, TDI may investigate a complaint or fraud report, or perform a market conduct examination. However, TDI has changed the proposed text to more clearly state that the insurer--not TDI--decides when and how an insured fails or refuses to cooperate. If an insurer decides that an insured has failed or refused to cooperate, presumably the insurer's records or claim file will show or demonstrate when the insurer made that decision. Those records or the claim file should also show that the insurer timely sent the Notice within seven days after making that decision. If TDI discovers during a Market Conduct examination, Enforcement investigation, or complaint investigation that there is evidence showing a violation of Insurance Code §551.1053 or the adopted rules, then the insurer may be subject to disciplinary action.

Comments on the Requirement to Send the Notice Within Five Days (§5.7104)

Comment. Several commenters state that the requirement that insurers send the Notice to the named insured within five days of deciding noncooperation is tight or too short, and not reasonable. They also state that the timing is inconsistent with the elements in Insurance Code §551.1053 because they think the Notice may

be given at different times depending on the facts and circumstances in a specific third-party claim.

Agency Response. TDI agrees with the commenters about the timeframe and adds two more days in the text as adopted, giving the insurer seven days instead of five to provide the Notice after the insurer makes its decision that an insured has failed or refused to cooperate. The timeframe in which the insurer must provide the Notice to the named insured is triggered by the insurer's decision. However, TDI recognizes that holidays and other circumstances may make a five-day timeline difficult to meet. Giving insurers additional time to send the Notice after making the decision may assist them in overcoming any challenges they might have in programming, addressing manual tasks, or drafting the Notice to comply.

TDI disagrees that specifying the timing to provide the Notice is inconsistent with Insurance Code §551.1053 because the statute requires the insurer to provide the Notice, and the intent of the statute is to encourage cooperation so that third-party claims and actions get resolved. Setting timeframes helps ensure that claims and actions are resolved promptly. Also, the rule allows the insurer--based on the facts and circumstances of each third-party claim--to decide whether and when the insured has failed to cooperate.

Comment. Several commenters asked for a minimum of 20 days to send the Notice because that is the amount of time that the insurer would have to file an answer if it defends an insured in a lawsuit.

Agency Response. TDI declines to extend the deadline to 20 days to send the Notice but agrees to extend it to seven days. Insurance Code §551.1053 specifies that the insurer must provide the Notice when an insured fails or refuses to cooperate in the investigation, settlement, or defense of a third-party liability claim or action or the insurer is unable to contact the insured using reasonable efforts for those purposes. The insurer's obligation to provide the Notice is not limited to the insured's failure or refusal to cooperate in defense of a third-party liability lawsuit. Similarly, the time to answer a lawsuit and the timing of an insurer's decision that an insured has failed or refused to cooperate are not codependent. The insurer decides when the insured has failed or refused to cooperate. The statute's purpose is to encourage the insured's cooperation so that the third party's claim can be settled, or the action resolved. Extending the time to 20 days may unnecessarily delay that resolution.

Comment on the Necessity and Enforceability of the Five-Day Requirement (§5.7104)

Comment. One commenter states that the five-day requirement to send the Notice is unenforceable and unnecessary.

Agency Response. TDI disagrees that the time requirement is unenforceable or unnecessary but has changed the time the insurer must send the Notice from five to seven days in the text as adopted. The time requirement is necessary to encourage prompt cooperation and to prevent delays in the investigation, settlement, or defense of the third-party claim or action.

Comment Conflating the Notice and Cooperation Timeframes (§5.7104 and §5.7105)

Comment. Several commenters opine that giving the insured 10 days to cooperate conflicts with the requirement to send the Notice within five days of determining that an insured has failed or refused to cooperate.

Agency Response. TDI disagrees. These are two successive timing requirements triggered by a single event--the insurer's decision that an insured has failed or refused to cooperate. After that decision is made, the insurer must provide the Notice to the named insured within seven days (previously five days) under §5.7104. Then, after the insurer sends the Notice, the insured has a minimum of 10 days to cooperate. TDI has agreed to increase the amount of time the insurer has to provide the Notice to the named insured from five to seven days under §5.7104.

Comment That Coverage Must Be Denied Before Nonrenewal (§5.7105)

Comment. Several commenters suggested that insurers should be allowed to:

1. send a notice under Insurance Code §551.1053;

2. deny coverage; and

3. then send a notice of nonrenewal.

Agency Response. TDI disagrees. Insurance Code §551.1053 does not have a prerequisite that the insurer deny coverage in a third-party claim or action before the insurer must comply with §551.1053. The statute requires the insurer to nonrenew a private passenger auto policy if the insured continues to fail or refuse to cooperate after the insurer has sent the Notice to the named insured. It also requires the insurer to provide the Notice to the named insured if an insured fails or refuses to cooperate in a claim or action, or if the insurer is unable to contact the insured using reasonable efforts.

Nothing in the statute states or suggests that there is any requirement to deny coverage. Indeed, there may be cases where an insured does not cooperate, but an insurer still has sufficient information to determine liability and pay the third-party claim. The statute expressly states that the Notice under Insurance Code §551.1053 is to be sent notwithstanding Insurance Code §551.105 and §551.106, so the commenters' suggested third step--to send a notice of nonrenewal under §551.105--is not contemplated under §551.1053.

Comments Asserting That Allowing Insureds 10 Days to Cooperate Is Confusing and Difficult to Apply (§5.7105)

Comment. Several commenters state that §5.7105 "appears to confuse the fact that if an insured wants the benefits of coverage (defense and indemnity) of a third-party claim against the insured, it is required to cooperate with the insurer. Thus, the reference in subsection (a) that an 'insured may cooperate at any time during the policy term' is confusing and inconsistent with the obligations under the policy." The commenters further state that the timeframe would be difficult to apply in certain factual scenarios and does not address the situation where an insurer cannot locate an insured.

Agency Response. As we understand these comments, TDI disagrees that §5.7105 is confusing or inconsistent. Although TDI acknowledges that there may be circumstances in which it might be challenging for the insurer to allow an insured an opportunity to cooperate, that opportunity is provided by Insurance Code §551.1053 rather than the rule. The adopted rule specifies a minimum number of days that the insurer must provide for the insured to cooperate.

TDI has removed the text specifying that the insured may cooperate at any time during the policy term to acknowledge that the factual scenario in each claim or action, the length of the policy term, and the timing of the insurer's decision may vary. The

adopted rule states that if an insurer decides that the insured has cooperated, then the insurer may not nonrenew the policy for that insured's failure or refusal to cooperate.

Once the insurer decides that an insured has failed or refused to cooperate, the timelines in the rule are triggered, and the insurer must provide the Notice to the named insured within seven days and then give the insured at least 10 days to cooperate. An insurer may decide that an insured failed or refused to cooperate within the same policy term that the claim or the lack of cooperation occurred, or it may make that decision in a subsequent policy term. For example, if the term in which the insurer makes the decision is 180 days in length, and the insurer decides the insured failed or refused to cooperate on day 20 of that term, the insurer has seven days to send out the Notice (by day 27), and the insured has more than 10 days to cooperate before that term (and coverage) expires on day 180.

Similarly, if an insurer decides that the insured failed or refused to cooperate on day 179, the insurer cannot renew the policy but must send the Notice within seven days of making that decision, and then must provide at least 10 days for the insured to cooperate. Because of this challenging timing scenario, the insurer can extend the term under §5.7106 by as much as 17 days and charge the policyholder for that extension. In this second example, if the insurer does not send the Notice until seven days after its decision on day 179, the extended term could be as long as 17 days, but if the insurer sends the Notice the day after making its decision--on day 180 of the term, the extended term might only be 10 days. Regardless of the extension length, if the insured does not cooperate during the extension, the coverage expires at the end of the extended term.

When the insurer cannot locate the insured, the insurer must still comply with Insurance Code §551.1053 and send the Notice to the named insured. The named insured may be a different person from the insured who failed or refused to cooperate. The named insured is sent the Notice for a reason. The named insured should know the insured--who may be a household member or a permissive driver--and is in the best position to encourage that insured to cooperate so that the named insured can potentially avoid the mandatory nonrenewal.

Comments on the Renewal Requirement if the Insured Cooperates After Receiving the Notice (§5.7105)

Comment. Several commenters suggest that it would be better to state that efforts will be made to prevent nonrenewal or reinstate the policy if the insured cooperates. These commenters believe that renewing the policy will be impossible to execute if the insured cooperates on the last day of the term before nonrenewal. They argue it is counter to the intent of the statute to require the insurer to renew the policy if the insured cooperates after the insurer has decided that the insured has not cooperated, and when the insurer has already taken two steps to comply with the statute by sending both the required Notice and sending a subsequent notice of nonrenewal.

Agency Response. TDI disagrees and declines to allow insurers to nonrenew the policy under Insurance Code §551.1053 when the insured subsequently cooperates. If an insurer sends the Notice and the insured subsequently cooperates, Insurance Code §551.1053 does not allow the insurer to then nonrenew the policy. Allowing nonrenewal after an insured cooperates would contradict the statute's express language and legislative intent. The language in Insurance Code §551.1053(b) expressly requires mandatory nonrenewal when an insured fails or refuses to cooperate. Insurance Code §551.1053(a)(3) implies that There is time for the insured to cooperate. Insurance Code §551.1053 does not give the insurer authority to nonrenew when an insured cooperates.

According to the statement of intent in the Legislature's bill analysis, "The purpose of this legislation is to give an incentive for the insurer to do all possible to contact their insured to get them to cooperate."

Not only does the insurer decide when an insured has failed or refused to cooperate but the reverse is also true--the insurer decides whether the insured has cooperated. If the insurer later decides the insured has cooperated, the insurer may not nonrenew under Insurance Code §551.1053 but might be able to nonrenew the policy, with proper 60-days' notice on the 12-month anniversary of the policy's original effective date, as contemplated in Insurance Code §551.105 and §551.106.

Comments on Policy Extension When Notice Is Sent Within 10 Days of Policy Expiration (§5.7105 and §5.7106)

Comment. Several commenters suggest that if the Notice under Insurance Code §551.1053 is sent less than 10 days before the end of the policy term, that the insurer should be allowed to cancel the policy instead of extending it. These commenters suggest that TDI adopt a rule authorizing cancellation of a renewed policy under the authority of Insurance Code §551.104(b)(3), which states that an insurer may cancel a policy if TDI determines that continuation of the policy would result in a violation of the Insurance Code or other insurance law in this state.

Several commenters express that an extension of the policy term is unworkable because their systems cannot extend policy terms. The commenters state that they believe the problem of shorter notice of nonrenewal when a policy is approaching the end of its term can be solved only through a cancellation or by nonrenewal following a temporary renewal.

Agency Response. TDI declines to make the requested changes. Insurance Code §551.1053 does not use the word "cancellation." Instead, it requires mandatory nonrenewal, notwithstanding Insurance Code §551.105 and §551.106. The effect of the commenters' suggestion would allow the insurer to act contrary to the statutory language by renewing the policy and then sending a 10-day notice of cancellation, rather than sending the Notice and mandatorily nonrenewing the policy at the end of the policy term or any extended term. This cancellation is prohibited by Insurance Code §551.104, which limits the allowable reasons for cancellation, and does not include the failure or refusal to cooperate in a claim or action. Insurance Code §551.1053 prohibits the insurer from renewing a policy if the insurer decides that the insured has continued to fail or refuse to cooperate.

The commenters did not explain why their systems cannot extend policy terms. TDI does not believe that an extension is unworkable because policy extensions already occur in the marketplace. However, TDI agrees to change the text requiring a policy extension in §5.7106 to instead make it clear that it is one way an insurer can comply with §5.7104 and §5.7105(b). This change recognizes that the insurer may make the decision that the insured has failed or refused to cooperate earlier in the policy term, allowing for plenty of time to send the Notice and to allow at least 10 days for the insured to cooperate. It also gives the insurer an incentive to seek the insured's cooperation as early as possible in the claims handling process. Under the adopted

rule, insurers must provide the insured with at least 10 days to cooperate and may extend the policy term to do so.

Comment. Several commenters question the statutory authority for an extension of the policy term. One commenter states that an extension is "contrary to the intent of the statute which is intended to penalize insureds who do not cooperate rather than to reward them with extended coverage."

Agency Response. TDI disagrees that it lacks the statutory authority to require an extension of the policy term and disagrees that the intent of the statute is to penalize insureds. TDI has authority to adopt and enforce reasonable rules necessary to carry out the provisions of Insurance Code Title 10, Subtitle C, concerning Automobile Insurance.

The SB 1602 bill analysis states, "The purpose of this legislation is to give an incentive for the insurance company to do all possible to contact their insured to get them to cooperate." Insurance Code §551.1053(a)(3) requires the insurer to notify the named insured that the insurer will not renew the policy if the insured *continues to* fail or refuse to cooperate. This contemplates an opportunity to cooperate, or to cure, that is inherent in the statute.

After the insurer makes the decision that an insured has failed or refused to cooperate, the insurer must comply with §5.7104 and §5.7105(b) by giving the named insured Notice and giving the insured at least 10 days to cooperate. For reasons previously explained, TDI has agreed to change §5.7106 to make it clear that extending the term is one way to comply with §5.7104 and §5.7105(b).

Comments Disagreeing with the Single Notice Requirement (§5.7107)

Comment. Several commenters disagree that the Notice described in Insurance Code §551.1053 is a single notice of nonrenewal. Rather, they say that it is a separate notice of noncooperation. These commenters believe the rule should allow insurers to first provide a notice of noncooperation and then subsequently provide a notice of nonrenewal. These commenters ask that TDI incorporate their proposed two-step notice process into the sample notices.

They further state that Insurance Code §551.1053 requires that notice of the following three elements be sent *before* a nonrenewal notice is sent:

1. Notice must state how an insured has failed or refused to cooperate;

2. The notice must include the specific claim (or action) where the insurer is requesting cooperation; and

3. Notice is given that the insurer will nonrenew coverage if the insured continues to fail or refuse to cooperate.

Agency Response. TDI disagrees that Insurance Code §551.1053 creates or requires a notice separate from the Notice sent under §551.1053. Therefore, TDI declines to create a two-step process requiring first a notice of noncooperation and then a notice of nonrenewal. Insurance Code §551.1053 expressly states that the mandatory nonrenewal takes place *notwithstanding* Insurance Code §551.105 and §551.106. The Legislature expressed that the policy must be nonrenewed when an insured fails or refuses to cooperate with the insurer. Insurance Code §551.1053 does not specify a secondary or other notice.

The Notice required by Insurance Code §551.1053 is a single notice--a special notice of mandatory nonrenewal and opportunity to cooperate--explaining that the policy nonrenewal is conditional on the insured's cooperation. Due to the enactment of Insurance Code §551.1053, there are now three different ways insurers can terminate a policy: cancellation, nonrenewal, and mandatory nonrenewal for failing or refusing to cooperate.

Sending a second additional notice contravenes statutory language in Insurance Code §551.1053, indicating that Insurance Code §551.105 and §551.106 are not part of the mandatory nonrenewal process. The single Notice approach implements the "notwithstanding" phrase in §551.1053(b), requiring the insurer to disregard Insurance Code §551.105 and §551.106. The single Notice approach recognizes the possibility that the Notice may be given near the end of a term, and still encourages cooperation by giving time for the insured to cooperate.

Requiring a second notice of nonrenewal would also create consumer confusion. In contrast, a clear and transparent single Notice written in plain language encourages prompt cooperation. The Notice is the only communication required to be sent under Insurance Code §551.1053 to notify the named insured that the policy will be mandatorily nonrenewed unless the insured cooperates. If an insurer sends the Notice and the insured cooperates before coverage ends, Insurance Code §551.1053 does not allow the insurer to nonrenew the policy for the insured's failure or refusal to cooperate, but the insurer may nonrenew the policy for other reasons.

TDI agrees that the three listed elements are statutorily required, and those elements are in adopted §5.7107, which specifies the required contents of the Notice.

Comments on the Contents of the Notice (§5.7107)

Comment. Several commenters state that some of the proposed elements in the Notice are too burdensome to implement, go beyond the scope of the statutory requirements, are too subjective, or are unreasonable.

Agency Response. TDI disagrees. TDI has authority to adopt and enforce reasonable rules necessary to carry out the provisions of Insurance Code Title 10, Subtitle C, concerning Automobile Insurance.

Insurance Code §551.1053 requires the insurer to provide written notice that states the information described in Insurance Code §551.1053(a)(1) - (3). Section 5.7107(b)(2) and (3) require the Notice to include the specific statutory requirements.

The rest of §5.7107 includes necessary elements to plainly convey enough information to the named insured to encourage the insured's cooperation in the claim or action, and to notify them of the mandatory nonrenewal. Adopted subsection (d) provides that insurers may include additional information in the notice, and is designed to assure insurers that they have flexibility in communicating with their customers. As adopted, subsection (d) is changed from the proposal to add examples of optional information--that (1) the insurer might send a renewal offer if the insurer has not already sent a notice of nonrenewal for other reasons under Insurance Code §551.105; and that (2) even if the insured cooperates, the insurer may nonrenew the policy for other reasons. Subsection (d)(2) was moved from proposed subsection (b)(9) to give the insurer the option of whether to provide that statement. Adopted subsection (e) informs insurers that they are not required to file their Notices unless TDI requests.

Comment. Several commenters state that certain Notice elements are unreasonable, too subjective, or go beyond the purview of Insurance Code §551.1053. Specifically, they take issue with the elements regarding the insurer's attempts to contact the insured; that the insured still has time to cooperate; that the insured must cooperate to stop nonrenewal; that if the insured doesn't cooperate, it will trigger nonrenewal; and the date of nonrenewal. The commenters suggest these requirements will require the Notices to be customized for every scenario, requiring manual typing.

Agency Response. TDI disagrees that the Notice elements are unreasonable, too subjective, or go beyond the purview of Insurance Code §551.1053. The statute requires giving a Notice that contains the necessary elements. The elements in §5.7107(b)(1) - (9) are contemplated or specifically required by Insurance Code §551.1053(a)(1) - (3). Insurance Code §551.1053 has been in effect for more than three years, and insurers should already be sending a Notice that gives the insured information about the claim or action, the insured's obligation to cooperate, and the consequence--i.e., mandatory nonrenewal--if the insured continues to fail or refuse to cooperate. To help ensure that the insured gets appropriate notice and to promote consistency between insurers, the rule lists the elements.

Comment. Several commenters suggest changing the section title to clarify that the Notice is the notice of mandatory nonrenewal and opportunity to cooperate, as required by Insurance Code §551.1053.

Agency Response. TDI agrees. As adopted, the section title has been changed to "Notice of Mandatory Nonrenewal and Opportunity to Cooperate Under Insurance Code §551.1053."

Comment. Several commenters express concern that proposed §5.7107(b)(3) requires insurers to inform the named insured of the insurer's attempts to contact the insured in all notices, even if an insurer has been able to contact an insured.

Agency Response. TDI agrees. As adopted, §5.7107(b)(3) has been changed to state that insurers are required to inform the named insured of contact attempts only if the insurer was unable to contact the insured.

Comment. Several commenters ask that TDI not adopt §5.7107(b)(6), opining that Insurance Code §551.1053 does not require the insurer to inform the named insured that there is still time to cooperate before the policy is nonrenewed.

Agency Response. TDI disagrees and declines to make a change. Insurance Code §551.1053 implies there is a period of time that the insured has to cooperate. Section 551.1053(a)(3) states the Notice must inform the named insured that "the insurer will not renew the policy if the insured *continues* to fail or refuse to cooperate" (emphasis added). Informing the insured that they still have time to cooperate promotes transparency and furthers the legislative intent to encourage cooperation.

Comment. Several commenters express concern that §5.7107(b)(7) as proposed required the insurer to explicitly inform the named insured that the insured had until the end of the policy term to cooperate. The commenters state that the duty to cooperate is ongoing and not restricted to the policy term in which the insurer makes its decision that the insured failed or refused to cooperate.

Agency Response. TDI agrees and has removed the phrase limiting the timeframe for cooperation from the text of §5.7107(b)(7) as adopted.

Comment. Several commenters disagree with the requirement that the insurer inform the named insured that if the insured cooperates, then the insurer will not nonrenew the policy for failure or refusal to cooperate. The commenters assert that this requirement is not stated in Insurance Code §551.1053 and that the statute only requires the insurer to nonrenew the policy. The commenters also state that a failure to cooperate may result in no coverage for a particular claim.

Agency Response. TDI disagrees that this requirement is outside the scope of Insurance Code §551.1053. Section 551.1053(a)(3) requires that the Notice inform the named insured that the insurer will not renew the policy if the insured continues to fail or refuse to cooperate. TDI has changed the adopted rule text to clarify that it is the insurer that decides whether the insured has cooperated.

Comment. Several commenters suggest eliminating the requirement in §5.7107(b)(8) (proposed §5.7107(b)(10)) that the insurer must inform the named insured of the date of nonrenewal because the rule "confuses the notice under Insurance Code §551.1053 with a notice of nonrenewal." The commenters argue that the Notice should not include a date of nonrenewal unless this rule authorizes a nonrenewal notice shorter than 60 days, and that the date of nonrenewal is the date the policy expires.

Agency Response. TDI declines to remove the date of nonrenewal as an element that must be in the Notice. The Notice required by Insurance Code §551.1053 is a special notice of mandatory nonrenewal, conditioned on the insured's cooperation. Adopted §5.7102 defines the Notice as a notice of mandatory nonrenewal and opportunity to cooperate. Unless the insurer is nonrenewing for other reasons, a second notice of nonrenewal under Insurance Code §551.105 and §551.106 is not allowed if the insurer has decided the insured failed or refused to cooperate. Insurance Code 551.1053(b) expressly states that notwithstanding Insurance Code §551.105 and §551.106, the insurer may not renew the policy if the insured fails or refuses to cooperate in the claim or action--as described in the Notice.

Informing the insured of the date of nonrenewal ensures that the named insured knows when their insurance coverage ends and should signal that they might need to seek other coverage. While TDI agrees that the date of nonrenewal is the date that the policy term expires, that might not be obvious to the insured.

Moreover, Insurance Code §551.1053 authorizes a shorter nonrenewal notice period than the 60 days ordinarily required by Insurance Code §551.105. The amount of time that remains in a policy term after the insurer gives the Notice depends on when the insurer decides that the insured has failed or refused to cooperate. It could be more or less than 60 days before the end of the policy term. Section 551.1053(b) expressly requires a mandatory nonrenewal notwithstanding the 60-day notice required by Insurance Code §551.105, and notwithstanding whether the nonrenewal occurs on a 12-month anniversary of the original effective date of the policy, which would ordinarily be prohibited by Insurance Code §551.106(b).

Comment on TDI's Authority to Promulgate a Notice (§5.7107 and §5.7108)

Comment. Several commenters express concerns about the sample Notices and argue that TDI does not have statutory authority to promulgate the form of a notice of nonrenewal.

Agency Response. The rule does not promulgate the form of the Notice. Section 5.7107 lists the elements that must be in the Notice, and §5.7108 provides sample Notices to help insurers comply with Insurance Code §551.1053. Insurers may use the sample Notices provided in §5.7108, but they are not required to. Insurers may create and use their own Notice, as long as it complies with Insurance Code §551.1053 and §5.7107.

Comment on the Spanish Notice (§5.7107)

Comment. Several commenters say that the rule requires the Notice in English and Spanish. They question TDI's authority to require a Spanish Notice and whether it is necessary. Commenters question why TDI is requiring a Spanish-language Notice for this rule when it does not for others.

Agency Response. TDI disagrees that it lacks statutory authority. TDI has authority to adopt and enforce reasonable rules necessary to carry out the provisions of Insurance Code Title 10, Subtitle C, concerning Automobile Insurance.

TDI clarifies that the rule does not require insurers to send the Notice in Spanish. The adopted rule text gives insurers the option to comply by either giving the Notice in both English and Spanish, or by giving the Notice in English with a statement in Spanish containing the insurer's phone number and stating that the policy will be nonrenewed if the insured continues to fail or refuse to cooperate.

The Spanish notice requirements are consistent with other rules intended to alert consumers of important rights or changes in their policies. This is similar to the English versions of the Consumer Bills of Rights in 28 TAC §5.9970 and §5.9971, which include statements in Spanish telling readers the purpose of the document and that they can call their company for information in Spanish. Both the English and Spanish versions of the Consumer Bill of Rights require the insurer to provide a phone number. Likewise, this is similar to the approach TDI took when adopting the Texas Liability Insurance Card, as described in 28 TAC §5.204(e).

The Notice's primary purpose is to encourage the insured to cooperate with the insurer in the investigation, settlement, or defense of the claim or action described by the Notice. Insureds need to know and understand what is being asked of them.

According to the 2020 U.S. Census, over 7 million Texas households speak Spanish as their primary language. Providing a Spanish statement in the Notice or translating the Notice to Spanish will help Spanish-speaking consumers understand their obligation to cooperate and inform them that their coverage might end if they continue to fail or refuse to cooperate.

The adopted rule text has been changed from the proposed text to clarify that insurers are not required to have a dedicated phone number for communicating with Spanish speakers.

Comment on the Sample Notices (§5.7108)

Comment. Several commenters state that the sample Notices do not contain all the elements in proposed §5.7107. The commenters state that the sample Notices contain different elements, but they do not specify which elements were different.

Agency Response. TDI disagrees that the sample Notices do not match the elements in §5.7107. The sample Notices are written in plain language and in at least 10-point type. The adopted sample Notices contain all the required elements, as well as two optional elements listed in §5.7107(d).

Comment. One commenter expresses concerns that the Notice may be interrelated with a situation in which a nonrenewal notice for a different permissible reason is also sent to the same insured. The commenter asks that the sample Notice emphasize the following text by moving it to the first paragraph, underlining it, and making the font bold: "Warning: Even if you cooperate, we may still not renew your policy for other reasons allowed by law."

Agency Response. TDI declines to move the text or change its formatting. The primary focus of the Notice is to encourage insureds to cooperate in the claim. Keeping the most relevant information at the top furthers this goal. TDI appreciates and acknowledges the importance of this warning, which is why it has been included as optional language for the Notice and is included on the sample Notices.

Comment on the Requirement That the Notice Must Be Sent Even if Otherwise Nonrenewing (§5.7110)

Comment. One commenter asks TDI to remove the requirement that an insurer must send the Notice even if the insurer has already sent a notice of nonrenewal for another reason. The commenter states that it makes no sense to send the Notice when a customer has already been nonrenewed.

Agency Response. TDI declines to remove this requirement. The intent of Insurance Code §551.1053 and the purpose of the Notice is to encourage the insured's cooperation so that the claim or action can be swiftly and efficiently investigated, settled, and, if necessary, defended by the insurer, allowing the third-party claimant to either be paid for their damages or to have a timely resolution to the claim or action, even if an insurer has already notified the policyholder that the insurer is nonrenewing their policy for other reasons.

Comments Requesting Negotiated Rulemaking

Comment. Several commenters ask for withdrawal of the proposed rule and that TDI instead consider a negotiated rulemaking process to implement SB 1602 and HB 2065. They suggested that TDI meet with insurance industry experts as a part of that process.

Agency Response. TDI declines to engage in negotiated rulemaking contemplated by Insurance Code §36.110 and Chapter 2008 of the Government Code. As the *Texas Negotiated Rulemaking Deskbook* (Center for Public Policy Dispute Resolution, 1996) points out, negotiated rulemaking does not exempt the agency from statutory requirements. Each requirement in this rule is either specifically required by Insurance Code §551.1053 or is necessary to give effect to the statute. Therefore, the majority of the issues raised by the commenters are not appropriate for negotiation, and amendments to §551.1053 would require legislative action.

Comments on the Insured's Duty to Cooperate

Comment. At the hearing, one commenter mentioned that Texas case law from 1976 states that whether an insured has failed or refused to cooperate is a question of fact and it may vary by instance. This commenter stated that the case law distinguishes between failure to cooperate in a claim from failure to cooperate in a lawsuit.

Agency Response. TDI agrees that whether an insured fails or refuses to cooperate with an insurer is a question of fact. The adopted rule acknowledges that it is the insurer's decision as to whether the insured failed or refused to cooperate with the insurer in the investigation, settlement, or defense of the claim or action.

Comment Requesting Examples of Noncompliant Policy Provisions

Comment. One commenter asks that TDI provide specific examples of policy provisions filed with TDI that do not comply with Insurance Code §551.1053. The commenter further suggests that TDI provide corresponding rationales explaining why the text was noncompliant.

Agency Response. TDI declines to provide examples of noncompliant policy forms in this rulemaking. Insurers that filed forms that did not comply with insurance laws were required to revise those forms during the filing review process before TDI could approve them, as contemplated in Insurance Code Chapter 2301. TDI declines to provide examples that do not comply because it only highlights examples TDI does not want insurers to follow. Moreover, TDI does not want to imply that those examples might be the only form or method of noncompliance. Parties interested in reviewing filed and approved forms or objections to policy form provisions may do so in the System for Electronic Rates & Forms Filing (SERFF), which is publicly available on the internet.

DIVISION 1. GENERAL PROVISIONS

28 TAC §§5.7005, 5.7007, 5.7011 - 5.7013

STATUTORY AUTHORITY. The commissioner adopts amended §§5.7005, 5.7007, and 5.7011 - 5.7013 under Insurance Code §§551.1053, 551.112, 1951.002, and 36.001.

Insurance Code §551.1053 requires insurers to nonrenew private passenger automobile insurance policies when an insured fails or refuses to cooperate with the insurer in the investigation, settlement, or defense of a third-party liability claim or action.

Insurance Code §551.112 authorizes the commissioner to adopt rules relating to the cancellation and nonrenewal of insurance policies.

Insurance Code §1951.002 authorizes the commissioner to adopt and enforce rules necessary to carry out the provisions of Insurance Code Title 10, Subtitle C.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§5.7005. Special One-Year Rule Applicable Only to Personal Automobile Policies.

(a) Purpose of rule. The purpose of this section is to:

(1) require continuity of coverage for at least one year when the policy is written for a lesser term; and

(2) allow cancellation at the expiration of a one-year term when coverage is written for more than one year.

(b) Cancellation or nonrenewal. An insurer may cancel or nonrenew personal automobile policies for any legal reason, if the purpose is to terminate coverage concurrently with the expiration of any annual period, beginning with the original effective date of the policy. The prohibition in §5.7002 of this title (relating to Cancellations) does not apply to such cancellations. An insurer that cancels on the anniversary, and in accordance with this subsection, must give the policyholder at least 60 days prior written notice of cancellation.

(c) Except as provided in Insurance Code §551.1053, concerning Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies, and Division 2 of this subchapter (relating to Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies), personal automobile policies that are written for less than one year must be renewed, at the option of the insured, for additional periods so as to accumulate a minimum of 12 months' continuous coverage.

§5.7007. Renewal of Policies.

(a) Except as provided in Insurance Code §551.1053, concerning Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies, and Division 2 of this subchapter (relating to Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies), a policy must be renewed at expiration, at the option of the policyholder, unless the insurer has mailed written notice of nonrenewal to the policyholder at least 60 days before the policy's expiration date. The insurer may comply with this provision by requiring or permitting its agent to notify the policyholder. However, it is the insurer's responsibility to give notice to the policyholder if the agent fails to notify the insured.

(b) An insurer may not decline to renew personal automobile policies because of the ages of the insureds.

§5.7012. Reason for Declination, Cancellation, or Nonrenewal.

Insurers must provide to policyholders or applicants a written statement of the reason or reasons for the declination, cancellation, or nonrenewal of any policy regulated by TDI, upon request by the policyholder or applicant.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

DIVISION 2. MANDATORY NONRENEWAL OF PRIVATE PASSENGER AUTOMOBILE INSURANCE POLICIES

28 TAC §§5.7101 - 5.7110

STATUTORY AUTHORITY. The commissioner adopts new §§5.7101 - 5.7110 under Insurance Code §§551.1053, 551.112, 1951.002, and 36.001.

Insurance Code §551.1053 requires insurers to nonrenew private passenger automobile insurance policies when an insured fails or refuses to cooperate with the insurer in the investigation, settlement, or defense of a third-party liability claim or action.

Insurance Code §551.112 authorizes the commissioner to adopt rules relating to the cancellation and nonrenewal of insurance policies.

Insurance Code §1951.002 authorizes the commissioner to adopt and enforce rules necessary to carry out the provisions of Insurance Code Title 10, Subtitle C.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§5.7101. Division Purpose and Applicability.

(a) This division implements Insurance Code §551.1053, concerning Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies.

(b) Insurance Code §551.1053 requires insurers to nonrenew a policy if the insured fails or refuses to cooperate with an insurer in an investigation, settlement, or defense of a third-party liability claim or action.

(c) This division applies to third-party liability claims and actions:

(1) involving insurers identified in Insurance Code §551.101, concerning Definition; and

(2) relating to private passenger automobile insurance policies that are:

(A) personal automobile insurance policies, or

(B) written for any governmental entity or political subdivision identified in Insurance Code §551.102(4), concerning Applicability of Subchapter.

(d) This division does not apply to policies written through the Texas Automobile Insurance Plan Association.

§5.7102. Definition.

In this division, "Notice" means the notice of mandatory nonrenewal and opportunity to cooperate required by Insurance Code §551.1053(a), concerning Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies.

§5.7103. Reasonable Efforts.

An insurer must use reasonable efforts to contact and encourage cooperation from an insured who fails or refuses to cooperate in an investigation, settlement, or defense of a third-party liability claim or action.

§5.7104. Notice Timing.

(a) An insurer must send the Notice to the named insured within seven days after the insurer decides that the insured failed or refused to cooperate.

(b) If an insurer decides during one policy term that an insured failed or refused to cooperate during any prior policy term, the insurer must send the Notice within seven days of making that decision.

(c) If an insurer decides that an insured failed or refused to cooperate, the insurer must send the Notice even if the insurer has already sent a notice of nonrenewal for another reason.

§5.7105. Prohibited Nonrenewal and Cooperation Timeframe.

(a) If an insurer decides that the insured has cooperated, the insurer may not nonrenew the policy for that insured's failure or refusal to cooperate.

(b) An insurer must give the insured at least 10 days to cooperate from the date the insurer sends the Notice, regardless of when the policy term ends.

§5.7106. Extension of Term and Additional Premium.

(a) If the insurer makes the decision that the insured failed or refused to cooperate when there are less than 17 days before the end of the policy term, one way the insurer may comply with §5.7104 and §5.7105(b) of this division (relating to Notice Timing, and Prohibited Nonrenewal and Cooperation Timeframe, respectively) is to extend the policy term. Extending the policy term gives the insurer time to send the Notice to the named insured within seven days and also gives the insured at least 10 days to cooperate.

(b) An insurer may charge additional premium for any extended term on a pro rata basis, based on the premium for the expiring term.

§5.7107. Notice of Mandatory Nonrenewal and Opportunity to Cooperate Under Insurance Code §551.1053.

(a) The Notice must be written in:

(1) plain language (see TDI's website for plain language guidance); and

(2) at least 10-point type.

(b) The Notice must inform the named insured:

(1) of the identity of the insured who failed or refused to cooperate, if known;

(2) how the insured failed or refused to cooperate;

(3) of the insurer's attempts to contact the insured, if the insurer has been unable to contact the insured;

(4) of the claim or other identifying number, or action for which the insurer is requesting cooperation;

(5) that the insurer will not renew the policy if the insured continues to fail or refuse to cooperate;

(6) that there is still time to cooperate;

(7) that the insured must cooperate to stop nonrenewal of the policy;

(8) of the date of nonrenewal; and

(9) that if the insurer decides that the insured has cooperated, then the insurer will not nonrenew the policy for failure or refusal to cooperate.

(c) Insurers must provide the Notice either:

(1) in English and in Spanish; or

(2) in English with a statement in Spanish on the first page that the policy will be nonrenewed if the insured continues to fail or refuse to cooperate. The statement must include the insurer's phone number.

(d) The Notice may include additional information that does not violate any statutes or rules, including that:

(1) the insurer might send a renewal offer if the insurer has not already sent a notice of nonrenewal for other reasons under Insurance Code §551.105, concerning Nonrenewal of Policies; Notice Required; and

(2) even if the insured cooperates, the insurer may nonrenew the policy for other reasons.

(e) Insurers are not required to file the Notice with TDI unless TDI requests it.

§5.7108. Sample Notice of Mandatory Nonrenewal and Opportunity to Cooperate.

The figures in this section provide samples of written Notices that comply with §5.7107 of this title (relating to Notice of Mandatory Nonrenewal and Opportunity to Cooperate under Insurance Code §551.1053). Insurers are not limited to using the samples in this section; they may use other content and formatting as long as the Notice they provide complies with this division.
Figure 1: 28 TAC §5.7108
Figure 2: 28 TAC §5.7108
Figure 3: 28 TAC §5.7108

§5.7109. Mandatory Nonrenewal Under Insurance Code §551.1053.

(a) After the insurer provides the Notice and gives the insured at least 10 days to cooperate, then--if the insured continues to fail or refuse to cooperate--the mandatory nonrenewal is effective at the end of the:

(1) policy term during which the insurer decides the insured initially failed or refused to cooperate, or

(2) extended term under §5.7106 of this title (relating to Extension of Term and Additional Premium).

(b) Where they conflict with the requirement to mandatorily nonrenew the policy under Insurance Code §551.1053, concerning Mandatory Nonrenewal of Private Passenger Automobile Insurance Policies, the following statutes do not apply:

(1) Insurance Code §551.105, concerning Nonrenewal of Policies; Notice Required; and

(2) Insurance Code §551.106, concerning Renewal and Reinstatement of Personal Automobile Insurance Policies.

(c) If the insured cooperates before the end of the policy term or the end of the extended term under §5.7106 of this title, then the insurer may not nonrenew the policy under Insurance Code §551.1053.

§5.7110. Nonrenewal Under Other Statutes.

(a) An insurer may nonrenew a policy for a reason other than an insured's failure or refusal to cooperate if the insurer complies with other laws governing renewal and nonrenewal, including Insurance Code §551.105, concerning Nonrenewal of Policies; Notice Required, and Insurance Code §551.106, concerning Renewal and Reinstatement of Personal Automobile Insurance Policies.

(b) To encourage cooperation, even if an insurer has already sent a notice of nonrenewal for another reason, the insurer must still provide the Notice required by this division and Insurance Code §551.1053(a).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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

SUBCHAPTER W. CONSUMER RIGHTS NOTICES

28 TAC §5.9970, §5.9971

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figures in 28 TAC §5.9970 and §5.9971 are not included in the print version of the Texas Register. The figures are available in the on-line version of the April 19, 2024, issue of the Texas Register.)

The commissioner of insurance adopts amendments to 28 TAC §5.9970 and §5.9971, concerning consumer rights notices for personal automobile insurance and homeowners, dwelling, and renters insurance. These notices explain how consumer rights are affected by applicable statutes and rules and are to be distributed by an insurer to each policyholder on issuance of a policy. Section 5.9970 and §5.9971 are adopted with changes to the proposed text published in the October 13, 2023, issue of the *Texas Register* (48 TexReg 5953) and addressed in a correction of error published in the October 27, 2023, issue of the *Texas Register* (48 TexReg 6416). These sections will be republished. The text of each section has been changed to provide a later applicable date than was included in the proposed text. In addition, changes have been made to the notices adopted by reference in both sections in response to comments and to the notices adopted by reference in §5.9970 to correct errors. Minor nonsubstantive grammatical corrections and formatting changes have been made to each form.

PETITION HISTORY. Under Insurance Code §501.156, the Office of Public Insurance Counsel (OPIC) sent petitions to the Texas Department of Insurance (TDI) requesting the adoption of updated consumer rights notices for automobile and homeowners insurance. OPIC filed its original petition on August 30, 2022, requesting that TDI adopt a revised consumer rights notice for personal automobile insurance (Auto Bill of Rights). TDI's proposal revising the Auto Bill of Rights was published in the April 14, 2023, issue of the *Texas Register.* However, following the publication of the proposal in the *Texas Register,* the 88th Legislature enacted legislation impacting the Auto Bill of Rights. Therefore, TDI withdrew its April 14, 2023, proposal amending the Auto Bill of Rights.

OPIC submitted another petition to TDI on August 28, 2023, requesting adoption of revisions to the Auto Bill of Rights and the consumer rights notice for homeowners, dwelling, and renters insurance (Homeowners Bill of Rights).

REASONED JUSTIFICATION. The previous versions of both the Auto Bill of Rights and the Homeowners Bill of Rights were adopted in May 2021 and are found in §5.9970 and §5.9971, respectively. Since the May 2021 amendments, the Legislature enacted legislation affecting the rights of insurance consumers. The adopted amendments are necessary to inform consumers of these changes.

Senate Bill 1602, 87th Legislature, 2021, added Insurance Code §551.1053, requiring mandatory nonrenewal of private passenger automobile policies when an insured fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a claim or action.

House Bill 2065, 88th Legislature, 2023, amended Insurance Code §551.1053 to apply only to third-party liability claims or actions.

House Bill 1900, 88th Legislature, 2023, amended the Insurance Code to require notice of nonrenewal no later the 60th day before the date of nonrenewal of certain insurance policies, including personal automobile insurance and homeowners, dwelling, and renters insurance. The bill amended Insurance Code §551.105, changing the requirement from 30 days' notice to 60 days' notice.

House Bill 1706, 88th Legislature, 2023, added new Insurance Code §4102.007, specifying that a commercial or residential property insurance policy may not include a provision prohibiting an insured from contracting with a public insurance adjuster for services.

The petition received from OPIC on August 28, 2023, updates the Auto Bill of Rights to include changes made by SB 1602, HB 2065, and HB 1900, and updates the Homeowners Bill of Rights to include changes made by HB 1900 and HB 1706.

Insurers must distribute the Auto Bill of Rights or Homeowners Bill of Rights to each policyholder on issuance of a new policy or on renewal if the updated consumer notice was not previously sent. Amending the Auto Bill of Rights and Homeowners Bill of Rights ensures that consumers get the most accurate and up-to-date information and insurers distribute current and accurate consumer rights information to policyholders.

In addition, the proposed text of the figures has been changed to correct errors in both Figure 1: 28 TAC §5.9971(b) and Figure 2: 28 TAC §5.9971(b). In each figure item 13, Notice of premium increase, incorrectly specified that insurance companies must provide 60 days' notice of a premium increase of 10% percent or more. This is corrected in the adopted text by changing this to 30 days' notice. The adopted amendments also correct two errors in Figure 1: 28 TAC §5.9971(b). The table of contents page number for "Where to Get Information" is changed from 2 to 3, and the title of Item 17 is changed from "Right to Cancel" to "Your right to cancel."

Finally, the text of §5.9970(f) and §5.9971(f) as proposed has been changed to delay the applicable date for the revised notices from May 1, 2024, as proposed, to November 1, 2024. This change will allow insurers sufficient lead time to incorporate the adopted changes. Insurance companies may begin using the new consumer rights notices immediately after the effective date of the rule adoption. They must begin using them no later than November 1, 2024.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI provided an opportunity for public comment on the rule proposal for a period that ended on November 13, 2023. TDI received comments from one commenter. The commenter was the Insurance Council of Texas, in support of the proposal with changes.

Comment on the Use of the Phrase "Unused Premium" in the Auto Bill of Rights and the Homeowners Bill of Rights

Comment. A commenter states that the term "unused premium," as used in both the Auto Bill of Rights and the Homeowners Bill of Rights, is misleading, deceptive, and may lead to consumer misunderstandings on how companies use premiums. The commenter says referring to premiums as unused could inadvertently imply to policyholders that they have a reserve of funds available for coverage, which can create unrealistic expectations. The commenter suggests replacing "unused premium" with "unearned premium."

Agency Response. TDI agrees that the phrase "unused premium" may lead to consumer misunderstanding and that the phrase "unearned premium" is preferable. In response to the comment, TDI has changed the word "unused" to "unearned" in the following figure locations: (1) Figure 1, 28 TAC §5.9970(b) (Auto Bill of Rights), page 5, Item 17, Your right to cancel, and Item 18, Refund of premium; and (2) Figure 1, 28 TAC §5.9971(b), (Homeowners Bill of Rights), page 5, Item 17, Right to cancel, and Item 18, Refund of premium.

Similarly, in response to the comment, TDI has changed the word "utilizada" to "retribuida" in the Spanish consumer rights notices in the following figure locations: (1) Figure 2, 28 TAC §5.9970(b) (Spanish Auto Bill of Rights), page 5, Item 17, Su derecho a cancelar, and Item 18, Reembolso de la prima; and (2) Figure 2, 28 TAC §5.9971(b) (Spanish Homeowners Bill of Rights), page 6, Item 17, Su derecho a cancelar, and Item 18, Reembolso de la prima.

Comments on Auto Bill of Rights Item 19, Limits on Using Claim History to Change Premium

Comment. A commenter says that the title of this item is misleading and may imply a broader scope than it encompasses. The commenter states that, to avoid confusion, the title should be amended to clarify that the item pertains to first-party claims and not to claims that have been paid or payable. The commenter suggests that the term "a claim you file" should be explained to avoid confusion or misinterpretation.

Agency Response. TDI disagrees with these comments and declines to make any change. TDI disagrees with the comment that the title of the item is misleading or overly broad. The title of the item is accurate because Insurance Code §1953.051 prescribes limits on using claim history to change premium.

TDI disagrees with the comment that the title of Item 19 should be amended to specify that the rating prohibition does not apply to claims paid or payable under the policy. The single explanatory sentence in Item 19, which closely tracks Insurance Code §1951.051, explains that the prohibition applies to claims not paid or payable under the policy.

TDI disagrees with the comment that the term "a claim you file" in the explanatory text of Item 19 needs additional explanation to avoid confusion or misinterpretation. This language very closely tracks Insurance Code §1951.051(b)(1)(B), which states that the rating plan prohibition applies to "a claim filed by an insured" under a personal automobile insurance policy.

Comment on Homeowners Bill of Rights Item 5, Deadline for Processing Claims and Payments

Comment. A commenter states that the item should be clarified to specify that the deadlines apply only to first-party claims. The comment states that this would avoid confusion for consumers or others reporting third-party claims.

Agency Response. TDI agrees with the comment. To clarify that the deadlines apply to first-party claims only, TDI has added the phrase "for your damages" to both the title and the second sentence of Item 5 in the Homeowners Bill of Rights. Similarly, in response to the comment, TDI has added the phrase "para sus daños" in the title and second sentence of Item 5 in the Spanish Homeowners Bill of Rights.

Comment on Homeowners Bill of Rights Item 12, Claim Disagreements

Comment. A commenter states that the item should be clarified to further explain the statement that a policyholder can "pay a licensed public adjuster to review the damage and handle the claim." The commenter states that public adjusters have no authority on coverage disagreements, and that the item should be clarified.

Agency Response. TDI disagrees with the comment that public insurance adjusters have no authority on coverage disagreements and declines to make any change. Insurance Code §4102.001 defines public insurance adjuster as a person acting on behalf of an insured in "negotiating for or effecting the settlement of a claim or claims for loss or damage under any policy of insurance covering real or personal property." This definition does not exclude public insurance adjusters from acting on behalf of an insured in coverage disagreements.

STATUTORY AUTHORITY. The commissioner adopts amendments to §5.9970 and §5.9971 under Insurance Code §501.156 and §36.001.

Insurance Code §501.156 requires OPIC to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance that TDI regulates, to be distributed under TDI rules.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§5.9970. Personal Automobile Insurance Consumer Bill of Rights.

(a) For purposes of this section, "insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write personal automobile insurance in this state. The term includes an affiliate, as described by Insurance Code §823.003(a), if that affiliate is authorized to write and is writing personal automobile insurance in this state.

(b) The Texas Department of Insurance adopts the 2024 version of the Consumer Bill of Rights - Personal Automobile Insurance (Auto Bill of Rights), and the Spanish language translation, as developed and submitted by the Office of Public Insurance Counsel:
Figure 1: 28 TAC §5.9970(b)
Figure 2: 28 TAC §5.9970(b)

(c) All insurers writing personal automobile insurance policies must provide with each new policy of personal automobile insurance a copy of the 2024 version of the Auto Bill of Rights. At the consumer's request, the insurer may provide an electronic copy of the Auto Bill of Rights instead of a hard copy. The insurer must provide the Auto Bill of Rights with each renewal notice for personal automobile insurance unless the insurer has previously provided the policyholder with the 2024 version of the Auto Bill of Rights.

(d) The Auto Bill of Rights must appear in no less than 10-point type and be on separate pages with no other text on those pages.

(e) Insurers must provide the Spanish language version of the 2024 version of the Auto Bill of Rights to any consumer who requests it.

(f) Insurers must provide the applicable Auto Bill of Rights included in this section beginning November 1, 2024. Before that date, insurers may provide the Auto Bill of Rights either as it currently is included in this section or as it was included in the section as the section was amended to be effective May 16, 2021.

§5.9971. Homeowners, Dwelling, and Renters Insurance Consumer Bill of Rights.

(a) For purposes of this section, "insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance in this state. The term includes an affiliate, as described by Insurance Code §823.003(a), if that affiliate is authorized to write and is writing residential property insurance in this state. The term does not include the Texas Windstorm Insurance Association or the Texas Fair Plan Association.

(b) The Texas Department of Insurance adopts the 2024 version of the Consumer Bill of Rights - Homeowners, Dwelling, and Renters Insurance (Homeowners Bill of Rights), and the Spanish language translation, as developed and submitted by the Office of Public Insurance Counsel:
Figure 1: 28 TAC §5.9971(b)
Figure 2: 28 TAC §5.9971(b)

(c) All insurers writing homeowners, dwelling, or renters insurance must provide with each new policy of any such insurance a copy of the 2024 version of the Homeowners Bill of Rights. At the consumer's request, the insurer may provide an electronic copy of the Homeowners Bill of Rights instead of a hard copy. The insurer must provide the Homeowners Bill of Rights with each renewal notice for any such insurance unless the insurer has previously provided the policyholder with the 2024 version of the Homeowners Bill of Rights.

(d) The Homeowners Bill of Rights must appear in no less than 10-point type and be on separate pages with no other text on those pages.

(e) The insurer must provide the Spanish language version of the 2024 version of the Homeowners Bill of Rights to any consumer who requests it.

(f) Insurers must provide the applicable Homeowners Bill of Rights included in this section beginning November 1, 2024. Before that date, insurers may provide the Homeowners Bill of Rights either as it is currently included in this section or as it was included in the section as the section was amended to be effective May 16, 2021.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 3, 2024.

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

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 166. ACCIDENT PREVENTION SERVICES

28 TAC §§166.1 - 166.3, 166.5

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to 28 TAC §§166.1 - 166.3, and 166.5, concerning certain submission requirements for insurance companies (companies) about their accident prevention services (APS). The amendments to §§166.1, 166.2, and 166.5 are adopted without changes to the proposed text published in the February 23, 2024, issue of the *Texas Register* (49 TexReg 960) and will not be republished. Section 166.3 is adopted with one change to the proposed text published in the February 23, 2024, issue of the *Texas Register* (49 TexReg 960) and will be republished. The change corrects a typo in subsection (b) from "subsection" to "section."

REASONED JUSTIFICATION. The amendments eliminate overly burdensome administrative regulations that companies must adhere to in order to demonstrate the sufficiency of their APS to DWC. The amendments bring these administrative rule requirements more in line with statutory requirements and are necessary to allow companies to streamline their services and focus on their APS by not having to track and submit as much additional information to DWC. Also, these amendments will allow DWC to direct our attention and resources on services that have proven to be more effective in providing occupational safety assistance to Texas employees and employers.

DWC's evaluation process included an informal draft proposal to gather information and comments on possible changes to the rule text before writing and posting the formal proposal. DWC considered the comments and information received through the informal process, as well as the comments received in response to the formal proposal, when drafting the amendments.

Section 166.1. The amendments to §166.1 apply nonsubstantive editorial and formatting changes to conform the section to the agency's current style and improve the rule's clarity.

Section 166.2. The amendments to §166.2 remove the requirement that companies must maintain written procedures and remove the requirement that a company must evaluate a policyholder's needs according to those written procedures. Because these requirements will be removed, the requirement that companies must, after evaluating and determining the policyholder's need for services, render all offers of services and the provision of services to the policyholder within a reasonable period of time, will also be removed. The Labor Code does not mandate these requirements. Also, DWC amended §166.2(b)(1) to update DWC's new mailing address.

Section 166.3. The amendments to §166.3 align the rule with statutory requirements. They remove the requirement that companies must file an initial annual report on their APS, but still require companies to file an annual report with DWC. The information required in the annual report is revised to reflect what is required under Labor Code §411.065. DWC forms were updated to incorporate the amendments regarding annual reports. The revised annual report form will be used beginning with 2024 reporting data and due by April 1, 2025.

Section 166.5. The amendments to §166.5 remove the requirement that DWC must conduct an initial inspection of each company and remove the requirement that a company must provide a copy of all APS procedures 60 days before an inspection. The amendments also remove the requirements that, for each policy selected by DWC for inspection, the company must provide the primary North American Industry Classification System (NAICS) code, the A.M. Best Hazard index number, and certain service and loss information. The amendments remove the requirements that DWC must issue a certificate to each company if the inspection is deemed adequate and withhold the certificate if a company's APS are inadequate.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received one written comment, and no oral comments. The commenter, that supported the proposal with changes, was the American Property Casualty Insurance Association (APCIA). DWC did not receive any comments against the proposal.

Comment on §166.2(b)(2) (Contact and surveys following fatalities). APCIA recommended that DWC eliminate the requirement that insurance companies must offer the policyholder a survey within seven working days of knowledge of a work-related fatality.

Agency Response to Comment on §166.2(b)(2) (Contact and surveys following fatalities). DWC appreciates the suggestion but declines to make the change because it is in the interest of the state for companies to reach out to a policyholder if a work-related death occurs. Companies are not required to complete the survey within seven days. They are required to contact the policyholder within seven days and offer a survey.

Comment on §166.2(b)(3) (Services requested by a policyholder). APCIA recommended that the current 15-day period following a policyholder request for insurers to provide APS other than surveys be extended to 30 days.

Agency Response to Comment on §166.2(b)(3) (Services requested by a policyholder). DWC appreciates the suggestion but declines to make the change because the rule allows the parties to extend this time period if they mutually agree to do so.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to 28 TAC §§166.1 - 166.3, and 166.5 under Labor Code §§411.061, 411.064, 411.065, 411.066, 411.068, 402.00111, 402.00116, and 402.061.

Labor Code §411.061 provides that a company must maintain adequate APS as a prerequisite for writing workers' compensation insurance in Texas.

Labor Code §411.064 provides that DWC may conduct inspections of a company to determine the adequacy of that company's APS.

Labor Code §411.065 provides that every company writing workers' compensation insurance in Texas must submit, at least annually, to DWC detailed information on the type of accident prevention facilities offered to the company's policyholders.

Labor Code §411.066 requires that the front of each workers' compensation insurance policy delivered or issued for delivery in this state contain notice that accident prevention services are available to the policyholder from the insurance company to appear in at least 10-point bold type.

Labor Code §408.068 states that a company commits an administrative violation if the company does not maintain or provide APS as required under Labor Code Chapter 411, Subchapter E.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other

workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§166.3. Annual Information Submitted by Insurance Companies.

(a) An insurance company writing workers' compensation insurance in Texas must file with the division an annual report on its accident prevention services no later than April 1 of each calendar year.

(b) An annual report required by this section must be filed with the division in the format and manner prescribed by the division.

(c) The annual reports must not include the expenses or the costs of underwriting visits to a policyholder's premises unless accident prevention services are provided during the visit. In that case, the proportionate costs of the accident prevention services may be included in the report.

(d) Insurance companies are responsible for timely and accurate reporting under this section. A report required by this section is considered filed with the division only when it accurately contains all of the required data elements and is received by the division.

(e) This section is effective July 1, 2024.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2024.

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Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER JJ. CIGARETTE, E-CIGARETTE, AND TOBACCO PRODUCTS REGULATION

34 TAC §3.1207

The Comptroller of Public Accounts adopts new §3.1207, concerning e-cigarette retailer permits, without changes to the proposed text as published in the February 23, 2024, issue of the *Texas Register* (49 TexReg 985). The rule will not be republished. The comptroller creates this rule to implement portions of Senate Bill 248, 87th Legislature, 2021, relating to regulating permits for the sale or delivery of e-cigarettes.

This section provides guidance on the permitting of the retail sale of e-cigarettes as provided in new Health and Safety Code, Chapter 147 (E-cigarette Retailer Permits).

In subsection (a), the comptroller defines commercial business location, e-cigarette retailer, permit holder, and place of business as found in Health and Safety Code, §147.0001 (Definitions); e-cigarette as found in Health and Safety Code, §161.081 (Definitions); and marketplace, marketplace provider and marketplace seller as found in Tax Code, §151.0242 (Marketplace Providers and Marketplace Sellers).

In subsection (b), the comptroller states that this section does not apply to a product that is approved for use in the treatment of nicotine or smoking addiction and is labeled with a "Drug Facts" panel.

The comptroller provides the permitting requirements and application process in subsection (c), effective January 1, 2022, for a person engaging in business as an e-cigarette retailer in Texas.

In subsection (d), the comptroller provides information on permit periods and applicable permit fees for new permits and renewals.

The comptroller provides payment requirements for obtaining an e-cigarette retailer permit in subsection (e).

In subsection (f), the comptroller includes qualification guidelines regarding the issuance of an e-cigarette retailer permit.

The comptroller lists requirements for the display of an e-cigarette retailer permit in subsection (g).

In subsection (h), the comptroller provides the conditions under which the comptroller may deny an application for an e-cigarette retailer permit.

The comptroller provides information related to the summary suspension of an e-cigarette retailer permit in subsection (i).

In subsection (j), the comptroller provides information relating to the final revocation or suspension of an e-cigarette retailer permit.

The comptroller addresses administrative penalties in subsection (k) for a person who violates provisions of this section.

In subsection (l), the comptroller provides the applicable offenses that may be committed by a person who engages in e-cigarette retailer related business without an e-cigarette retailer permit.

The comptroller did not receive any comments regarding adoption of the amendment.

The new section is adopted under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture) and §111.0022 (Application to Other Laws Administered by Comptroller) which provide the comptroller with authority to prescribe, adopt, and enforce rules relating to the administration and enforcement provisions of Tax Code, Title 2, and taxes, fees, or other charges which the comptroller administers under other law.

The new section implements Health and Safety Code, Chapter 147 (E-cigarette Retailer Permits).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 2, 2024.

TRD-202401367

Jenny Burleson
Director, Tax Policy Division
Comptroller of Public Accounts
Effective date: April 22, 2024
Proposal publication date: February 23, 2024
For further information, please call: (512) 475-2220

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 20. TEXAS WORKFORCE COMMISSION

CHAPTER 801. LOCAL WORKFORCE DEVELOPMENT BOARDS
SUBCHAPTER A. GENERAL PROVISIONS

40 TAC §801.1

The Texas Workforce Commission (TWC) adopts amendments to the following section of Chapter 801, relating to Local Workforce Development Boards:

Subchapter A. General Provisions, §801.1

Amended §801.1 is adopted without changes to the proposal, as published in the January 5, 2024, issue of the *Texas Register* (49 TexReg 26), and, therefore, the adopted rule text will not be published.

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

The purpose of the Chapter 801 rule change is to address changes in Texas Government Code §2308.256(a) and (g) because of the passage of House Bill (HB) 1615 by the 88th Texas Legislature, Regular Session (2023). Regarding Local Workforce Development Board (Board) composition, the bill removes the requirement that a Board member must have expertise in child care or early childhood education and adds the requirement that a Board must have representatives from the child care workforce.

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS

(Note: Minor editorial changes are made that do not change the meaning of the rules and, therefore, are not discussed in the Explanation of Individual Provisions.)

SUBCHAPTER A. GENERAL PROVISIONS

TWC adopts the following amendments to Subchapter A:

§801.1. Requirements for Formation of Local Workforce Development Boards

Section 801.1 is amended by amended Texas Government Code §2308.256(a) to add that a Board must include a representative from the child care workforce and subsection §2308.256(g) subsequently removes the requirement that at least one Board member shall have expertise in child care or early childhood education by amending §801.1 as follows:

--Section 801.1(g)(2)(C)(vi) is removed because of the amended Texas Government Code §2308.256(a) requirement. The subsequent clause is renumbered.

--Section 801.1(g)(2)(D)(i) and (ii) are also removed and the language in §801.1(g)(2)(D)(ii) is merged into §801.1(g)(2)(D).

TWC hereby certifies that the rules have been reviewed by legal counsel and found to be within TWC's legal authority to adopt.

PART III. PUBLIC COMMENTS

The public comment period closed on February 19, 2024. TWC received one comment from an individual.

COMMENT: One individual supported the requirement that a Board must have representatives from the child care workforce.

RESPONSE: The Commission appreciates the support. No changes were made in response to this comment.

PART IV. STATUTORY AUTHORITY

The rules are adopted to implement House Bill 1615, 88th Texas Legislature, Regular Session (2023), which amended Texas Government Code §2308.256 to require that Boards include a representative of the child care workforce.

The rules are adopted under:

--Texas Government Code §2308.253, which provides TWC with the specific authority to establish rules related to local workforce development boards; and

--Texas Labor Code §301.0015 and §302.002(d), which provide TWC with the general authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of TWC services and activities.

The adopted rules relate to Texas Government Code Chapter 2308.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 1, 2024.

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Les Trobman
General Counsel
Texas Workforce Commission
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For further information, please call: (512) 850-8356