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 C. INFRASTRUCTURE AND RELIABILITY

16 TAC §25.57
The Public Utility Commission of Texas (commission) adopts new 16 Texas Administrative Code (TAC) §25.57, relating to Power Outage Alert Criteria. The commission adopts this rule with changes to the proposed rule as published in the December 31, 2021 issue of the Texas Register (46 TexReg 9148). This rule establishes the criteria for the content, activation, and termination of regional and statewide power outage alerts as required by Tex. Govt.' Code §411.301(b), enacted by the 87th Texas Legislature as part of Senate Bill 3. The rule will be republished.

The commission received comments on the proposed rule from AEP Texas Inc., CenterPoint Energy Houston Electric, LLC, and Texas-New Mexico Power Company (collectively, Joint TDUs); Electric Reliability Council of Texas, Inc. (ERCOT); Entergy Texas Inc. (ETI); the Lower Colorado River Authority and Lower Colorado River Authority Transmission Services (collectively, LCRA); Office of Public Utility Counsel (OPUC); Oncor Electric Delivery Company LLC (Oncor); Southwestern Electric Power Company (SWEPCO); Southwestern Public Service Company (SPS); Texas Competitive Power Advocates (TCPA); Texas Electric Cooperative's Inc. (TEC); Texas Public Power Association (TPPA); and Vistra Corporation (Vistra).

"Commission"

ERCOT observed that the proposed rule makes several references to "the commission," such as notices that must be provided to the commission and that the commission can recommend the issuance, update, or termination of a power outage alert. ERCOT recommended that the commission consider expanding these references to include the executive director or a designee. ERCOT argued this would provide more flexibility to the commission in developing its power outage alert processes without requiring future rulemaking projects. ERCOT further argued that codifying "that certain actions may only be given to or taken by the Commission results in practical and legal limitations on the ability to rapidly respond to a dynamic situation" and provided the example of ERCOT operators resending firm load-shed instructions at 1 a.m. on a Saturday night. In this instance, ERCOT continued, it would be desirable to terminate the power outage alert, but that under the proposed rule it may require the commission to convene an emergency open meeting subject to specific legal requirements, such as audio, visual, and internet-broadcasting requirements.

Commission Response
The commission agrees with ERCOT that, for practical reasons, the duties associated with the rule are more properly assigned to the executive director. Imminent system-wide load shed events would require a swift response under circumstances that would make convening an open meeting impractical or even impossible. Therefore, the commission modifies the rule to replace all references to "the commission" with "the executive director." The commission further adds language to adopted subsection (c) allowing a designee to act on behalf of the executive director under this section. Under the adopted rule, the executive director or a designee will receive notices from ERCOT and transmission service providers (TSPs) in power regions outside of ERCOT of likely system-wide load shed events, request additional information as necessary, and recommend the issuance, update, or termination of power outage alerts as circumstances require.

Termination criteria
Joint TDUs argued the proposed rule should be modified because Tex. Gov't. Code §411.301(b) directs the commission to adopt termination criteria for a power outage alert and recommended that such criteria should be "when the reliability coordinator terminates or cancels the 'load shed instructions' that gave rise to the power outage alert's activation."

Commission Response
The commission agrees with Joint TDUs that Tex. Gov't. Code §411.301(b) requires the commission to establish criteria for terminating a power outage alert. The commission modifies subsection (c) to allow the executive director to recommend the termination of a power outage alert when the conditions that led to the issuance of the power outage alert are no longer applicable and are unlikely to recur in the near future.

Accessibility
TPPA recommended the commission ensure, to the best of its ability, that language or accessibility barriers do not prevent Texans from receiving a power outage alert in a meaningful way. TPPA recommended that the power outage alert be, at a minimum, issued in English and Spanish and be integrated with TDD/TTY equipment.

Commission Response
The commission declines to modify the rule to address accessibility and language barriers as recommended by TPPA. DPS is the state agency tasked with administering this program and is-
suing power outage alerts, and the commission does not control the methods, platforms, or technology that will be used to broadcast these alerts to the public.

Proposed 25.57(a) - "Purpose and Applicability"

Proposed subsection (a) establishes the applicability of proposed §25.57. LCRA requested the commission modify this section, in part, to read: "This section applies to power outage alerts issued in the Electric Reliability Council of Texas (ERCOT) power region and (transmission service providers) in power regions in Texas other than the ERCOT power region."

Commission Response

The commission declines to modify the applicability language as requested by LCRA. This subsection identifies the entities required to comply with the rule, not the areas of the state in which it applies. The rule requires action by, and therefore applies to, ERCOT and TSPs in power regions other than ERCOT.

The commission adds a clarification to subsection (a) that power outage alerts can be regional or statewide. The commission also replaces all references to the "ERCOT power region" throughout the rule with references to the "ERCOT region," for consistency with §25.5 (relating to Definitions).

Proposed 25.57(b)(1) - "Load Shed Instructions"

Proposed paragraph (b)(1) defines the term "load shed instructions" as "directions given by a reliability coordinator to a TSP to reduce electricity usage along its systems by a described amount to prevent longer and larger outages for an entire power region."

TEC argued that the proposed definition of "load shed instructions" does not "include all instances of system-wide load shed" and objected to the phrase "longer and larger outages." Specifically, TEC asserted that controlled outages may not always prevent "longer and larger outages" from occurring when a reliability coordinator issues an emergency alert.

Commission Response

The commission agrees with TEC that "longer and larger outages" is an unnecessary inclusion in the definition of "load shed instructions" and removes the phrase from the adopted definition.

LCRA recommended the definition of "load shed instructions" be revised to include "distribution service providers, or their agents." ERCOT recommended revisions to the definition of "load shed instructions" to include the potential for the reliability coordinator to issue direction to a TSP's agent.

Commission Response

The commission agrees with LCRA and ERCOT that it is appropriate to include a reference to a TSP's agent in the definition of "load shed instructions." However, a reference to distribution service providers is unnecessary. In the context of this rule, the phrase load shed instructions is used to identify the trigger for notice requirements applicable to ERCOT and TSPs outside of ERCOT, and the trigger for the executive director to consider recommending the issuance of a power outage alert. Because each of these triggers is based on load shed instructions being issued system-wide, it is sufficient to link the trigger to the issuance of instructions to a TSP or its agent, as recommended by ERCOT, even if load shed instructions may also be issued to distribution service providers.

LCRA and ERCOT recommended the definition clarify the reliability coordinator's directions are for firm load shed, because there are other actions that a reliability coordinator may instruct a TSP or its agent to take that would result in reduced electricity usage but not warrant a power outage alert.

Commission Response

The commission agrees with LCRA and ERCOT that the definition of "load shed instructions" should specify that the reliability coordinator is directing a TSP or its agent to shed firm load and modifies the definition accordingly.

Proposed 25.57(c) - Issuance of a power outage alert

Proposed subsection (c) describes the process by which the commission may recommend DPS issue a power outage alert based on information it has received from ERCOT and TSPs in power regions other than ERCOT. Under proposed subsection (c), the issuance of a power outage alert may be recommended when load shed instructions have been issued or are likely to be issued because the system-wide power supply in one or more power regions within Texas may be inadequate to meet demand. Paragraph (c)(3) states that in determining whether to recommend the issuance of a power outage alert, the commission will consider the likelihood of system-wide load shedding being issued, the expected length of time the load shed instructions will be in effect, and any other relevant information.

TPPA noted that the proposed rule appears to require ERCOT and TSPs outside of ERCOT to report all load shed instructions, including local events confined to an area served by a single TSP. TPPA argued that local events are best handled by local TSPs and requested clarification on whether the commission would require entities to issue a power outage alert for events that affect only one TSP.

Commission Response

The commission agrees with TPPA that local providers are best equipped for communicating with customers concerning localized power outages. Power outage alerts will only be issued on a system-wide basis and the commission clarifies throughout the rule that ERCOT and TSPs in power regions other than ERCOT only need to notify the commission when the load shed instructions are issued, or are likely to be issued, on a system-wide basis.

The commission modifies the language of (c) to assign authority related to power outage alerts to the executive director or a designee and adds provisions related to the update and termination of power outage alerts as described in the commission's response to general comments above. The commission also reorganizes the information in this subsection for clarity.

ERCOT and ETI each proposed that the commission modify the rule to state that the commission may recommend the issuance of a power outage alert based on information received from ERCOT "or" TSPs in power regions other than ERCOT, rather than ERCOT "and" these TSPs. These commenters argued stated that the conditions in each power region are often different, and the commission may need to issue a power outage alert in one region even if other regions are not at risk of load shed.

Commission Response

The commission agrees with ERCOT and ETI that the executive director should consider information related to a particular power region when determining whether to issue a power outage alert for that region and modifies the rule accordingly.
Joint TDUs argued that the primary criterion for activating a power outage alert should be the issuance of actual load shed instructions. Joint TDUs opposed the issuance of power outage alerts if load shed instructions are only "likely to be issued," stating that this criterion is vague and "does not appear to allow for the proactive engagement of the customer-facing entities such as the TDUs prior to activation."

Vistra interpreted the language of proposed (c) as establishing a substantial certainty standard for the issuance of a power outage alert and requested that the commission verify that this is correct. Vistra further requested that the commission more uniformly incorporate substantial certainty into this subsection by modifying it to read: "[t]he issuance of a {power outage alert} may be recommended when load shed instructions have been issued or are likely to be issued because the system-wide power supply in one or more power regions within Texas 'is likely to be insufficient to meet demand.'"

Commission Response

The commission disagrees with Joint TDUs that power outage alerts should only be issued when load shed instructions have been issued. The purpose of a power outage alert is to notify the public when there is likely to be system-wide power outages so that the public can stay informed and make any necessary preparations. If the executive director has information that reliably predicts a system-wide load shed event, the executive director may recommend the issuance of a power outage alert at that time. However, the commission agrees with Vistra that a power outage alert should only be issued when there is an actual likelihood of supply being inadequate to meet demand and modifies the rule accordingly.

TPPA noted that the language permitting the recommendation of a power outage alert when "the system-wide power supply... may be inadequate to meet demand" could be interpreted in multiple ways and requested that the commission clarify the language. TPPA acknowledged that this language was statutory, but argued that the public should understand under what conditions a power outage alert might be issued.

Commission Response

The commission declines to modify the provision. A power outage alert serves to notify the public of an actual or imminent potential system-wide load shed event to assist members of the public in responding to such an event. Broadly speaking, this would occur when system-wide available generation, minus essential operating reserves, is projected to be less than system-wide load. However, the energy industry is rapidly evolving, as are the technologies, resource types, and services in each power region. A precise activation standard for power outage alerts could quickly become obsolete or apply unevenly across power regions. Accordingly, the adopted rule provides the executive director flexibility to consider the available information in context when determining whether to recommend the issuance of a power outage alert.

OPUC, SWEPCO, and Joint TDUs each argued that the commission should provide information to certain groups prior to, or contemporaneously with, the issuance of a power outage alert. OPUC recommended the rule require the commission to notify OPUC when a power outage alert is issued. OPUC asserts this sharing of information will facilitate timely and efficient responses by OPUC to customer concerns.

Joint TDUs and SWEPCO recommended the rule allow for engagement of TDUs, TSPs, and other customer-facing entities prior to the issuance of a power outage alert. Joint TDUs also requested that all market participants receive the alert notice that the commission sends to DPS to initiate a power outage alert. SWEPCO asked that the content of power outage alerts be shared with TSPs to ensure consistent communication.

Commission Response

The commission declines to modify the rule to include any provisions governing how the commission communicates information related to power outage alerts to OPUC, utilities, or other interested parties. This rule establishes the criteria for the issuance and termination of power outage alerts. It does not govern the commission's other communications during load shed events. The commission communicates urgent information to outside parties through a variety of different avenues. While many of these communications may take place concurrently with the issuance of a power outage alert, the actual issuance of power outage alerts rests with DPS, not the commission - the alert notice has the authority to pursue the alternatives. TPPA, for example, is not a commission-developed notice and will only be utilized by the commission for its intended purpose. Moreover, formalizing any requirements governing how and when the commission must communicate with third parties about the substance of power outage alerts may reduce the flexibility and efficiency with which the commission can recommend power outage alerts or disseminate other critical information.

Proposed 25.57(c)(2) - Alternative communications

Proposed paragraph (c)(2) permits the commission to, concurrently with the issuance of a power outage alert, disseminate information related to the power outage alert by alternative means of communication.

Vistra and TCPA opposed proposed paragraph (c)(2). Specifically, Vistra and TCPA expressed concern for the rule language which states that the commission may disseminate information "as an alternative to recommending the issuance of a system-wide power outage alert." Because the commission currently has the authority to pursue the alternative, Vistra argued that this language should be deleted so the proposed rule is focused solely on the issuance of power outage alerts. TCPA similarly recommended deleting the same phrase from the proposed rule for clarity and consistency.

Commission Response

The commission agrees with Vistra and TCPA that the commission already has the authority to pursue the alternative information dissemination methods in proposed paragraph (d)(2) and removes the provision from the adopted rule.

Proposed §25.57(d)(1)(A) and §25.57(d)(1)(B) - ERCOT notifications to the commission

Proposed subparagraph (d)(1)(A) requires ERCOT to notify the commission when its forecasts indicate system-wide generation supply may be insufficient to meet demand within the next 48 hours. Proposed subparagraph (d)(1)(B) requires ERCOT notify the commission when it issues or is preparing to issue load shed instructions.

TEC argued that the 48-hour period prescribed in subparagraphs (d)(1)(A) may be too long. TEC noted that "in most cases either the market will respond to a potential supply shortfall or ERCOT
will issue Reliability Unit Commitment (RUC) instructions or take other reliability actions to manage the shortfall."

Commission Response

The commission disagrees with TEC that 48 hours is too far in advance for ERCOT to notify the commission that its forecasts indicate that system-wide supply may be inadequate to meet system-wide demand. The 48-hour period does not trigger the issuance of a power outage alert but begins the exchange of information between ERCOT and the commission regarding the possibility of a load shed event. The executive director will not recommend the issuance of a power outage alert without first considering whether system-wide load shed can be avoided by other ERCOT reliability actions.

Vistra recommended replacing the phrase "may be insufficient" from proposed subparagraph (d)(1)(A) with the phrase "is likely to be insufficient" for consistency with the phrase "likely to be" as used in proposed subsection (c). Vistra also argued that this change would ensure that power outage alerts are not issued so often that customers become desensitized to them. TCPA similarly recommended that the commission replace the word "may" in proposed subparagraph (d)(1)(A) with "are likely to" for consistency with the issuance threshold under proposed subsection (c).

Commission Response

The commission agrees with Vistra and TCPA to conform the language in paragraph (d)(1)(A) and subsection (c) for consistency and to ensure that power outage alerts are not issued in the absence of an actual or likely system-wide load shed event. The commission updates the language in paragraph (d)(1)(A) accordingly.

ERCOT recommended striking the phrase "or is preparing to issue" from proposed subparagraph (d)(1)(B) so that ERCOT is not issuing multiple notices for the same emergency event.

Commission Response

The commission agrees with ERCOT that proposed (d)(1)(B) would require ERCOT to provide the commission with redundant notices and modifies the rule as recommended. ERCOT is required to notify the executive director when ERCOT's forecasts indicate that system-wide generation supply is likely to be insufficient to meet demand or when ERCOT issues system-wide load shed instructions. The precise details and timing of these notices will be determined by ERCOT, in consultation with commission staff, under adopted paragraph (d)(4).

Proposed §25.57(d)(2) - Initiating circumstances

Proposed subparagraph (d)(2)(D) requires ERCOT to include, if applicable and known, the initiating event or circumstances that prompted the load shed instructions.

Vistra and TCPA argued the rule should focus on communicating the risk of power outages and not the reasons for the power outages. Specifically, Vistra recommended the commission "generally refrain from identifying causes in a power outage alert unless such information is both unambiguously and holistically understood at the time as well as applicable to the preparatory nature of the alert." Vistra was concerned that subparagraph (d)(2)(D) indicated that power outages might contain information about the cause of power outages before the causes are fully understood.

Commission Response

Subparagraph (d)(2)(D) outlines the information that ERCOT is required to provide to the executive director to enable the executive director to determine whether to recommend the issuance of a power outage alert. This information will not be included in the content of the power outage alert unless it is deemed relevant and of assistance to electricity customers in accordance with paragraph (f)(4). However, the commission does modify the language of subparagraph (d)(2)(D) to clarify that ERCOT must also provide, if applicable and known, the initiating event or circumstances that might prompt the issuance of load shed instructions to account for notices provided in accordance with subparagraph (d)(1)(A).

Proposed §25.57(d)(3) - ERCOT updates to the commission

Proposed paragraph (d)(3) requires ERCOT to notify the commission if any of the conditions listed under paragraph (d)(1), the paragraph outlining when ERCOT must initially notice the commission, have materially changed or are no longer applicable.

ERCOT recommended alternative language to clarify that ERCOT notify the commission when "in ERCOT's judgment" there has been a material change in any of the considerations listed under paragraph (d)(1). ERCOT further recommended that an additional provision be added to the proposed rule that incorporates by reference §25.362(e) (relating to ERCOT Governance) which imposes requirements on access to information held by ERCOT.

Commission Response

The commission modifies adopted paragraph (d)(3) to require ERCOT to notify the executive director when system-wide load shed instructions have been recalled or when, in ERCOT's judgment, there are material changes in ERCOT's forecasts. This modification incorporates ERCOT's proposed edit that would require ERCOT to notify the commission of changes in its forecast that ERCOT deems material, while also requiring ERCOT to notify the executive director when it recalls load shed instructions. During any load shed event, ERCOT will be in constant communication with the commission and the executive director, but these two basic notification triggers are necessary to ensure a power outage alert is not active for longer than necessary.

The commission declines to incorporate §25.362(e) by reference, as it is unnecessary. The provisions of §25.362(e) already apply to information provided under this section.

Proposed §25.57(e) - Power outage alert for power regions other than ERCOT

Proposed subsection (e) details the timing and content of the notification requirements for TSPs in power regions other than ERCOT. Proposed paragraph (e)(1) requires a TSP to notify the commission when it has received load shed instructions. Proposed paragraph (e)(2) prescribes the content of the notice. Proposed paragraph (e)(3) further requires the TSP to notify the commission when the applicable reliability coordinator has recalled load shed instructions as well as information regarding power outages and restoration within the TSP's service territory.

SPS recommended revisions to proposed paragraphs (e)(1) and (e)(3) to clarify that notifications are only required for system-wide load shed events. SPS asserted that TSPs have the best capabilities for handling load shed events that are localized to their service territory.
The commission agrees that power outage alerts should only be issued for system-wide load shed events and modifies the rule accordingly.

SWEPCO recommended that the regional transmission operator (RTO), not a TSP, be the entity responsible for notifying the commission of load shed events, under proposed subsection (e). SWEPCO maintained that a TSP should not bear the responsibility of notifying the commission and further contended that proposed subsection (e) should be revised to be consistent with proposed subsection (d) for the ERCOT power region, which states that ERCOT, as the RTO, is responsible for notifying the commission. SWEPCO explained that the "RTO has clear and immediate visibility of grid conditions" and that the content of notices and additional information as required under other provisions of the proposed rule can only be answered by the RTO and not a TSP. Therefore, SWEPCO stated that requiring a TSP to notify the commission in non-ERCOT regions of Texas would only result in a delay of the power outage alert issuance and divert a TSP’s operators from executing the reliability coordinator’s load shed directive.

Commission Response
The commission disagrees with SWEPCO that the RTO should be responsible for notifying the executive director of load shed events outside of the ERCOT region. Unlike ERCOT, the commission does not have oversight authority over RTOs outside of the ERCOT region and cannot direct the actions of these RTOs. The executive director will, of course, consider any relevant information provided by these RTOs in determining whether to recommend the issuance or termination of a load shed event. The commission expects notification as soon as possible when a TSP has been given load shed instructions and getting the information from the TSPs is the most expedient way for the commission to obtain the information. Since the RTOs outside of ERCOT are responsible for operating the electric grid in multiple states, and report to multiple state, federal and local jurisdictions, the commission believes it will be more expedient to receive load shed instruction information from the TSPs. The commission has required ERCOT to perform this function in the ERCOT territory because the commission has jurisdictional oversight over ERCOT. Therefore, in areas outside of ERCOT, the commission will require the TSPs to inform the commission when they are given load shed instructions.

The commission also disagrees with SWEPCO’s arguments that load shed events do "not leave time for... dissemination of information about the event" and that the time it would take to notify the commission that it had received load shed instructions would interfere with its ability to properly execute the load shed instructions and even, potentially, delay the issuance of the power outage alert. Under these same conditions, SWEPCO states that "it will be important for SWEPCO to immediately be aware of {a power outage alert's} contents" and that the commission should provide details about the power outage alert "simultaneous with or even prior to the issuance to the public." The multi-medium customer communication activities that SWEPCO indicated it conducts demonstrates that communicating basic information surrounding a load shed event to the commission is not an unduly burdensome requirement. Moreover, the commission has simplified the notification requirements, as described below, and will work with TSPs in accordance with subsection (e)(3) to address any remaining logistical concerns.

TEC argued that the requirement for a TSP to provide notice to the commission should be "limited in scope to only reflect the information the transmission service provider can confidently provide." TEC recommended deleting the phrase "any available information regarding power outages," under proposed paragraph (e)(3) as overly broad and potentially including substantial amounts of data that is either irrelevant or publicly available. Lastly, TEC stated that deletion of the phrase would avoid duplication of the requirements in sections (e)(2)(B) and (e)(3) regarding power restoration.

Commission Response
The commission agrees with TEC that a TSP should only be required to provide information that it can confidently provide. Accordingly, the commission strikes proposed paragraph (e)(2) from the rule.

The commission disagrees with TEC that a TSP should not be required to provide information on power outages and the expectation for power restoration in proposed paragraph (e)(3). This information will help the executive director assess how long the power outage alert should remain in effect. However, in response to TEC’s concerns, the commission modifies the rule to only require a summary of information regarding power outages and the expectation of power restoration.

Proposed §25.57(e)(4) - Notification procedures
Proposed subparagraph (e)(4) requires a TSP covered by this section to establish a procedure, in consultation with commission staff, to provide the commission with notifications required under subsection (e).

TEC requested clarification on the procedures to provide notifications under proposed paragraph (e)(4). TEC requested that the commission establish the procedures for guidance such as an emailed template, rather than require TSPs to create a new procedure. TEC stated that such guidance would promote the commission’s goals of receiving consistent, standardized information regarding load shed instructions outside of ERCOT.

ETI argued that messaging to public and governmental officials during circumstances when a load shed event is imminent will require close coordination with all entities involved. ETI supported proposed paragraph (e)(4) as providing an avenue for TSPs to work with commission staff to establish a procedure to provide the required notifications that fits the specific circumstances of each TSP.

Commission Response
The commission agrees with ETI that the notification procedures must be flexible to fit the specific circumstances of each TSP and declines to adopt a standard form or procedure as requested by TEC. However, the commission does not oppose the development of a uniform approach by TSPs and commission staff. Accordingly, the commission adds language to paragraph (e)(3) allowing commission staff to develop a standardized process for providing the required notifications.

Proposed 25.57(f) - Content of power outage alert
Proposed subsection (f) requires the power outage alert to include a statement that electricity customers may experience a power outage and, when known and as applicable: whether load shed is occurring or expected to occur; a brief explanation of the circumstances surrounding the load shed event; where an electricity customer should seek assistance while the customer's power may be out; a disclaimer that a customer may not neces-
sarily experience load shed; and any other information deemed
relevant and of assistance to electricity customers.

Joint TDUs commented that proposed subsection (f) lacks
substantive criteria for a power outage alert. Specifically, Joint
TDUs argued that the criteria in proposed subsection (f) does
not include information regarding the "expected duration, mitiga-
tion measures being undertaken, and the number of potentially
affected customers within the affected power region." Joint
TDUs recommended providing more substantive information in
the power outage alert.

Vistra and TCPA argued the rule should focus on communicating
the risk of power outages and not the reasons for the power out-
ages. Specifically, Vistra recommended the commission "gener-
ally refrain from identifying causes in a power outage alert unless
such information is both unambiguously and holistically under-
stood at the time as well as applicable to the preparatory nature
of the alert." TCPA argued that the commission has many other
channels to communicate additional information.

Commission Response
The commission agrees with Vistra and TCPA that the content of
a power outage alert should focus on the risk of power outages
and, accordingly, strikes the requirement that a power outage alert
contain a brief explanation of the circumstances surrounding
the load shed event. Similarly, the commission declines to
require that power outage alerts include information on expected
duration, mitigation measures, and affected customer counts,
as recommended by Joint TDUs. The commission and service
providers can communicate this information to customers when
available through other channels. Moreover, this information
may still be provided in a power outage alert if "deemed rele-
vant and of assistance to customers."

The commission also modifies the language of adopted subsection
(f) to allow a power outage alert to contain the required infor-
mation or instructions on how to obtain the required information.
This language will allow DPS the flexibility to disseminate help-
ful information to customers in the most efficient manner possible
during a system-wide load shed event.

Proposed §25.57(f)(4) - Customer assistance
Proposed §25.57(f)(4) requires a power outage alert to provide,
when known and applicable, where an electricity customer can
seek assistance while the electricity customer's power may be
out. TPPA requested clarification on what kinds of "assistance"
the commission is envisioning this involves to better facilitate a
coordinated response.

Commission Response
The commission is constantly working with industry and its
partner governmental agencies to improve the content of
communications with the public surrounding electricity-related
events. The customer assistance information provided in power
outage alerts may include links to websites with additional
information about safety procedures during the power outage,
and telephone numbers for contacting emergency services.
However, the commission will not limit the discretion of DPS
or its other state agency partners to identify and provide other
information that may be helpful to the public during load shed
events.

The new rule is adopted under PURA §14.002, which provides
the Public Utility Commission with the authority to make, adopt,
and enforce rules reasonably required in the exercise of its pow-

ers and jurisdiction. The new rule is also adopted under Tex.
Gov't. Code §411.301, which requires the commission to adopt
criteria for the content, activation, and termination of power out-

age alerts.

Cross Reference to Statute: Public Utility Regulatory Act


(a) Purpose and Applicability. This section establishes criteria
for the activation, content, and termination of regional and statewide
power outage alerts as required by Tex. Gov't Code §411.301(b). This
section applies to the Electric Reliability Council of Texas (ERCOT)
and to transmission service providers in power regions in Texas other
than the ERCOT region.

(b) Definitions.

(1) Load shed instructions--Directives given by a reliabil-
ity coordinator to a transmission service provider or its agent to reduce
firm load along its systems by a prescribed amount.

(2) System-wide--The entirety of a power region.

(c) Issuance and termination of a power outage alert. The
executive director may recommend the Texas Department of Public
Safety issue, update, or terminate a power outage alert. A designee
may act on behalf of the executive director under this section.

(1) The executive director may recommend the Texas De-
partment of Public Safety issue a power outage alert statewide or for
one or more specific power regions in Texas. The issuance of a power
outage alert may be recommended for power regions in which sys-
tem-wide load shed instructions have been issued or are likely to be
issued because the system-wide power supply is likely to be inadequate
to meet demand.

(2) In determining whether to recommend the issuance of a
power outage alert, the executive director will consider the likelihood
of system-wide load shed instructions being issued, the expected length
of time the load shed instructions will be in effect, and any other rele-
vant information. In determining whether to recommend the issuance
of a power outage alert in the ERCOT region, the executive director
will consider information received from ERCOT under subsection (d)
of this section. In determining whether to recommend the issuance of
a power outage alert in a power region other than the ERCOT region,
the executive director will consider information received from trans-
mision service providers in that power region under subsection (e) of
this section.

(3) The executive director may recommend the termination
of a power outage alert when the conditions that led to the issuance
of the power outage alert are no longer applicable and are unlikely to recur
in the near future.

(d) Power outage alerts for the ERCOT region.

(1) ERCOT must notify the executive director when:

(A) ERCOT's forecasts indicate system-wide gener-
sation supply is likely to be insufficient to meet demand within the next
48 hours; or

(B) ERCOT issues system-wide load shed instructions.

(2) A notice under paragraph (1) of this subsection must
include any available, relevant information to assist the executive di-
rector in determining whether to recommend the issuance of a power
outage alert and what information should be included in the power out-
age alert. The notice must include, but is not limited to:
(A) Whether system-wide load shed instructions have been issued;

(B) Whether system-wide power supply is forecasted to be insufficient to meet demand and, if so, an estimated time when load shed instructions may be issued;

(C) If applicable and known, an estimated time when load shed instructions may be recalled; and

(D) If applicable and known, the initiating event or circumstances that prompted or might prompt the issuance of load shed instructions.

(3) ERCOT must notify the executive director when system-wide load shed instructions have been recalled or when, in ERCOT’s judgment, there are material changes in ERCOT’s forecasts. This notice must include information on any of the remaining conditions listed under paragraph (1) of this subsection that are still applicable.

(4) ERCOT must establish a procedure, in consultation with commission staff, to provide the executive director with notifications required under this subsection.

(5) Upon request by the executive director, ERCOT must provide additional information and updates.

(e) Power outage alerts for power regions other than the ERCOT region.

(1) A transmission service provider in a power region other than the ERCOT region must notify the executive director when it has received system-wide load shed instructions from the applicable reliability coordinator.

(2) The transmission service provider must notify the executive director when the applicable reliability coordinator has recalled the system-wide load shed instructions. The transmission service provider’s notice must include a summary of any available information regarding power outages and the expectation for power restoration within its service territory.

(3) A transmission service provider subject to this subsection must establish a procedure, in consultation with commission staff, to provide the executive director with notifications required under this subsection. Commission staff may develop a form, internet portal, or other standardized process for providing the executive director with notifications required under this subsection. If commission staff develops such a standardized process, a transmission service provider’s procedure must utilize this standardized process.

(4) Upon request by the executive director, a transmission service provider must provide additional information and updates.

(f) Power outage alert content. When known and as applicable, the power outage alert must provide the following information or instructions on how to obtain the following information:

(1) Whether system-wide load shed is occurring or expected to occur imminently;

(2) A statement that an electricity customer may experience a power outage;

(3) Where an electricity customer can seek assistance while the electricity customer’s power may be out; and

(4) Any other information deemed relevant and of assistance to electricity customers.

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 May 26, 2022. TRD-202202049
Andrea Gonzalez
Rules Coordinator
Public Utility Commission of Texas
Effective date: June 15, 2022
Proposal publication date: December 31, 2021
For further information, please call: (512) 936-7244

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 77. SERVICE CONTRACT PROVIDERS AND ADMINISTRATORS

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 77, §§77.10, 77.20, 77.22, 77.41, 77.42, and the proposed repeal of existing rules at §§77.92, 77.94-77.110, regarding the Service Contract Providers and Administrators Program. The amendments and repeals are adopted without changes to the proposed text as published in the February 11, 2022, issue of the Texas Register (47 TexReg 624). These rules will not be republished.

The Commission also withdrew proposed amendments to an existing rule at 16 TAC, Chapter 77, §77.70, as published in the February 11, 2022, issue of the Texas Register (47 TexReg 624).

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The adopted rules under 16 TAC Chapter 77 reflect the addition of residential service contracts as a fourth type of service contract under Tex. Occ. Code, Chapter 1304, Service Contract Providers and Administrators. The addition of residential service contracts to this chapter occurred during the 87th regular Legislative Session in House Bill 1560, §§4.01 - 4.13. House Bill 1560 repealed Tex. Occ. Code, Chapter 1303 and transferred regulatory oversight of residential service contracts from the Texas Real Estate Commission to the Texas Department of Licensing and Regulation effective September 1, 2021.

HB 1560 directs the Department to enact rules related to residential service contacts by June 1, 2022. The rules relating to residential service contracts as they existed at the Texas Real Estate Commission were transferred without changes to 16 TAC Chapter 77 on September 1, 2021. These transferred rules served as placeholders while the Department determined what rule amendments or rule repeals were necessary to bring rules relating to residential service contracts into line with the previously existing service contract provider rules at 16 TAC, Chapter 77, §§77.1 - 77.91.

The adopted rules repeal the entirety of the transferred rules at 16 TAC Chapter 77, §§77.92, 77.94 - 77.110. The remaining adopted rules streamline and consolidate the transferred rules into the previously existing service contract provider rules at 16 TAC Chapter 77, §§77.1 - 77.91. The adopted rules also amend the previously existing service contract provider rules at 16 TAC, Chapter §§77.1 - 77.91 to reflect the addition of residential ser-
service contracts to Tex. Occ. Code, Chapter 1304 and 16 TAC Chapter 77.

The adopted rules are necessary to create similar requirements between the provision and administration of residential service contracts and the three other types of service contracts under 16 Tex. Occ. Code, Chapter 1304 and 16 TAC, Chapter 77, §§77.1 - 77.91.

SECTION-BY-SECTION SUMMARY

The adopted rules amend §77.10(6)(C) by updating language and adding residential service contracts to the previously existing definition of "Service Contract" in §77.10(6)(D).

The adopted rules amend §77.20 by adding a requirement for all service contract providers to notify the Department of any changes to a controlling person within 30 days of the change occurring.

The adopted rules amend §77.22 by adding a requirement for all service contract administrators to notify the Department of any changes to a controlling person within 30 days of the change occurring.

The adopted rules amend §77.41 by adding a provision to allow residential service contract providers to use a reimbursement insurance policy as a form of financial security.

The adopted rules amend §77.42 by adding a minimum amount of financial security deposit for a residential service contract provider.

The adopted rules repeal §§77.92 and 77.94 - 77.110 because they are no longer necessary and are subsumed by the existing and proposed amended rules in §§77.1 - 77.91.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the February 11, 2022, issue of the Texas Register (47 TexReg 624). The deadline for public comments was March 14, 2022. The Department received comments from three interested parties on the proposed rules during the 30-day public comment period. The public comments are summarized below.

Comment--The department received one comment from The Service Contract Industry Council (SCIC) which describes itself "as a national trade association whose member companies include manufacturers, service contract providers, administrators, and retailers offering service contracts covering motor vehicles, homes, and consumer goods throughout the country".

SCIC's comment concerned a proposed amendment to 16 TAC §77.70(k). The proposed amendment would require licensees to report new "affiliations" to TDLR within 30 days of entering the relationship. SCIC opposed this proposed rule amendment stating that it added a requirement for licensees and was so broad in the term "affiliation" or "affiliate", that it did not sufficiently define or explain when such a relationship would give rise to the required reporting.

The SCIC is otherwise in favor of the proposed rules to 16 TAC Chapter 77.

Department Response--The department reviewed the proposed amended rule at 16 TAC §77.70(k) and engaged in an internal analysis of the comment. It was determined that the proposed amended rule should be removed from this rule packet.

Comment--The department received three comments from American Home Shield (AHS), a licensee offering residential service contracts in Texas and nationwide.

AHS' first comment mirrored those from SCIC And NHSCA in relation to a proposed amendment to 16 TAC 77.70(k). The proposed amendment would add a requirement for licensees to report all "affiliations" to TDLR within 30 days of entering the relationship. AHS echoed the concerns raised by SCIC And NHSCA about the proposed amended rule and stated that it was both too broad and did not sufficiently define an "affiliate" or "affiliation".

Department Response--The department reviewed the proposed amended rule at 16 TAC §77.70(k) and engaged in an internal analysis of the comment. It was determined that the proposed amended rule should be removed from this rule packet.

Comment--AHS submitted a second comment relating to the proposed amended rule at 16 TAC §77.41(c). The proposed amended rule states that a provider may use a reimbursement insurance policy as financial security under Texas Occupations Code §1304.157(c). AHS opined that the rule should be further amended to specifically state that providers who fall under Texas Occupations Code §1304.157(c) do not have to comply with mandates found in 16 TAC §77.41(b)(1) - (2).

The rule as currently written states that the requirements in 16 TAC §77.41(b)(1) - (2) relate to providers using a reimbursement policy insurance as financial security under Texas Occupations Code §1304.151 and §1304.152.

Department Response--After a thorough evaluation of the comment and the proposed rule, it was determined that TDLR will not further amend 16 TAC §77.41(c). The proposed amended rule at 16 TAC §77.41(c) clearly does not apply to providers using reimbursement insurance policy as financial security under Texas Occupations Code §1304.157(c). Therefore, the requested addition to the proposed amendment is redundant and unnecessary.
Department staff thank AHS for its comment and participation in this rule making effort.

Comment—AHS submitted a third comment relating to TDLR Form SCP012 and asking for specific changes to the form. TDLR Form SOC012 is an internally drafted form that is not subject to the rule making process. Accordingly, TDLR staff will review comments relating to the form for potential changes separate from this rulemaking process.

Department Response—Department staff thank AHS for its comment and participation in this rule making effort.

AHS is otherwise in favor of the proposed rules to 16 TAC Chapter 77.

COMMISSION ACTION

At its meeting on May 24, 2022, the Commission adopted the proposed amendments to existing rules at 16 TAC, Chapter 77, §§77.10, 77.20, 77.22, 77.41, 77.42, and the proposed repeal of existing rules at §§77.92, 77.94 - 77.110, as published in the Texas Register.

The Commission also adopted the withdrawal of §77.70 in response to the public comments.

16 TAC §§77.10, 77.20, 77.22, 77.41, 77.42

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapters 51 and Tex. Occ. Code, Chapter 1304, as amended by HB 1560 during the 87th Legislative session, which authorize the Commission, the Department’s governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapters 51 and Tex. Occ. Code, Chapter 1304, as amended by HB 1560 during the 87th regular Legislative session. No other statutes, articles, or codes are affected by the adopted rules.

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 May 26, 2022.

TRD-202202047
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: June 15, 2022
Proposal publication date: February 11, 2022
For further information, please call: (512) 475-4879

16 TAC §§77.92, 77.94 - 77.110

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapters 51 and Tex. Occ. Code, Chapter 1304, as amended by HB 1560 during the 87th Legislative session, which authorize the Commission, the Department’s governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapters 51 and Tex. Occ. Code, Chapter 1304, as amended by HB 1560 during the 87th regular Legislative session. No other statutes, articles, or codes are affected by the adopted repeals.

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 May 26, 2022.

TRD-202202047
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: June 15, 2022
Proposal publication date: February 11, 2022
For further information, please call: (512) 475-4879

16 TAC §§77.92, 77.94 - 77.110

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 105. FOUNDATION SCHOOL PROGRAM

SUBCHAPTER CC. COMMISSIONER'S RULES CONCERNING SEVERANCE PAYMENTS

19 TAC §105.1021

The Texas Education Agency adopts an amendment to §105.1021, concerning severance payment reporting and reductions in Foundation School Program (FSP) funding. The amendment is adopted without changes to the proposed text as published in the March 4, 2022 issue of the Texas Register (47 TexReg 1052) and will not be republished. The adopted amendment modifies the rule to include open-enrollment charter schools, as authorized by House Bill (HB) 189, 87th Texas Legislature, Regular Session, 2021.

REASONED JUSTIFICATION: Section 105.1021 defines the requirements for determining whether a payment to a departing superintendent is a severance payment and whether the commissioner will reduce a school district's FSP funding by the amount that a severance payment to a superintendent exceeds the amount that is equal to one year's salary and benefits under the superintendent's terminated contract. The rule currently applies only to school districts.

HB 189, 87th Texas Legislature, Regular Session, 2021, added Texas Education Code (TEC), §12.104(b-4), which applies the severance payment provisions of TEC, §11.201(c), to open-enrollment charter schools.

The adopted amendment implements HB 189 by applying the rule's provisions to open-enrollment charter schools.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began March 4, 2022, and ended April 4, 2022. Following is a summary of the public comments received and the corresponding agency responses.

Comment: The Texas-American Federation of Teachers (Texas AFT) commented that §105.1021(a)(2) should include in the def-
inition of superintendent anyone who receives a severance or payout.

Response: The agency disagrees. TEC, §11.201, applies only to superintendents, which limits §105.1021 to superintendents and does not allow for any employee who may receive a severance or payout.

Comment: Texas AFT and Texas State Teachers Association (TSTA) commented that the rule should require school districts and charter schools to disclose all contracts that include a severance provision or payout provision for any charter school employee no matter the employee's actual title.

Response: The agency disagrees. TEC, §11.201, applies only to superintendents, which limits §105.1021 to superintendents.

Comment: Texas AFT commented that the reporting form should include a column showing the cost of the severance package on a per-pupil basis. Also, the organization commented that there should be a biennial report created for the legislature so they can see the data and make additional legislative changes if needed.

Response: This comment is outside of the scope of the proposed rulemaking; however, the agency provides the following clarification. Information related to superintendent severance payments is reported annually to the State Board of Education.

Comment: TSTA stated that the definition of "superintendent" in §150.1201(a)(2) does not make clear that a superintendent must also include an administrator serving under another title as though that person were the superintendent of a school district. TSTA commented that the definition should include the administrator serving as educational leader and chief executive officer of the school district or open-enrollment charter school as though that person were the superintendent of a school district.

Response: The agency disagrees. TEC, §12.104(b-4), requires that severance payments be reported for the administrator serving as educational leader and chief executive officer of a charter school as though that person were the superintendent of a school district. In addition, amended §105.1021(a)(2) specifies that "superintendent" means the educational leader and chief executive officer of an independent school district or open-enrollment charter school. Schools cannot avoid reporting severance payments by use of a title other than superintendent.

STATUTORY AUTHORITY. The amendment is adopted under Texas Education Code (TEC), §11.201(c), which requires the commissioner to reduce a district's Foundation School Program funds by the amount of a payment made by the district to a superintendent on early termination from the superintendent's contract that exceeds an amount equal to one year's salary and benefits under the superintendent's terminated contract; and TEC, §12.104(b-4), as amended by House Bill 189, 87th Texas Legislature, Regular Session, 2021, which makes the severance payment provisions of TEC, §11.201(c), applicable to open-enrollment charter schools.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §11.201(c) and §12.104(b-4).

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 May 25, 2022.

Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: June 14, 2022
Proposal publication date: March 4, 2022
For further information, please call: (512) 475-1497

CHAPTER 120. OTHER TEXAS ESSENTIAL KNOWLEDGE AND SKILLS

The State Board of Education (SBOE) adopts the repeal of §120.1 and amendments to §§120.3, 120.5, 120.7, and 120.9, concerning Texas Essential Knowledge and Skills (TEKS) for character traits. The repeal and amendments are adopted without changes to the proposed text as published in the February 25, 2022 issue of the Texas Register (47 TexReg 860) and will not be republished. The adopted revisions update the standards for positive character traits to align with the requirements of Senate Bill (SB) 123, 87th Texas Legislature, Regular Session, 2021.

REASONED JUSTIFICATION: In 2019, the 86th Texas Legislature passed House Bill 1026, requiring the SBOE to integrate positive character traits into the essential knowledge and skills adopted for Kindergarten-Grade 12, as appropriate. The legislation required the SBOE to include the following positive character education traits in the standards: courage; trustworthiness, including honesty, reliability, punctuality, and loyalty; integrity; respect and courtesy; responsibility, including accountability, diligence, perseverance, and self-control; fairness, including justice and freedom from prejudice; caring, including kindness, empathy, compassion, consideration, patience, generosity, and charity; good citizenship, including patriotism, concern for the common good and the community; and respect for authority and the law; school pride; and gratitude. The legislation also required school districts and open-enrollment charter schools to adopt a character education program that includes the required positive character traits. At the January 2020 SBOE meeting, a discussion item on character traits instruction was presented to the Committee of the Full Board. The committee requested that staff prepare a proposal to add essential knowledge and skills for positive character traits as a new chapter in the Texas Administrative Code. The SBOE adopted the TEKS for positive character traits effective August 1, 2021. The new TEKS were implemented beginning with the 2021-2022 school year.

The 87th Texas Legislature, Regular Session, 2021, passed SB 123, which required the SBOE to add personal skills to the TEKS for positive character traits. The legislation added responsible decision-making skills, interpersonal skills, and self-management skills to the required topics to be addressed in the standards.

The adopted amendments to §§120.3, 120.5, 120.7, and 120.9 add the required new topics to the TEKS for positive character traits in Kindergarten-Grade 12. The changes will be implemented beginning with the 2022-2023 school year.

In addition, §120.1, which contains implementation language for the subchapter, is being repealed. Implementation language is included as new subsection (a) for each course.

The SBOE approved the proposed revisions for first reading and filing authorization at its January 28, 2022 meeting and for second reading and final adoption at its April 8, 2022 meeting.
In accordance with Texas Education Code, §7.102(f), the SBOE approved the revisions for adoption by a vote of two-thirds of its members to specify an effective date earlier than the beginning of the 2022-2023 school year. The earlier effective date will allow districts of innovation that begin school prior to the statutorily required start date to implement the proposed rulemaking when they begin their school year. The effective date is 20 days after filing as adopted with the Texas Register.

SUMMARY OF COMMENTS AND RESPONSES: The public comment period on the proposal began February 25, 2022, and ended at 5:00 p.m. on April 1, 2022. The SBOE also provided an opportunity for registered oral and written comments at its April 2022 meeting in accordance with the SBOE board operating policies and procedures. Following is a summary of the public comments received and responses.

Comment. The Texas American Federation of Teachers (AFT) expressed support for the proposed amendments because they align with statute and allow flexibility of implementation as either direct or embedded instruction in a district’s curriculum.

Response. The SBOE agrees that the standards as proposed are aligned to recent statutory changes and allow appropriate flexibility.

Comment. Texas AFT stated that the proposed standards for positive character traits support districts’ ongoing efforts to support the well-being of students and to establish a foundation for 21st century workplace skills that are essential in students’ future education and career endeavors.

Response. The SBOE agrees that the standards as proposed support development of positive character traits and personal skills.

Comment. Texas AFT expressed support for the emphasis on compassion, empathy, and cooperation while recognizing multiple perspectives and differences among people in the TEKS for positive character traits because they are skills that are vitally important to responsible citizenship and meaningful civic discourse.

Response. The SBOE agrees that the standards as proposed support the development of positive character traits, including responsible citizenship.

Comment. One parent expressed concern with the TEKS for positive character traits and stated that the authorizing legislation was not subject to debate.

Response. The SBOE disagrees that the standards are cause for concern. Additionally, the SBOE provides the following clarification. Texas Education Code (TEC), §29.906, requires the SBOE to integrate positive character traits and personal skills into the essential knowledge and skills adopted for Kindergarten-Grade 12 and identifies specific traits and personal skills that must be addressed.

Comment. One parent expressed opposition to the TEKS for positive character traits and stated that it is a parent’s duty, not the school’s, to teach their children character.

Response. The SBOE agrees that parents are also responsible for teaching character. However, the SBOE disagrees that character should not be addressed in the state curriculum standards. Additionally, the SBOE provides the following clarification. TEC, §29.906, requires the SBOE to integrate positive character traits and personal skills into the essential knowledge and skills adopted for Kindergarten-Grade 12 and identifies specific traits and personal skills that must be addressed.

SUBCHAPTER A. CHARACTER TRAITS

19 TAC §120.1

STATUTORY AUTHORITY. The repeal is adopted under Texas Education Code (TEC), §7.102(c)(4), which requires the State Board of Education (SBOE) to establish curriculum and graduation requirements; TEC, §28.002(a), which identifies the subjects of the required curriculum; TEC, §28.002(c), which requires the SBOE to identify by rule the essential knowledge and skills of each subject in the required curriculum that all students should be able to demonstrate and that will be used in evaluating instructional materials and addressed on the state assessment instruments; and TEC, §29.906, as amended by Senate Bill 123, 87th Texas Legislature, Regular Session, 2021, which requires the SBOE to integrate positive character traits and personal skills into the essential knowledge and skills adopted for Kindergarten-Grade 12, as appropriate.

CROSS REFERENCE TO STATUTE. The repeal implements Texas Education Code, §§7.102(c)(4); 28.002(a) and (c); and 29.906, as amended by Senate Bill 123, 87th Texas Legislature, Regular Session, 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 May 25, 2022.
For The STATUTORY Effective 47 Cristina Proposal Director, TRD-202202035 KNOWLEDGE Section subjects as the essential proposed Texas and career of Texas Education skills Regular TexReg found information, the SBOE education Secretary to 865) TEKS technical to as EDUCATION required (TEC), by the (SBOE) to be §7.102(c)(4), legal knowledge in §28.002(c), which requires the SBOE to identify by rule the essential knowledge and skills of each subject in the required curriculum, and the completion of the Texas Resource Review. Texas Education Agency (TEA) staff provided an overview of CTE programs of study and a skills gap analysis that is being completed to inform review and revision of the CTE TEKS.

Also during the January 2021 meeting, staff provided an update on plans for the review and revision of CTE courses that satisfy a science graduation requirement as well as certain courses in the health science; education and training; and STEM programs of study. Applications to serve on these CTE TEKS review work groups were posted on the TEA website in December 2020. TEA staff provided SBOE members applications for approval to serve on a CTE work group at the January 2021 SBOE meeting. Additional applications were provided to SBOE members in February and March 2021. Work groups were convened from March-July 2021 to develop recommendations for the CTE courses. At the June 2021 SBOE meeting, a discussion item for proposed new 19 TAC Chapter 130 was presented to the board. At the September 2021 SBOE meeting, one representative from each CTE TEKS review committee provided invited testimony to the SBOE Committee of the Full Board.

The SBOE postponed first reading and filing authorization for a selection of courses from the education and training and STEM programs of study: §127.317, Child Development; §127.318, Child Guidance; §127.323, Human Growth and Development; §127.783, Engineering Design and Presentation I; and §127.784, Engineering Design and Presentation II, to allow additional time to review and finalize recommendations. Education and training CTE TEKS work groups met in October and November 2021 to continue finalizing their recommendations for revisions to the CTE TEKS.

New §§127.317, 127.318, 127.323, 127.783, and 127.784 update the CTE TEKS to ensure the standards for the courses are up to date. In order to avoid confusion regarding the year of implementation, the new sections include an implementation subsection with specific implementation language for each course.

Currently, CTE courses are codified in 19 TAC Chapter 130. Due to the current structure of 19 TAC Chapter 130, there are not enough section numbers available in Chapter 130 to add all of the proposed new courses in their assigned subchapters. To accommodate the addition of these new courses and future courses, the CTE TEKS in Chapter 130 are being moved to existing 19 TAC Chapter 127, Texas Essential Knowledge and Skills for Career Development, and that chapter has been renamed “Texas Essential Knowledge and Skills for Career Development and Career and Technical Education.” The move of CTE subchapters from Chapter 130 to Chapter 127 will take place over time as the TEKS in each subchapter are revised. In order to avoid confusion regarding the year of implementation, the new
sections include an implementation subsection with specific implementation language for each course.

At adoption, a technical edit was made in §127.318(d)(1) to correct the lettering of subparagraphs (A)-(F).

The SBOE approved the proposed new sections for first reading and filing authorization at its January 28, 2022 meeting and for second reading and final adoption at its April 8, 2022 meeting.

In accordance with Texas Education Code, §7.102(f), the SBOE approved the new sections for adoption by a vote of two-thirds of its members to specify an effective date earlier than the beginning of the 2022-2023 school year. The earlier effective date will enable districts to begin preparing for implementation of the revised CTE TEKS. The effective date is 20 days after filing as adopted with the Texas Register.

SUMMARY OF COMMENTS AND RESPONSES: The public comment period on the proposal began February 25, 2022, and ended at 5:00 p.m. on April 1, 2022. The SBOE also provided an opportunity for registered oral and written comments at its April 2022 meeting in accordance with the SBOE board operating policies and procedures. Following is a summary of the public comments received and responses.

Comment. One teacher expressed support for the addition of new §74.11(k), which would allow districts to exempt students from specific CTE prerequisites for CTE courses that may satisfy a mathematics or science graduation requirement if the district determines the student is not using the course to complete a program of study.

Response. This comment is outside the scope of the proposed rulemaking.

Comment. One administrator expressed concern that there will be significant negative impacts if there is not an exemption for CTE prerequisite courses for students not earning a program of study.

Response. This comment is outside the scope of the proposed rulemaking.

Comment. One administrator stated that requiring law enforcement classes as a mandatory prerequisite for all students taking Forensic Science limits districts’ ability to recruit new students into the law enforcement program of study beyond the students' sophomore year and is not supported by the commenter's district Law and Public Safety District Advisory Committee.

Response. This comment is outside the scope of the proposed rulemaking.

SUBCHAPTER G. EDUCATION AND TRAINING

19 TAC §§127.317, 127.318, 127.323

STATUTORY AUTHORITY. The new sections are adopted under Texas Education Code (TEC), §7.102(c)(4), which requires the State Board of Education (SBOE) to establish curriculum and graduation requirements; TEC, §28.002(a), which identifies the subjects of the required curriculum; TEC, §28.002(c), which requires the SBOE to by rule identify the essential knowledge and skills of each subject in the required curriculum that all students should be able to demonstrate and that will be used in evaluating instructional materials and addressed on the state assessment instruments; TEC, §28.002(n), which allows the SBOE to by rule develop and implement a plan designed to incorporate foundation curriculum requirements into the career and technical education (CTE) curriculum required in TEC, §28.002; TEC, §28.002(o), which requires the SBOE to determine that at least 50% of the proposed CTE courses are cost effective for a school district to implement; TEC, §28.025(a), which requires the SBOE to determine by rule the curriculum requirements for the foundation high school graduation program that are consistent with the required curriculum under TEC, §28.002; TEC, §28.025(b-2), which requires the SBOE to allow by rule a student to comply with the curriculum requirements for the third and fourth mathematics credits under TEC, §28.025(b-1)(2), or the third and fourth science credits under TEC, §28.025(b-1)(3), by successfully completing a CTE course designated by the SBOE as containing substantially similar and rigorous content; and TEC, §28.025(b-17), which requires the SBOE to ensure by rule that a student may comply with curriculum requirements under TEC, §28.025(b-1)(6), by successfully completing an advanced CTE course, including a course that may lead to an industry-recognized credential or certificate or an associate degree.

CROSS REFERENCE TO STATUTE. The new sections implement Texas Education Code, §§7.102(c)(4); 28.002(a), (c), (n), and (o); and 28.025(a), (b-2) and (b-17).


(a) Implementation. The provisions of this section shall be implemented by school districts beginning with the 2024-2025 school year.

(1) No later than August 31, 2024, the commissioner of education shall determine whether instructional materials funding has been made available to Texas public schools for materials that cover the essential knowledge and skills identified in this section.

(2) If the commissioner makes the determination that instructional materials funding has been made available, this section shall be implemented beginning with the 2024-2025 school year and apply to the 2024-2025 and subsequent school years.

(3) If the commissioner does not make the determination that instructional materials funding has been made available under this subsection, the commissioner shall determine no later than August 31 of each subsequent school year whether instructional materials funding has been made available. If the commissioner determines that instructional materials funding has been made available, the commissioner shall notify the State Board of Education and school districts that this section shall be implemented for the following school year.

(b) General requirements. This course is recommended for students in Grades 11 and 12. Prerequisite: Child Development or Child Development Associate Foundations. Students shall be awarded two credits for successful completion of this course.

(c) Introduction.

(1) Career and technical education instruction provides content aligned with challenging academic standards, industry-relevant technical knowledge, and college and career readiness skills for students to further their education and succeed in current and emerging professions.

(2) The Education and Training Career Cluster focuses on planning, managing, and providing education and training services and related learning support services.

(3) Child Guidance is a course that addresses the knowledge and skills related to child growth and guidance, equipping students to develop positive relationships with children and effective care.
giver skills. Students use these skills to promote the well-being and healthy development of children, strengthen a culturally diverse society, and pursue careers related to the care, guidance, and education of children, including those with special needs. Instruction may be delivered through school-based laboratory training or through work-based delivery arrangements such as cooperative education, mentoring, and job shadowing.

(4) Students are encouraged to participate in extended learning experiences such as career and technical student organizations and other leadership or extracurricular organizations.

(5) Statements that contain the word “including” reference content that must be mastered, while those containing the phrase “such as” are intended as possible illustrative examples.

(d) Knowledge and skills.

(1) The student demonstrates professional standards/employability skills as required by business and industry. The student is expected to:

   (A) demonstrate effective verbal, nonverbal, written, and electronic communication skills;
   (B) demonstrate effective collaboration skills within the workplace;
   (C) identify characteristics of effective leaders and team members;
   (D) explain the importance of time management to succeed in the workforce;
   (E) apply work ethics and professionalism in a job setting; and
   (F) use appropriate problem-solving and critical-thinking skills.

(2) The student practices ethical and legal responsibilities associated with providing childcare services. The student is expected to:

   (A) apply ethical codes of conduct in a childcare setting;
   (B) create coherent written communication between parents and childcare staff;
   (C) identify regulatory and compliance guidelines for maintaining documentation in childcare settings, including educational, personnel, and public records;
   (D) advocate through appropriate means for children when necessary;
   (E) comply with laws and regulations related to childcare services;
   (F) determine potential uses and management of technology, media, and resources to foster healthy child development; and
   (G) employ safeguards to prevent misuse and abuse of technology and media with children.

(3) The student analyzes childcare options for children of various ages. The student is expected to:

   (A) compare the financial considerations of childcare options;
   (B) examine criteria for selecting quality childcare; and
   (C) review minimum standards for licensing and regulations for center-based and home-based programs.

(4) The student analyzes responsibilities that promote health and wellness of children. The student is expected to:

   (A) monitor student behavior for signs of physical illness and emotional disturbances in children;
   (B) practice child guidance techniques that contribute to the health and wellness of children such as adequate rest, exercise, safety, and sanitation;
   (C) apply procedures for creating safe environments for children; and
   (D) create a meal plan for children, including nutritious snacks, following appropriate food guidelines.

(5) The student analyzes the effect of play in the development of children. The student is expected to:

   (A) discuss the various types of guidance and their effects on children;
   (B) determine and apply appropriate guidance techniques; and
   (C) distinguish between guidance techniques and behavior that could be considered inappropriate, harmful, or abusive.

(6) The student applies appropriate guidance techniques for children of various ages and developmental levels, including those with special needs. The student is expected to:

   (A) create examples of play that promote the physical, intellectual, emotional, and social development of children; and
   (B) implement strategies to encourage socially appropriate constructive and creative play, including indoor and outdoor activities.

(6) The student applies appropriate guidance techniques for children of various ages and developmental levels, including those with special needs. The student is expected to:

   (A) create examples of play that promote the physical, intellectual, emotional, and social development of children; and
   (B) implement strategies to encourage socially appropriate constructive and creative play, including indoor and outdoor activities.

(7) The student will implement appropriate strategies and practices for optimizing the development of children ages birth through twelve months, including those with special needs. The student is expected to:

   (A) create and implement activities for the development of sensory skills;
   (B) create and implement activities for the development of language skills;
   (C) create and implement activities for the development of physical and motor skills; and
   (D) create and implement activities for the development of social skills.

(8) The student will implement appropriate strategies and practices for optimizing the development of children ages 13 months through 35 months, including those with special needs. The student is expected to:

   (A) create and implement lesson plans for the development of physical skills;
   (B) create and implement lesson plans for the development of vocabulary and language skills;
   (C) create and implement lesson plans for the development of appropriate mathematics skills;
   (D) create and implement lesson plans for the development of appropriate science skills; and
(E) create and implement lesson plans for the development of social and emotional skills.

(9) The student will implement appropriate strategies and practices for optimizing the development of children ages 3 through 5 years, including those with special needs. The student is expected to:

(A) create and implement lesson plans for the development of physical skills;
(B) create and implement lesson plans for the development of appropriate reading and language skills;
(C) create and implement lesson plans for the development of appropriate mathematics and problem-solving skills;
(D) create and implement lesson plans for the development of appropriate science skills; and
(E) create and implement lesson plans for the development of social and emotional skills.

(10) The student makes informed career decisions that reflect personal, family, and career goals. The student is expected to:

(A) analyze the impact of career decisions on personal and family goals;
(B) assess personal interests, aptitudes, and abilities needed in the childcare profession;
(C) develop short- and long-term career goals;
(D) evaluate employment and entrepreneurial opportunities; and
(E) evaluate educational requirements for early childhood development and services.

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 May 25, 2022.

TRD-202202036
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: June 14, 2022
Proposal publication date: February 25, 2022
For further information, please call: (512) 475-1497

TITLE 22. EXAMINING BOARDS
PART 3. TEXAS BOARD OF CHIROPRACTIC EXAMINERS
CHAPTER 79. UNPROFESSIONAL CONDUCT
22 TAC §79.5

The Texas Board of Chiropractic Examiners (Board) adopts new 22 TAC §79.5 (Associating with an Unlicensed Individual) with non-substantive changes from the text as published in the March 11, 2022, issue of the Texas Register (47 TexReg 1169). The rule will be republished. Texas Occupations Code §201.5025(a)(5-7) (Prohibited Practices by Chiropractor or License Applicant) forbids a licensee from associating with an individual whose license to practice chiropractic has been suspended or revoked in any jurisdiction. This language does not explicitly prohibit a licensee from associating with an individual who surrendered a license to the Board in lieu of disciplinary action, although the Board has that authority implicitly through other statutes and Board rules.

The Board offers licensees who have been arrested for serious violent or financial crimes the option of immediately surrendering their licenses to the Board instead of going through the time and expense of a revocation hearing at the State Office of Admin-
The Board believes this option better fulfills its duty to protect the public than an administrative hearing by quickly removing from the ranks of licensed chiropractors an individual who has shown to be a danger to patients.

Occupations Code §201.5025(a)(5 - 7) prohibits licensees from associating with, in any manner, individuals who have had their license to practice chiropractic suspended or revoked in any jurisdiction. This new rule makes explicit that the prohibition includes individuals who have surrendered their licenses in lieu of discipline.

Comment: The Board received one comment about the proposed rule from the Texas Chiropractic Association (TCA). TCA suggested that the rule include a qualifier to make it clear that the prohibition on associating with an individual whose license was revoked, suspended, or surrendered only extends to a chiropractor’s professional activities as a chiropractor. The Board agrees with the suggestion and has modified the text accordingly.

The rule is adopted under Texas Occupations Code §201.152, which authorizes the Board to adopt rules necessary to perform the Board’s duties and to regulate the practice of chiropractic.

No other statutes or rules are affected by this new rule.

§79.5. Associating with an Unlicensed Individual.

(a) In the practice of chiropractic, a licensee may not knowingly employ, contract with, or associate with an individual whose license to practice chiropractic has been:

(1) suspended;
(2) revoked; or
(3) surrendered in lieu of discipline.

(b) In the practice of chiropractic, a licensee may not knowingly employ, contract with, or associate with an individual who has been convicted of the unlawful practice of chiropractic in any jurisdiction.

(c) A licensee may not aid or abet the practice of chiropractic by an unlicensed individual.

(d) A licensee violating this section is subject to disciplinary action.

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 May 24, 2022.
TRD-202202021
Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Effective date: June 13, 2022
Proposal publication date: March 11, 2022
For further information, please call: (512) 305-6700

CHAPTER 80. COMPLAINTS

22 TAC §80.1

The Texas Board of Chiropractic Examiners (Board) adopts amended 22 TAC §80.1, concerning Duty to Respond to Complaint, without changes to the text as published in the March 11, 2022, issue of the Texas Register (47 TexReg 1170). The rule will not be republished.

This amendment simply removes email as one of the two formal methods the Board must use to notify an individual of a complaint filed against him. The amendment keeps the procedural requirement that the Board must notify an individual of a complaint by registered mail.

The Board received no comments about the proposed amendment.

The amended rule is adopted under Texas Occupations Code §201.152, which authorizes the Board to adopt rules necessary to perform the Board’s duties and to regulate the practice of chiropractic, and Texas Occupations Code §201.205, which requires the Board to adopt rules concerning the investigation of a complaint filed with the Board.

No other statutes or rules are affected by this amended rule.

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 May 24, 2022.
TRD-202202023
CHAPTER 82. INTERNAL BOARD PROCEDURES

22 TAC §82.4
The Texas Board of Chiropractic Examiners (Board) adopts new 22 TAC §82.4 (Family Leave Pool) without changes to the proposed text as published in the March 11, 2022, issue of the Texas Register (47 TexReg 1173). Government Code §§661.021 - 661.028 requires state agencies to adopt rules to permit agency employees to contribute earned hours to a family leave pool. The rule will not be republished.

The Board received no comments concerning the new rule.

The rule is adopted under Texas Occupations Code §201.152, which authorizes the Board to adopt rules necessary to perform the Board’s duties and to regulate the practice of chiropractic, and Texas Government Code §§661.021 - 661.028, which requires the Board to establish a family leave pool by rule.

No other statutes or rules are affected by this new rule.

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 May 24, 2022.

TRD-202202025
Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Effective date: June 13, 2022
Proposal publication date: March 11, 2022
For further information, please call: (512) 305-6700

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 742. MINIMUM STANDARDS FOR LISTED FAMILY HOMES

SUBCHAPTER E. BASIC CARE REQUIREMENTS

26 TAC §742.508
The Texas Health and Human Services Commission (HHSC) adopts new §742.508, concerning What are the requirements when an infant is engaged in tummy time, in Texas Administrative Code, Title 26, Part 1, Chapter 742, Minimum Standards for Listed Family Homes, Subchapter E, Basic Care Requirements.

New §742.508 is adopted without changes to the proposed text as published in the March 18, 2022, issue of the Texas Register (47 TexReg 1442). This rule will not be republished.

BACKGROUND AND JUSTIFICATION
The new rule is necessary to implement the portion of Senate Bill 225, 87th Legislature, Regular Session, 2021, that amended Chapter 42, Texas Human Resources Code by adding Section 42.04291. This new section requires the HHSC Executive Commissioner to establish standards for listed family homes and reg-
istered and licensed child-care homes for the visual and auditory supervision of an infant engaged in time on the infant's stomach while awake (that is, tummy time). To meet this legislative requirement, HHSC Child Care Regulation proposed a new rule for listed family homes that specifies supervision requirements for when an infant is engaged in tummy time activities.

COMMENTS

The 31-day comment period ended April 18, 2022. During this period, HHSC received three comments regarding the proposed rule from a parent-advocate. A summary of the comments relating to the rule and HHSC's responses follows.

Comment: One commenter requested that HHSC revise the rule to require a maximum distance the caregiver can be from an infant who is positioned in tummy time.

Response: HHSC disagrees with the comment and declines to revise the rule. This additional requirement could restrict the caregiver's ability to meet the needs of other children because there is a great deal of variability in the layout of child-care homes and the caregiver must move around frequently to meet the needs of other children in care (for example, diapering, administering first aid, preparing food and bottles, etc.). It would also be difficult to enforce. HHSC believes that the proposed requirements that the caregiver be able to see and hear an infant positioned for tummy time activities, and intervene as necessary to ensure the safety of the infant, sufficiently address any risk to the infant engaged in tummy time activities.

Comment: One commenter requested that HHSC revise the rule to require the caregiver be in the same room with an infant who is positioned in tummy time.

Response: HHSC disagrees with the comment and declines to revise the rule. HHSC believes that the proposed requirements that a caregiver be able to see and hear an infant positioned for tummy time activities, and intervene as necessary to ensure the safety of the infant, sufficiently address any risk to the infant engaged in tummy time activities. Because there is a great deal of variability in the layout of child-care homes and the caregiver must move around frequently to meet the needs of other children in care, this additional requirement could restrict the caregiver's ability to meet the needs of other children (for example, diapering, administering first aid, preparing food and bottles, etc.). It would also be difficult to enforce. In response to the comment, HHSC will add additional guidance to the Helpful Information box that follows the rule in the minimum standards courtesy publication, further clarifying that the caregiver must remove the infant from tummy time when the caregiver must step away from the room and the caregiver will not be able to see and hear the infant.

Comment: One commenter requested that HHSC revise the rule to require a time limit for tummy time as recommended by pediatricians. For example, two minutes maximum for a child three months of age with no signs of distress.

Response: HHSC disagrees with the comment and declines to revise the rule. The American Academy of Pediatrics (AAP) recommends an infant be placed on the tummy 2-3 times each day for a short period of time (3-5) minutes, increasing the amount of time as the baby shows enjoyment of the activity. While this information is included in the Helpful Information box that follows the rule in the courtesy publication of the minimum standards, the AAP recommendation may not be appropriate for all infants and would be difficult to enforce. Additionally, the rule contains requirements for (1) repositioning the infant to maintain the infant's comfort and safety; and (2) moving the infant to a safe sleeping space if the infant falls asleep while positioned on the infant's stomach. Each of these components of the rule serve as a preventative measure to ensure an infant is not left in tummy time for too long. In response to the comment, HHSC will add a link in the Helpful Information box to the AAP website that offers information and resources about tummy time.

STATUTORY AUTHORITY

The new section is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.02011, which transferred the regulatory functions of the Texas Department of Family and Protective Services to HHSC. In addition, Texas Human Resources Code §42.042(a) requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

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 May 24, 2022.

TRD-202202012
Karen Ray
Chief Counsel
Health and Human Services Commission

Effective date: June 13, 2022
Proposal publication date: March 18, 2022
For further information, please call: (512) 438-3269

CHAPTER 747. MINIMUM STANDARDS FOR CHILD-CARE HOMES

SUBCHAPTER H. BASIC CARE REQUIREMENTS FOR INFANTS

26 TAC §747.2318

The Texas Health and Human Services Commission (HHSC) adopts new §747.2318, concerning What are the requirements when an infant is engaged in tummy time, in Texas Administrative Code, Title 26, Part 1, Chapter 747, Minimum Standards for Child-Care Homes, Subchapter H, Basic Care Requirements for Infants.

New §747.2318 is adopted without changes to the proposed text as published in the March 18, 2022, issue of the Texas Register (47 TexReg 1443). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

The new rule is necessary to implement the portion of Senate Bill 225, 87th Legislature, Regular Session, 2021, that amended Chapter 42, Texas Human Resources Code by adding Section 42.04291. This new section requires the HHSC Executive Commissioner to establish standards for listed family homes and registered and licensed child-care homes for the visual and auditory supervision of an infant engaged in time on the infant's stomach while awake (that is, tummy time). To meet this legislative requirement, HHSC Child Care Regulation proposed a new rule for licensed and registered child-care homes that specifies su-
pervision requirements for when an infant is engaged in tummy time activities.

**COMMENTS**

The 31-day comment period ended April 18, 2022. During this period, HHSC received four comments regarding the proposed rule from a registered child-care home provider and a parent-advocate. A summary of the comments relating to the rule and HHSC’s responses follows.

Comment: One commenter stated that she does not place the infants in her care in tummy time because a child will develop the muscles needed to hold its head up while on a caregiver's shoulder. She further stated the proposed rule is unenforceable and HHSC should focus instead on better education for caregivers regarding early childhood development.

Response: HHSC disagrees with the comment and declines to revise the rule. The rule is legislatively mandated. The proposed rule does not require a caregiver to utilize tummy time but will help ensure the safety of an infant engaged in these activities. With regard to enforcement, HHSC is accustomed to monitoring and enforcing supervision rules in child-care homes and will monitor and enforce the proposed rule as it does other supervision rules. Lastly, while the proposal did not include child development training, HHSC agrees that training in early childhood development is a critical component of caring for infants in a child-care setting. HHSC does not provide training for caregivers but does share training resources to aid caregivers in obtaining training from various sources. HHSC also requires the primary caregiver in a licensed child-care home or registered child-care home to obtain 30 hours of annual training in various topics, including child development.

Comment: One commenter requested that HHSC revise the rule to require a maximum distance the caregiver can be from an infant who is positioned in tummy time.

Response: HHSC disagrees with the comment and declines to revise the rule. This additional requirement could restrict the caregiver's ability to meet the needs of other children because there is a great deal of variability in the layout of child-care homes and the caregiver must move around frequently to meet the needs of other children in care (for example, diapering, administering first aid, preparing food and bottles, etc.). It would also be difficult to enforce. HHSC believes that the proposed requirements that the caregiver be able to see and hear an infant positioned for tummy time activities, and intervene as necessary to ensure the safety of the infant, sufficiently address any risk to the infant engaged in tummy time activities.

Comment: One commenter requested that HHSC revise the rule to require the caregiver be in the same room with an infant who is positioned in tummy time.

Response: HHSC disagrees with the comment and declines to revise the rule. HHSC believes that the proposed requirements that a caregiver be able to see and hear an infant positioned for tummy time activities and intervene as necessary to ensure the safety of the infant, sufficiently address any risk to the infant engaged in tummy time activities. Because there is a great deal of variability in the layout of child-care homes and the caregiver must move around frequently to meet the needs of other children in care, this additional requirement could restrict the caregiver’s ability to meet the needs of other children (for example, diapering, administering first aid, preparing food and bottles, etc.). It would also be difficult to enforce. In response to the comment, HHSC will add additional guidance to the Helpful Information box that follows the rule in the minimum standards courtesy publication further clarifying that the caregiver must remove the infant from tummy time when the caregiver must step away from the room and the caregiver will not be able to see and hear the infant.

Comment: One commenter requested that HHSC revise the rule to require a time limit for tummy time as recommended by pediatricians. For example, two minutes maximum for a child three months of age with no signs of distress.

Response: HHSC disagrees with the comment and declines to revise the rule. The American Academy of Pediatrics (AAP) recommends an infant be placed on the tummy 2-3 times each day for a short period of time (3-5) minutes, increasing the amount of time as the baby shows enjoyment of the activity. While this information is included in the Helpful Information box that follows the rule in the courtesy publication of the minimum standards, the AAP recommendation may not be appropriate for all infants and would be difficult to enforce. Additionally, the rule contains requirements for (1) repositioning the infant to maintain the infant’s comfort and safety; and (2) moving the infant to a safe sleeping space if the infant falls asleep while positioned on the infant's stomach. Each of these components of the rule serve as a preventative measure to ensure an infant is not left in tummy time for too long. In response to the comment, HHSC will add a link in the Helpful Information box to the AAP website that offers information and resources about tummy time.

**STATUTORY AUTHORITY**

The new section is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.02011, which transferred the regulatory functions of the Texas Department of Family and Protective Services to HHSC. In addition, Texas Human Resources Code §42.042(a) requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

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 May 24, 2022.

TRD-202202013
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: June 13, 2022
Proposal publication date: March 18, 2022
For further information, please call: (512) 438-3269

**TITLE 28. INSURANCE**

**PART 1. TEXAS DEPARTMENT OF INSURANCE**

**CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES**
SUBCHAPTER F. RATE REVIEW FOR HEALTH BENEFIT PLANS

28 TAC §§3.501 - 3.507

The Commissioner of Insurance adopts new Subchapter F concerning the rate review process for individual and small group major medical coverage, to be added to 28 TAC Chapter 3, Sections 3.501 - 3.503, 3.506, and 3.507 are adopted without changes to the proposed text published in the April 8, 2022, issue of the Texas Register (47 TexReg 1844). Section 3.504 and §3.505 were revised in response to public comments. The rules will be republished.

REASONED JUSTIFICATION. The new subchapter is necessary to implement Insurance Code Chapter 1698, as added by Senate Bill 1296, 87th Legislature, 2021. Insurance Code Chapter 1698 requires the Commissioner to establish a process under which the Texas Department of Insurance (TDI) will review health benefit plan rates and rate changes for compliance with state and federal law, including rules establishing geographic rating areas. Adopted Subchapter F establishes a process to review the rates for individual and small group major medical coverage as provided by Chapter 1698. The new subchapter includes §§3.501 - 3.507. These sections state the rule's purpose and applicability, identify the rating standards, establish geographic rating areas, and provide guidance to address additional factors and requirements related to the review process and public disclosure requirements.

Federal law requires that federal regulators review certain health insurance rate increases if states do not do so. Prior to the passage of SB 1296, federal regulators were reviewing these rates because Texas law has not provided a mechanism for state review since 2013. Insurance Code Chapter 1698 returns the rate review process to the state, consistent with federal rate review rules in 45 CFR Part 154.

The adopted sections of the new subchapter are described in the following paragraphs.

Section 3.501. Section 3.501(a) describes the purpose of the subchapter, which is to implement Insurance Code Chapter 1698 and establish an effective rate review program consistent with 45 CFR §154.301, concerning CMS's Determinations of Effective Rate Review Programs.

Subsection (b) explains that the subchapter applies to plans subject to Insurance Code Chapter 1698, while subsection (c) clarifies that the subchapter does not apply to (1) short-term limited-duration insurance; (2) grandfathered health plan coverage; and (3) individual limited scope plans, including dental benefit plans and vision benefit plans. The plans listed under subsection (c) are not subject to the same federal rating standards and are reviewed instead for compliance with other existing state rating standards, including Insurance Code Chapter 560; Insurance Code Chapter 1501, Subchapter E; and 28 TAC §26.11.

Section 3.502. Section 3.502 defines the following terms for use in the subchapter: "actuarial value (AV)," "cost-sharing reductions (CSRs)," "essential health benefits (EHBs)," "federal medical loss ratio standard," "HHS," "issuer," "index rate," "plan," "product," "qualified actuary," "single risk pool," and "Unified Rate Review Template (URRT)."

Section 3.503. Section 3.503 requires that all rate filings under Subchapter F comply with all applicable state and federal requirements, including specified provisions from the Insurance Code, United States Code, and Code of Federal Regulations.

Section 3.504. Section 3.504 addresses how issuers may vary rates based on geographic rating area. Insurance Code Chapter 1698 grants the Commissioner the authority to implement rules establishing geographic rating areas to use when reviewing the rates in compliance with 42 USC §300gg.

Subsection (a) provides that issuers may vary the rates based on rating areas, which are determined using the policyholder's or contract holder's address.

Subsection (b) establishes 27 rating areas that issuers must use for rates, beginning in 2023. Each rating area consists of a certain number of Texas counties in compliance with 45 CFR §147.102(b)(3). Currently, Texas uses the federal default rating areas, composed of 25 Metropolitan Statistical Areas and one area that includes all rural areas. The adopted new rating areas place rural areas with nearby metropolitan areas and are based around health care districts and the regions defined by the Texas Health and Human Services Commission. The newly established rating areas could have a positive effect on rural communities by generating competition in areas where a limited variety of health plans is currently available.

In the proposal, King County was mistakenly listed in rating area 24 (Wichita Falls) instead of rating area 14 (Lubbock). That mistake is corrected in the section as adopted.

Section 3.505. Section 3.505(a) prohibits an issuer from using a rate with respect to a plan if the rate filing has not been filed with TDI for review, does not comply with applicable rating standards, or has been withdrawn.

Subsection (b) requires that issuers submit an annual rate filing no later than June 15 for any individual or small group market plan that is to be issued on or after January 1 in the following calendar year. Subsection (b) also prohibits an issuer from modifying an annual rate filing later than October 1 prior to the calendar year for which the filing was submitted.

Subsection (c) applies only to small group issuers and allows them to submit a rate filing for a quarterly rate change as long as the filing is submitted at least 105 days before the effective date of the rate change.

Subsection (d) requires that rate filings include the index rate for the single risk pool and reflect every product and plan that is part of the single risk pool in the applicable market. Subsection (d) also advises that issuers are not required to enter CSR plan variations separately.

Subsection (e) requires issuers to submit rate filings under Subchapter F through the electronic system designated by TDI in accordance with any technical instructions provided for the electronic system. The electronic system currently in use is the System for Electronic Rate and Form Filings (SERRF); additional technical guidance on filing is contained in TDI rules in 28 TAC Chapter 3, Subchapter A, and in 28 TAC §11.301.

Subsection (f) requires that rate filings made under Subchapter F include the following: (1) the URRT; (2) written descriptions justifying rate increases of 15% or more in a 12-month period; (3) rating filing documentation, including an actuarial memorandum signed by a qualified actuary; (4) a rates table that identifies the applicable rate for each plan depending on an individual's rating area, tobacco use, and age; (5) an enrollment spreadsheet that contains the information specified in subparagraphs (A) through
(C) of the paragraph; and (6) an actuarial value (AV) and cost-sharing factor spreadsheet.

The AV and cost-sharing factor spreadsheet included with each rate filing must include a certain induced-demand factor based on the plan type (e.g., bronze plans, silver plans, gold plans, and platinum plans). The spreadsheet must also include a CSR adjustment factor of 1.35-applicable to individual silver plans on the exchange that accounts for the average costs attributable to CSRs. In setting this factor, TDI considered the different CSR plan distribution with respect to (1) the eligibility criteria for CSRs; (2) the potential distribution of enrollees; (3) the maximum AV that may be provided across all silver plans; and (4) variation in induced demand.

Subsection (g) states that TDI will publish templates on its website that issuers may use to submit the required data.

Subsection (h) requires that an issuer provide any additional information needed to evaluate the rate filing upon TDI’s request.

Subsection (i) requires an issuer to submit current and prior year data on enrollment, premiums, and claims by June 15, when the issuer does not intend to issue a plan that would require a rate filing for the next calendar year but has enrollment in a plan that is subject to Subchapter F in the current or prior year. This data enables TDI to consider medical claims trends and understand the impact of a change to an issuer’s market participation. In response to comment, the timeframe for which current year cumulative data must be reported was shortened from May 31 to March 31.

Section 3.506. Section 3.506(a) provides that TDI will evaluate whether the issuer has provided sufficient data and documentation upon receipt of a rate filing under Subchapter F and may request additional information as necessary to make a determination on the filing. The issuer must provide any additional information requested within 10 business days of the request. If TDI requests additional information but the issuer fails to provide the requested information or establish a plan to provide the information that is acceptable to TDI, TDI will deem the filing withdrawn and notify the issuer of the withdrawal.

Subsections (b) and (c) explain the factors TDI will examine and consider, which include (1) the reasonableness of the assumptions used by the issuer to develop the rates and the validity of the historical data underlying the assumptions; (2) the issuer’s data related to past projections and actual experience; (3) the reasonableness of assumptions used by the issuer to estimate the rate impact of the reinsurance and risk adjustment programs; (4) the issuer’s data related to implementation and ongoing utilization of certain factors as required by 42 USC Subchapter XXV, Part A, concerning Individual and Group Market Reforms; (5) factors specified in the Insurance Code; (6) factors listed in 45 CFR §154.301(a)(4); and (7) whether the issuer complies with rating standards under §3.503.

Subsection (d) provides that TDI will also consider the factors from Insurance Code §1698.052(c) when reviewing rates for a qualified health plan. Those factors include:

- the purchasing power of consumers who are eligible for a premium subsidy under federal law;
- if the plan is in the silver level, whether the rate is appropriate in relation to the rates charged for qualified health plans offering different levels of coverage, accounting for any funding or lack of funding for CSRs and the covered benefits for each level of coverage; and
- whether the plan issuer used the induced-demand factors developed by the Centers for Medicare and Medicaid Services (CMS) for the level of coverage offered by the plan or any state-specific induced-demand factors established by TDI.

Subsection (e) provides that the standard for determining that a rate increase is unreasonable is whether the rate is excessive, unjustified, or unfairly discriminatory. Subsection (e)(1) explains that a rate filing is excessive if it causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage.

Subsection (e)(2) explains that a rate increase is unjustified if the issuer provides incomplete or inadequate information or otherwise does not provide a basis for TDI to determine the reasonableness of the rate increase.

Subsection (e)(3) explains that a rate increase is unfairly discriminatory on the basis of Insurance Code §§560.002(c), which provides that a rate is unfairly discriminatory if it is not based on sound actuarial principles; does not bear a reasonable relationship to the expected loss and expense experience among risks; or is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or insured.

Subsection (f) provides that a rate will be deemed compliant at the expiration of 60 days from the date the rate is filed, unless the filing is withdrawn or TDI has determined that the rate is noncompliant or granted an extension. If TDI has not finalized its determination before the 60th day, TDI may extend the period by up to 10 days, with notice to the issuer. The issuer may also extend the time frame for review or waive the right to deem the rate compliant.

Subsection (g) provides that TDI will identify deficiencies for any rate filing that does not comply with the applicable rating standards and ask for corrections. If the issuer fails to make the necessary corrections within 10 business days or establish a plan that is acceptable to TDI to address the identified deficiencies, the filing will be determined to be noncompliant and TDI will notify the issuer of the determination.

Subsection (h) explains that TDI will communicate objections to a rate increase and give the issuer an opportunity to provide additional information or modify the filing prior to TDI determining that the rate increase is unreasonable. Subsection (h) also describes what will happen when TDI determines that a rate increase is unreasonable but that the issuer is legally permitted to implement the rate increase. In this case, TDI will issue a final determination and brief explanation. After receipt of this, the issuer is required to submit a final justification for the rate increase and prominently post information concerning the rate increase on its website, consistent with 45 CFR §154.230, which requires that the issuer keep the posting on its website for at least three years.

Section 3.507. Section 3.507 addresses public disclosure and input related to rate increases, consistent with 45 CFR §154.301(b). Subsection (a) provides that information related to an adopted annual rate increase of 15% or more will be made publicly available on a website published by CMS.

Subsection (b) supplies the TDI email address to which public comments concerning adopted rate increases may be sent.

Subsection (c) states that final rate increases will be publicly available on a website published by CMS no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

ADOPTED RULES  June 10, 2022  47 TexReg 3469
Subsection (d) provides that TDI will make information related to proposed or final rate filings publicly available in a manner consistent with federal law.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received comments from six commenters on the proposed new sections. Commenters in support of the proposal were AARP, Every Texan, Texas 2036, and the Texas Medical Association. Commenters in support of the proposal with changes were Superior HealthPlan and the Texas Association of Health Plans.

Comments generally.

Comment. Several commenters state that they support the rule as proposed and encourage its adoption. Specifically, the commenters state they support the inclusion of uniform induced-demand factors and the reference to Insurance Code Chapter 1698 in §3.503.

Agency Response. TDI appreciates the support.

Comment on §3.504.

Comment. One commenter notes an error in the list of rating areas. King County should be in rating area 14 (Lubbock) as noted on the CMS website, and not rating area 24 (Wichita Falls).

Agency Response. TDI agrees with the comment and has made the noted correction.

Comments on §3.505.

Comment. A commenter asks whether TDI will be developing its own standards when considering rate increases of 15% or more or using the federal standards.

Agency Response. TDI intends to have similar review of increases as federal standards. Review standards are specified in §3.506. Carriers need to submit a final justification for rate increases more than 15%, as required by §3.506(h).

Comment. One commenter states a preference for a CSR load factor of 1.40 in §3.505(f). The commenter states that this number would align with the expected member migration in which enrollees receiving no CSRs, or minimal CSRs (in the 73% AV plan), would no longer purchase silver plans. Two other commenters expressly support the proposed CSR adjustment factor of 1.35.

Agency Response. TDI disagrees with the first commenter and declines to make the suggested change. The factor of 1.35 as proposed is based on the actual 2021 enrollment distribution across the silver plan variations. TDI believes it is more prudent to base the factor on data currently available rather than on future projections that could change based on a variety of factors. However, TDI plans to monitor the market to determine whether enrollment distribution changes warrant a change to the CSR adjustment factor in future years. If a change becomes necessary, this would occur through an amendment to the rules.

Comment. One commenter suggests a change to the proposed requirements in §3.505(i) that apply to issuers that do not intend to issue a plan in the subsequent calendar year. The proposed requirement includes submission of current year cumulative data on June 15, including data through May 31. The commenter requests that TDI change the current year cumulative data to be through March 31. The commenter states that this would align the provisions with the requirements of the enrollment spread-sheet to include the number of covered lives as of March 31 and provide adequate time for gathering the data.

Agency Response. TDI agrees and has made the change.

Comment on §3.507.

Comment. A commenter requests clarification from TDI on whether the intent is to follow the CMS dates for publication of carrier-proposed rate filings.

Agency Response. CMS will publish carrier-proposed rate filings according to the schedule it determines. TDI will provide a link to the filings published by CMS on its website: tdi.texas.gov/health/ratereview.html.


Insurance Code §1698.051 requires that the Commissioner by rule establish a process under which the Commissioner will review individual and small group health benefit plan rates and rate changes for compliance with Chapter 1698 and other applicable state and federal laws, including 42 USC §§300gg, 300gg-94, and 18032(c) and those sections implementing regulations, including rules establishing geographic rating areas.

Insurance Code §1698.052(b) - (d) authorize the Commissioner to adopt rules and provide guidance regarding requirements related to individual health benefit plan rates.

Insurance Code §1701.060 specifies that the Commissioner may adopt rules necessary to implement the purpose 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.

§3.504. Geographic Rating Areas.

(a) An issuer may vary rates based on rating area, which is determined:

(1) in the individual market, using the primary policyholder’s or contract holder’s address; and

(2) in the small group market, using the group policyholder’s or contract holder’s principal business address.

(b) For the purposes of this subchapter, rating areas for plan or policy years beginning on or after January 1, 2023, are established as follows.

(1) Rating area 1 (Abilene) consists of the following Texas counties:

(A) Brown;

(B) Callahan;

(C) Coleman;

(D) Comanche;

(E) Eastland;

(F) Fisher;

(G) Haskell;

(H) Jones;

(I) Kent;
(J) Mitchell; (K) Nolan; (L) Runnels; (M) Scurry; (N) Shackelford; (O) Stephens; (P) Stonewall; (Q) Taylor; and (R) Throckmorton.

(2) Rating area 2 (Amarillo) consists of the following Texas counties:
   (A) Armstrong; (B) Briscoe; (C) Carson; (D) Castro; (E) Childress; (F) Collingsworth; (G) Dallam; (H) Deaf Smith; (I) Donley; (J) Gray; (K) Hall; (L) Hansford; (M) Hartley; (N) Hemphill; (O) Hutchinson; (P) Lipscomb; (Q) Moore; (R) Ochiltree; (S) Oldham; (T) Parmer; (U) Potter; (V) Randall; (W) Roberts; (X) Sherman; (Y) Swisher; and (Z) Wheeler.

(3) Rating area 3 (Austin) consists of the following Texas counties:
   (A) Bastrop; (B) Blanco; (C) Burnet; (D) Caldwell; (E) Fayette; (F) Hays; (G) Lee; (H) Llano; (I) Travis; and (J) Williamson.

(4) Rating area 4 (Beaumont) consists of the following Texas counties:
   (A) Angelina; (B) Hardin; (C) Houston; (D) Jasper; (E) Jefferson; (F) Nacogdoches; (G) Newton; (H) Orange; (I) Polk; (J) Sabine; (K) San Augustine; (L) San Jacinto; (M) Shelby; (N) Trinity; and (O) Tyler.

(5) Rating area 5 (Brownsville) consists of the following Texas counties:
   (A) Cameron; (B) Kenedy; and (C) Willacy.

(6) Rating area 6 (College Station) consists of the following Texas counties:
   (A) Brazos; (B) Burleson; (C) Grimes; (D) Leon; (E) Madison; (F) Milam; (G) Robertson; and (H) Washington.

(7) Rating area 7 (Corpus Christi) consists of the following Texas counties:
   (A) Aransas; (B) Bee; (C) Jim Wells; (D) Kleberg; (E) Live Oak;
(F) Nueces;
(G) Refugio; and
(H) San Patricio.

(8) Rating area 8 (Dallas) consists of the following Texas counties:
(A) Collin;
(B) Dallas;
(C) Ellis;
(D) Hunt;
(E) Kaufman; and
(F) Navarro; and
(G) Rockwall.

(9) Rating area 9 (El Paso) consists of the following Texas counties:
(A) Brewster;
(B) Culberson;
(C) El Paso;
(D) Hudspeth;
(E) Jeff Davis; and
(F) Presidio.

(10) Rating area 10 (Houston) consists of the following Texas counties:
(A) Galveston; and
(B) Harris.

(11) Rating area 11 (Killeen/Temple) consists of the following Texas counties:
(A) Bell;
(B) Coryell;
(C) Hamilton;
(D) Lampasas;
(E) Mills; and
(F) San Saba.

(12) Rating area 12 (Laredo) consists of the following Texas counties:
(A) Duval;
(B) Jim Hogg;
(C) McMullen;
(D) Webb; and
(E) Zapata.

(13) Rating area 13 (Longview) consists of the following Texas counties:
(A) Gregg;
(B) Harrison;
(C) Marion; and
(D) Panola.

(14) Rating area 14 (Lubbock) consists of the following Texas counties:
(A) Bailey;
(B) Cochran;
(C) Crosby;
(D) Dickens;
(E) Floyd;
(F) Garza;
(G) Hale;
(H) Hockley;
(I) King;
(J) Lamb;
(K) Lubbock;
(L) Lynn;
(M) Motley;
(N) Terry; and
(O) Yoakum.

(15) Rating area 15 (McAllen) consists of the following Texas counties:
(A) Brooks;
(B) Hidalgo; and
(C) Starr.

(16) Rating area 16 (Midland/Odessa) consists of the following Texas counties:
(A) Andrews;
(B) Borden;
(C) Crane;
(D) Dawson;
(E) Ector;
(F) Gaines;
(G) Glasscock;
(H) Howard;
(I) Loving;
(J) Martin;
(K) Midland;
(L) Pecos;
(M) Reeves;
(N) Terrell;
(O) Upton;
(P) Ward; and
(Q) Winkler.
Rating area 17 (San Angelo) consists of the following Texas counties:

(A) Coke;  
(B) Concho;  
(C) Crockett;  
(D) Irion;  
(E) Kimble;  
(F) Mason;  
(G) McCulloch;  
(H) Menard;  
(I) Reagan;  
(J) Schleicher;  
(K) Sterling;  
(L) Sutton; and  
(M) Tom Green.

Rating area 18 (San Antonio) consists of the following Texas counties:

(A) Atascosa;  
(B) Bandera;  
(C) Bexar;  
(D) Comal;  
(E) Dimmit;  
(F) Edwards;  
(G) Frio;  
(H) Gillespie;  
(I) Gonzales;  
(J) Guadalupe;  
(K) Kendall;  
(L) Kerr;  
(M) Kinney;  
(N) La Salle;  
(O) Maverick;  
(P) Medina;  
(Q) Real;  
(R) Uvalde;  
(S) Val Verde;  
(T) Wilson; and  
(U) Zavala.

Rating area 19 (Sherman/Dennison) consists of the following Texas counties:

(A) Cooke;  
(B) Fannin; and  
(C) Grayson.

Rating area 20 (Texarkana) consists of the following Texas counties:

(A) Bowie;  
(B) Camp;  
(C) Cass;  
(D) Delta;  
(E) Franklin;  
(F) Hopkins;  
(G) Lamar;  
(H) Morris;  
(I) Red River; and  
(J) Titus.

Rating area 21 (Tyler) consists of the following Texas counties:

(A) Anderson;  
(B) Cherokee;  
(C) Henderson;  
(D) Rains;  
(E) Smith;  
(F) Van Zandt; and  
(G) Wood.

Rating area 22 (Victoria) consists of the following Texas counties:

(A) Calhoun;  
(B) DeWitt;  
(C) Goliad;  
(D) Jackson;  
(E) Karnes;  
(F) Lavaca; and  
(G) Victoria.

Rating area 23 (Waco) consists of the following Texas counties:

(A) Bosque;  
(B) Falls;  
(C) Freestone;  
(D) Hill;  
(E) Limestone; and  
(F) McLennan.

Rating area 24 (Wichita Falls) consists of the following Texas counties:

(A) Archer;  
(B) Baylor;  
(C) Clay;  
(D) Cottle;  
(E) Foard;
§3.503. Required Rate Filings.

(a) An issuer may not use a rate with respect to a plan if:

(1) the issuer has not filed the rate with TDI for review;

(2) the rate filing does not comply with the standards in §3.503 of this title (relating to Rating Standards); or

(3) the rate filing has been withdrawn.

(b) Each issuer must submit an annual rate filing no later than June 15 for any individual or small group market plan that will be issued effective on or after January 1 in the following calendar year. A small group issuer may include scheduled quarterly trend increases within the annual rate filing. An issuer may have only one active annual single risk pool rate filing in each market. An issuer may not modify an annual rate filing later than October 1 prior to the calendar year for which the filing was submitted.

(c) A small group issuer may submit a rate filing for a quarterly rate change that takes effect on April 1, July 1, or October 1. A small group issuer may have only one active quarterly single risk pool rate filing at a given time. Notwithstanding §26.11 of this title (relating to Restrictions Relating to Premium Rates), a small group issuer must submit a quarterly rate filing at least 105 days before the effective date of the rate change.

(d) A rate filing must include the index rate for the single risk pool and reflect every product and plan that is part of the single risk pool in the applicable market. Issuers are not required to enter CSR plan variations separately.

(e) Rate filings made under this subchapter must be submitted through the electronic system designated by TDI, according to any technical instructions provided for the electronic system and consistent with the rules and procedures in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §11.301 of this title (relating to Filing Requirements).

(f) Rate filings made under this subchapter must include the following:

(1) the URRT (Part I);

(2) for a rate increase that is 15% or more within a 12-month period that begins on January 1, as determined by 45 CFR §154.200(b) and (c), concerning Rate Increases Subject to Review, a written description justifying the rate increase (Part II) that complies with 45 CFR §154.215(e), concerning Submission of Rate Filing Justification;

(3) rating filing documentation (Part III) that complies with 45 CFR §154.215(f) and that includes an unredacted actuarial memorandum signed by a qualified actuary;

(4) a rates table that identifies the applicable rate for each plan, depending on an individual's rating area, tobacco use, and age;

(5) an enrollment spreadsheet that contains, with respect to each county:

(A) the number of covered lives, as of March 31 of the current year, that are enrolled in each of the following plan types, separated on the basis of whether the enrollment is through the federal exchange or off-exchange:

(i) catastrophic plans;

(ii) bronze plans;

(iii) silver plans, separated as follows:

(I) silver plans with an AV of 70%;

(II) silver plans with an AV of 73%;

(III) silver plans with an AV of 87%;

(IV) silver plans with an AV of 94%; and

(V) silver plans with an AV of 100%;

(iv) gold plans; and

(v) platinum plans;

(B) whether the plan is available in the county in the current calendar year; and

(C) whether the plan will be available in the county in the next calendar year; and

(F) Hardeman;

(G) Jack;

(H) Knox;

(I) Montague;

(J) Wichita;

(K) Wilbarger; and

(L) Young.

(25) Rating area 25 (Fort Worth) consists of the following Texas counties:

(A) Denton;

(B) Erath;

(C) Hood;

(D) Johnson;

(E) Palo Pinto;

(F) Parker;

(G) Somervell;

(H) Tarrant; and

(I) Wise.

(26) Rating area 26 (Houston SW) consists of the following Texas counties:

(A) Austin;

(B) Brazoria;

(C) Colorado;

(D) Fort Bend;

(E) Matagorda;

(F) Waller; and

(G) Wharton.

(27) Rating area 27 (Houston NE) consists of the following Texas counties:

(A) Chambers;

(B) Liberty;

(C) Montgomery; and

(D) Walker.
(6) an AV and cost-sharing factor spreadsheet that contains:
   (A) the plan ID specified in the URRT; and
   (B) the component factors of an AV and cost-sharing design of plan field in the URRT, which should not include adjustments that account for the morbidity of the population expected to enroll in the plan, including:
      (i) the AV of the plan, calculated consistent with 45 CFR §156.135, concerning AV Calculation for Determining Level of Coverage;
      (ii) the induced-demand factor of 1.00 for bronze plans, 1.03 for silver plans, 1.08 for gold plans, and 1.15 for platinum plans; and
      (iii) for individual silver plans on the exchange, a CSR adjustment factor of 1.35, that accounts for the average costs attributable to CSRs, to the extent that issuers are not otherwise being reimbursed for those costs. If issuers are being reimbursed for those costs by HHS, consistent with 42 USC §18071, concerning Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans, then the CSR adjustment factor would not apply.
   (g) Issuers may submit data using the templates available on TDI's website at www.tdi.texas.gov/health/ratereview.html.
   (h) On request from TDI, an issuer must provide any additional information needed to evaluate the rate filing.
   (i) An issuer that does not intend to issue a plan that would require a rate filing for the next calendar year, but that has enrollment in a plan that is subject to this subchapter in the current year or the prior year, must submit the data for such plan under paragraphs (1) and (2) of this subsection, as applicable, to TDI no later than June 15. For example, in June of 2022, an issuer must submit data under paragraph (1) of this subsection for the 2021 calendar year, and data under paragraph (2) of this subsection for the first five months of calendar year 2022. An issuer that does not have data to submit under paragraph (2) of this subsection is still required to submit data under paragraph (1) of this subsection.
   (1) For prior year cumulative data, an issuer must submit:
      (A) allowed claim costs, defined as total payments made under the plan to health care providers on behalf of covered members and including payments made by the issuer, member cost-sharing, cost-sharing paid by HHS on behalf of low-income members, and net payments from any federal or state reinsurance arrangement or program;
      (B) incurred claim costs, defined as allowed claim costs as specified in subparagraph (A) of this paragraph, less member cost-sharing, cost-sharing paid by HHS on behalf of low-income members, and any net payments from a federal or state reinsurance arrangement;
      (C) earned premium; and
      (D) member months.
   (2) For current year cumulative data through March 31, an issuer must submit:
      (A) earned premium;
      (B) member months; and
      (C) the enrollment spreadsheet required under subsection (f)(5) of this section.

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 May 27, 2022.
TRD-202202057
Allison Eberhart
Deputy General Counsel
Texas Department of Insurance
Effective date: June 16, 2022
Proposal publication date: April 8, 2022
For further information, please call: (512) 676-6587

CHAPTER 21. TRADE PRACTICES
SUBCHAPTER TT. ALL-PAYOR CLAIMS DATABASE

28 TAC §§21.5401 - 21.5406


REASONED JUSTIFICATION. Insurance Code Chapter 38, Subchapter I, requires establishment of an all-payor claims database to increase public transparency of health care information and improve the quality of health care in this state. Insurance Code §38.403 provides that the Commissioner is to adopt rules establishing fixed terms for members of a stakeholder advisory group. Insurance Code §38.404 requires the Texas Department of Insurance (the department) to collaborate with the Center for Health Care Data at The University of Texas Health Science Center at Houston (the Center) to aid in the establishment of the database. Insurance Code §38.409 requires the Commissioner, in consultation with the Center, to adopt rules that specify the types of data a payor is required to provide; detail the schedule, frequency, and manner of data submission; and establish oversight and enforcement mechanisms.

Section 21.5401. New §21.5401 identifies the types of health plans that are subject to the requirements to produce all-payor claims data files. As proposed, the list of plans subject to these requirements includes county employee health benefit plans established under Local Government Code Chapter 157 and group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172. The department invited comments on whether these plans qualify as a "payor" under Texas Insurance Code §38.402(7) and can be subject to the requirements of this rulemaking. The department received one comment on this subject that was in support of including these types of plans within the scope of the rules. New §21.5401 also specifies that the data required by new Subchapter TT is limited to Texas resident members.

In response to other comments, §21.5401(b)(9) is changed to permit, but not require, payors to submit data with respect to Medicare Supplement plans.
Section 21.5402. New §21.5402 provides definitions of terms used throughout the new rules, including various types of data files. The department changes "The Center for Healthcare Data" to "The Center for Health Care Data" in paragraph (2) of this section.

Section 21.5403. New §21.5403 describes the database's common data layout (CDL) and permits the Center to provide flexibility for payors submitting data by issuing a submission guide or other technical guidance for existing requirements. It also specifies that any inconsistencies in the Center's submission guide and these rules will be controlled by the text of the rules. The Texas All-Payer Claims Database (APCD) CDL is modified in response to comments. As a result, the version number and date of the Texas APCD CDL is updated. Changes made to the Texas APCD CDL include:

- Threshold values are removed for several data fields where they are inapplicable because the fields are required only if available.
- The Unassigned field is clarified to indicate that it is not a required field.
- The Employment Status field is changed to be required only if available, and the threshold is removed in response to a comment.
- The description of the Allowed Amount field is modified to clarify the instruction for capitated claims in response to a comment.
- Threshold values are clarified for certain data fields in the medical claims data file that previously indicated, "Not required if Provider ID can be linked to provider file." The threshold values now match the values for the corresponding fields in the provider data file.
- Threshold values are clarified for certain data fields in the medical and pharmacy claims data files that previously indicated, "May be left blank if Member ID links to eligibility file." The threshold values now match the values for the corresponding fields in the eligibility data file.
- Data fields are added to the dental claims file. The data fields are consistent with the All-Payer Claims Database Common Data Layout established by the National Association of Health Data Organizations. Added data fields are either optional or required only if available.

Section 21.5404. New §21.5404 provides technical requirements concerning the formatting, encryption, and transmission of data. It instructs payors or their designees to register with the Center to obtain their credentials and unique member identification (ID) numbers to be used with the submission and naming of data. It also prohibits the submission of duplicate data submitted by a third party. In response to comments, subsection (a) is modified to permit, rather than require, certain payors to ask sponsors of health benefit plans referenced in Insurance Code §38.407 whether they will voluntarily submit plan data. In response to comments, the adopted rule clarifies that the Texas Health and Human Services Commission may submit data on behalf of all payors participating in applicable plans and programs overseen by the Commission. Also in response to comments, the adopted rule now permits, but does not require, payors to submit data with respect to Medicare Supplement plans.

Section 21.5404 also lists the data files that must be submitted consistent with the requirements of the APCD CDL, including standardized values and code sources. It requires files to include information that enables the data to be separated on the basis of the types of plans. It clarifies certain requirements for claims data files, including specifying that all claims data must be submitted for a given reporting period based on the claim adjudication date. In response to comments, the adopted rule permits files to be submitted within multiple zip files, and clarifies the types of denied claims that must be reported.

This new section also sets forth requirements related to reporting members' social security numbers or unique member IDs, requires enrollment and eligibility data to be reported at the individual member level, and requires header and trailer records for file submissions. In response to comments, the adopted rule relaxes requirements about when a unique member ID may change.

The department also changes "USB disk" to "USB drive" in paragraph (d)(1) and "transmit the filing" to "transmit the files" in paragraph (d)(4) of this section.

Section 21.5405. New §21.5405 describes the timing and frequency of the required data submissions. It also directs payors to submit test data, historical data, and monthly data on the basis of notice provided by the Center. As proposed, the initial date for submission of monthly data would be no sooner than January 1, 2023. In response to comments, that date is changed to March 1, 2023, and additional time is provided for the submission of test and historical data files. This new section also provides an extension for certain small payors; allows other payors an opportunity to request an extension or a temporary exception from some requirements related to the submission of data; and outlines the Center's role in assessing, receiving, requesting corrections to, and rejecting data. In response to comments, the adopted rule adds a requirement that the Center communicate receipt of data and respond to a request for an extension or temporary exception within 14 calendar days.

Section 21.5406. New §21.5406 prescribes the fixed terms to be served by members of the stakeholder advisory group, as directed by statute. It provides dates for the initial terms of the stakeholder advisory group as well as the staggered terms. This new section outlines the obligations of members with respect to required disclosures, conflicts of interest, standards of conduct, and removal for good cause.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received comments from five commenters on the proposed rule. Commenters in support of the proposal with changes were America's Health Insurance Plans, the Center for Health Care Data at The University of Texas Health Science Center at Houston, Texas Association of Health Plans, Texas Association of Life & Health Insurers, and USAA Life Insurance Company.

Comments on the proposed rule generally.

Comment. A commenter requests careful consideration of appropriately funding any data collection program to maintain it and avoid collection of low-quality data after it is developed. The commenter asserts that submitting data quarterly can be challenging and costly.

Agency Response. The department appreciates the input but is unable to address funding in the rules. HB 2090 does not provide a mechanism to fund the database through the adoption of rules. Further, the proposed rules provide for monthly submission of data, not quarterly as the commenter asserts.
Comment. A commenter requests that the rule clarify that payors are not required to submit any data on performance-based contracting arrangements. The commenter asserts that the APCD is a claims database, "so requiring data on items that are not claims related, such as drug rebates or performance-based provider contract data... should be expressly prohibited by the rules."

Agency Response. The department agrees that the focus of the rule is on claims but declines to make changes to the rule because the department does not believe adding clarifying language is necessary. The rule text and the common data layout reflect the nature of the claims that are to be submitted to the APCD.

Comments on §21.5401.

Comment. Four commenters request striking Medicare Supplement plans from the list of plans subject to the rules, and two commenters request an explicit exclusion of Medicare Supplement plans from the rules. Two of the four commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts that the Legislature did not intend HB 2090 to apply to a policy where Medicare is the primary payor.

One commenter asserts that smaller carriers will be burdened by the reporting and the additional cost will increase rates and discourage new carriers offering Medicare Supplement plans from entering the market. Two commenters assert that inclusion of Medicare Supplement plan data does not enhance transparency, while another commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan.

Three of the four commenters assert that because federal law dictates provider charges and benefits of Medicare Supplement plans, the value of that data is limited. Three commenters assert that because Medicare Supplement plans are fixed indemnity products, they have no relation to the cost of services rendered, and the inclusion of this data would skew reporting. Two commenters assert that the data is not useful and will require extensive resources to produce.

On the other hand, one commenter asserts that Medicare Supplement plan data is valuable and, for example, could provide insight into the affordability of medical care and how access to medical care differs between seniors who have traditional Medicare alone and those with both Medicare and a Medicare Supplement plan. The commenter encourages inclusion of Medicare Supplement plan data and asserts that both federal and state law define Medicare Supplement plans as a type of benefit plan or health benefit plan, and that HB 2090 was not intended to exclude Medicare Supplement plans.

Agency Response. The department disagrees with the assertion that HB 2090's reporting requirements do not extend to payors providing Medicare Supplement benefit plans. Insurance Code §38.402(7)(A) defines "payor" broadly, including in the definition, "an insurance company providing health or dental insurance" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services, supplies, or devices to a patient. . . ." Insurance Code §1652.002 defines a Medicare supplement benefit plan as a "policy of accident and health insurance." And insurance companies providing Medicare Supplement benefit plans either pay, reimburse, or otherwise contract with providers. In addition, Insurance Code §38.404(c)(4)(A) requires certain information to be collected and submitted to the database, including whether health services, supplies, or devices were provided to an individual through a Medicaid or Medicare program.

Still, the department understands the commenters' concerns regarding costs to produce this data. As a result, and in the interest of maximizing cost effectiveness, particularly in the early phases of the database's implementation, the department makes reporting Medicare Supplement plan data voluntary by revising §21.5401(b)(9) and §21.5404(a). If the cost-benefit analysis for this data changes, the department may consider future amendments to the rules to require reporting of certain Medicare Supplement plan data.

Comment. A commenter supports the applicability of the rule to group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program, contained in §21.5401(b)(16). The commenter suggests keeping the direct reference to Chapter 172 entities to ensure the inclusion of their data.

Agency Response. The department agrees and believes retaining the language accomplishes the goal of the statute.

Comment. Three commenters request striking Medicare Advantage Plans from the list of plans subject to the rules. Two of the three commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts that the Legislature did not intend HB 2090 to apply to a policy where Medicare is the primary payor. The third commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan. Three commenters assert that because federal law dictates provider charges and benefits of Medicare Advantage Plans, the value of that data is limited. Two commenters assert that the data is not useful and will require extensive resources to produce. One commenter asserts that federal law precludes the department from requiring the submission of data, and another commenter expresses support for this assertion.

On the other hand, a fourth commenter indicates that a majority of other states' APCDs require Medicare Advantage Plan data while noting that, to the commenter's knowledge, there has been no litigation challenging the submission of claims from Medicare Advantage Plans. The commenter also asserts that the Legislature is aware of the principles of statutory construction and chose to exclude only "fully self-funded ERISA plans." The commenter says that if the Legislature had wanted to exclude a particular plan type from having to submit data to the APCD, it would have done so.

Agency Response. The department disagrees with the assertion that HB 2090's reporting requirements do not extend to payors providing Medicare Advantage Plans and that federal law precludes the state from requiring payors to submit data related to Medicare Advantage Plans. The department also believes Medicare Advantage Plan data is valuable. Thus, the department declines to make a change.

An entity defined as a "payor" by HB 2090 is required to submit claims data in accordance with that law. In Insurance Code §38.402(7), the Legislature defines "payor" broadly, including in the definition "an insurance company providing health... insurance" or "a health maintenance organization" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services, supplies, or devices to a patient. . . ." An entity providing a Medicare Advantage Plan...
meets that definition and thus is required to submit claims data as required by HB 2090 and these rules.

The department also does not believe that federal law precludes the mandatory submission of data for Medicare Advantage Plans. Standards established under 42 CFR part 422 generally govern Medicare Advantage Plans, and those standards supersede conflicting state laws and regulations. See 42 CFR §422.402 (Federal Preemption of State Law). But the proposed rules do not impact or change Medicare Advantage Plans' eligibility, enrollment, benefits, the payment of claims, or any other area governed by the federal standards in part 422. Also, under 42 USC §1395w-25, an organization providing Medicare Advantage Plans must be "organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage. . . ." Medicare Advantage Plans provide hospital and medical coverage similar to other major medical plans that are subject to reporting, and pay, reimburser, or otherwise contract with providers. The department also finds it noteworthy that other states' APCDs collect Medicare Advantage Plan data, and to date no parties have brought legal challenges against those states based on federal preemption arguments.

The department also believes that the collection of Medicare Advantage plan data is valuable, and the absence of such data would prevent the database from meeting the goals of the statute. The database aims to collect information on health care utilization, access, outcomes, and quality across the Texas population—not just information on covered benefits and costs, and not just information on the commercial health insurance market.

Comment. Three commenters request striking Medicare Part D prescription drug benefit plans from the list of plans subject to the rules. Two commenters assert that the Legislature did not intend to include Medicare or supplemental plans within the scope of HB 2090, while one commenter asserts the Legislature did not intend to apply HB 2090 to a policy where Medicare is the primary payor. One commenter asserts that claims data from Medicare plans could not be reasonably comparable to claims under a major medical health benefit plan. Three commenters assert that because federal law dictates provider charges and benefits of Part D plans, the value of that data is limited. Two commenters assert that the data is not useful and will require extensive resources to produce. One commenter asserts that federal law precludes the department from requiring the submission of data. Another commenter expresses support for this federal preemption comment.

Agency Response. The department disagrees that HB 2090's reporting requirements do not extend to payors providing Medicare Part D prescription drug benefit plans and that federal law precludes the state from requiring payors to submit data related to Medicare Part D prescription drug benefit plans. The department also believes Medicare Part D prescription drug benefit plan data is valuable. Thus, the department declines to make a change.

An entity defined as a "payor" by HB 2090 is required to submit claims data in accordance with that law. In Insurance Code §38.402(7), the Legislature defines "payor" broadly, including in the definition, "an insurance company providing health... insurance" or "a health maintenance organization" that pays, reimburses, or otherwise contracts "with a health care provider for the provision of health care services, supplies, or devices to a patient. . . ." An entity providing a Medicare Part D prescription drug plan meets that definition and thus is required to submit claims data as required by HB 2090 and these rules.

The department also does not believe that federal law precludes the mandatory submission of data for Medicare Part D plans. Standards established under 42 CFR part 423 generally govern Medicare Part D plans, and those standards supersede conflicting state laws and regulations. See 42 CFR §423.440(a) (Federal Preemption of State Law). But the proposed rules do not impact or change Medicare Part D plans' eligibility, enrollment, benefits, the payment of claims, or any other area governed by the standards in part 423. Also, under 42 USC §1395w-112, a sponsor of a Medicare Part D prescription drug plan must be "organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage. . . ."

The department also believes that the collection of Medicare Part D plan data is valuable, and the absence of such data would prevent the database from meeting the goals of the statute. Medicare Part D plans provide prescription drug coverage similar to other major medical plans that are subject to reporting. The database aims to collect information on health care utilization, access, outcomes, and quality across the Texas population—not just information on covered benefits and costs, and not just information on the commercial health insurance market.

Comment. A commenter requests changing the "or" to "and" in §21.5401(b)(23).

Agency Response. The department declines to make changes to the proposed rule in response to the comment. The language contained in §21.5401(b)(23) is consistent with the definition of "payor" in Insurance Code §38.402(7)(B).

Comment. Two commenters thank the department for specifying in §21.5401(c) that the rules apply only to the reporting of claims for applicable policies issued to Texas resident members.

Agency Response. The department thanks the commenters for the support and agrees that this clarification accomplishes the goal of the statute.

Comments on §21.5403.

Comment. A commenter objects to the requirement in §21.5403(a) for payors to comply with a particular version of the Texas APCD CDL. The commenter asks the department to remove the specificity and allow the Center to select the version of the CDL with stakeholder input, asserting that "it is important for Texas to have the flexibility to change the version type without having to go through the entire rulemaking process."

Another commenter suggests limiting changes to the data submission guide and other sub-regulatory guidance to no more than once per year. The commenter also suggests making significant updates through statutory changes instead of rulemaking.

Agency Response. The department declines to make a change in response to either commenter. The department believes the level of specificity included in the Texas APCD CDL as adopted is currently appropriate, and that it was the Legislature's intent that any changes to it should be made through the rulemaking process under the Administrative Procedure Act to allow the public an opportunity to participate. See Tex. Ins. Code §38.409(a). The Legislature delegated the responsibility to determine APCD data submission requirements to the department and the Center. See id. §38.404 and §38.409. Further, the adoption of the
Texas APCD CDL by rule allows for more flexibility than relying only on statutory changes by the Legislature.

Comment. A commenter objects to the following required fields contained in the APCD CDL described in §21.5403:
- Employment Status (CDLME059)
- Payor Claim Control Number (CLDMC005, CDLPC005) and Claim Version Number (CDLM007, CDLPC007, CDLDC007)
- Sequence Number (CDLME015)
- Other Coverage Under This Plan (CDLME036, CDLME0387, CDLME039)

Agency Response. With respect to the Employment Status field, the department recognizes that the field is not relevant to dependents; however, the employment status of the subscriber provides important information. The Texas APCD CDL is modified to make this field required only if available and remove the threshold.

With respect to the Payor Claim Control Number fields and Claim Version Number fields, the department understands that some payors may have claims systems limitations that prevent the claims reported from fully meeting the requirements of the Texas APCD CDL. Nevertheless, the department believes that data files should contain a Payor Claim Control Number (PCCN) that applies to the entire claim and is unique within a payor’s system. The PCCN should be consistent across claim versions and not used as a transaction number. A combination of the PCCN and version number (CLDMC007) will be used to determine which rows will carry forward into the final claim. If possible, it is also imperative that a reversal uses the same PCCN as the original paid claim. Payors that are unable to provide PCCNs that fully meet the requirements of the Texas APCD CDL should request a temporary exception as provided by §21.5405(d).

With respect to the Sequence Number field, the department understands that the sequence number representing the subscriber and dependents may change over time. The submission guide is modified to acknowledge this.

With respect to the Other Coverage Under This Plan field, the department makes no change in response to the comment. To clarify what information is sought, the three codes referenced are defined as indicators requiring “yes” or “no” as a response as to whether medical coverage, pharmacy coverage, or dental coverage is provided as part of the plan. The responses are expected to be from the perspective of the plan submitting the data. These fields do not seek information concerning other coverage provided by other payors.

Comments on §21.5404.

Comment. A commenter recommends that the rules clarify in §21.5404(a) that the Texas Health and Human Services Commission (HHSC) may submit data to the APCD for CHIP, the STAR+PLUS Medicare-Medicaid Pilot program, and Medicaid managed care plans on behalf of all applicable payors.

Agency Response. The department agrees that submitting HHSC data for applicable payors who participate in these various plans or programs is appropriate and changes the relevant proposed language in §21.5404(a) from “may submit data on Medicaid managed care plans on behalf of all applicable payors” to “may submit data on behalf of all applicable payors participating in a plan or program identified in §21.5401(b)(17) - (b)(20) of this title (relating to Applicability).”

Comment. Two commenters object to the written election in §21.5404(a) with respect to plans for which reporting is optional per Insurance Code §38.407. One commenter asserts that “the written opt-out election and response requirements” are in violation of federal law and U.S. Supreme Court decisions and would be subject to preemption, and the commenter urges the department to remove them. The second commenter asserts that the mandatory ask is in violation of state law by depriving the administrator of the ability to decide whether to submit data and suggests replacing “must ask the plan sponsor” with “may ask the plan sponsor.”

A third commenter is grateful for the rules’ inclusion of informing voluntary data reporters in §21.5404 but is understanding that this component may eventually be deleted.

Agency Response. The department disagrees with the first commenter’s characterization of the proposed language as an “opt-out election” and notes that the statute provides otherwise-exempt payors the ability to opt in to submitting data to the APCD. The proposed language permitted, but did not require, a payor to submit data on behalf of a plan that is exempt from state regulation under ERISA. However, the department agrees that the language proposed by the second commenter is appropriate and adopts the revised language.

Comment. A commenter requests clarification that a payor may submit multiple zip files for its large data files instead of a single zip file as proposed in §21.5404(d).

Agency Response. The department agrees and changes the proposed language to accommodate this request.

Comment. A commenter objects to the inclusion of capitated claims data in §21.5404(h). The commenter asserts that “many claims processing systems are unable to provide useful data for claims subject to a capitation payment arrangement” and do not provide a “fee-for-service equivalent” for these capitated claims to be submitted with APCD data. The commenter requests the department to clarify that capitated claims are required only when estimates are available.

Agency Response. The department understands that reporting for claims subject to a capitation payment arrangement will look different from claims paid under a fee-for-service arrangement. Under the Texas APCD CDL, claims that are paid under capitation are identified under the Payment Arrangement Type fields. Within the Plan Paid Amount fields, the amount may be set to ‘0’ for capitated claims. Under the Allowed Amount fields, the payor may also report ‘0.’ The description in the Texas APCD CDL is modified to remove the statement instructing payors to report the maximum amount contractually allowed.

Comment. Three commenters address the inclusion of denied claims as a data element described in §21.5404(i)(3), stating that collecting and submitting such data is burdensome, of low value, incomplete, or inaccurate. One of these commenters asserts that the requirement is not consistent with “the plain meaning of the intent of the reporting data base... to report paid claims” and says it should be deleted. Another commenter also says submission of data on denied claims should not be required, but suggests using Claim Adjustment Reason Codes (CARCs) to clarify which types of "administrative denials" are to be included in the data reporting if any data is required for denied claims, and the commenter lists four CARCs that should be excluded.
One commenter asserts that "some denied claim information" contains valuable information worthy of inclusion in a payor's submission of data to the APCD. The commenter points out that the submission guide anticipates the exclusion of some fully denied claims, such as for a duplicate claim, but also that claims denied because the service or procedure is an uncovered benefit would be useful information for researchers.

Agency Response. The department understands the commenters' concerns and adopts changes to alleviate them. Section 21.2405(i)(3) is modified to clarify that denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. However, denied claims are required when they provide information that supports the objectives of the statute. For example, when a denied claim accurately reflects care that was provided, but that was not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. The submission guide is modified to identify the particular CARCs that must be submitted to the APCD. A claim or claim line may be omitted if it is denied using a CARC that has not been identified as required within the submission guide.

Comment. A commenter objects to the provision in §21.5404(l) requiring a payor to use the same unique qualifier for the member's entire period of coverage, even if the member's name, plan type, or other enrollment information changes, when the payor does not have that member's social security number. The commenter says this is not feasible because of the variety of changes that might apply to a member, including name changes or movement between employers and plans. The commenter recommends that the rules require payors to use a unique member ID for a member's entire period of coverage under a particular plan.

Agency Response. The department agrees and makes the change requested to clarify that the requirement for a payor to provide documentation linking member IDs when the unique member ID changes is required only when such documentation is available.

Comments on §21.5405.

Comment. A commenter suggests that the first monthly data collection described in §21.5405 not be due until June 1, 2023, to provide "more flexibility to ensure that this process is done correctly." Another commenter says the timeline is aggressive and suggests using the standard submission schedule of other states but does not explain what the standard schedule entails.

Agency Response. The department does not agree it is necessary to delay data reporting an additional 150 days. However, the department understands concerns regarding payors having sufficient time to submit the claims data required by the rule and adjusts the dates of the data collection as follows:

- the Center will provide notice of the timeline to submit registration and test data no later than 90 days before the data is due, and test data will be due no sooner than October 1, 2022;
- the Center will provide notice of the timeline for submitting historical data from January 1, 2019, to the most recent reporting period no later than 120 days before the data is due, and the historical data will be due no sooner than January 1, 2023; and
- the Center will provide notice of the timeline for submitting monthly data no later than 180 days before the commencement of the monthly data submission, and the initial monthly data submission will be due no sooner than March 1, 2023.

Comment. A commenter emphasizes the importance of obtaining historical data, as described in §21.5405(b)(2), to create a baseline of pre-COVID information. Another commenter notes that data older than three years may require additional work to access from payors' systems.

Agency Response. The department agrees that January 1, 2019, is appropriate and makes no changes to the language. In recognition of the time that will be needed for issuers to assemble the historical data reports, the department extends the timeline for submitting historical data, so that it will be required no sooner than January 1, 2023.

Comment. A commenter states appreciation for the submission extension for smaller carriers under §21.5405(c), but requests and recommends an exemption for smaller benefit plans from the rules instead. The commenter asserts that "requiring plans with less than 1,000 covered residents to submit data would be extremely burdensome and provide very little useful data." The commenter asserts that with such a small sample size, "the likelihood of them begin able to meet the CDL reporting thresholds drops significantly." A different commenter asserts that the exemption and modified timeline for small carrier submission in the proposed rules are workable solutions.

Agency Response. The department declines to make the first commenter's change. Reporting is required at the payor level, not at the plan level. HB 2090 does not exempt smaller plans from its data submission requirements. Further, the department believes the data submission deadline extension in §21.5405(c) provides an adequate accommodation for smaller issuers.

Comment. A commenter requests the rules establish a presumption for the granting of a temporary exception or extension when requested by a payor under §21.5405(d) or (e), respectively.

Agency Response. The department understands the commenter's concerns and changes the language in proposed §21.5405(d) and (e) to address those concerns and provide details concerning when a request is deemed accepted or withdrawn and to provide a 14-day timeline for the Center to respond or request additional information.

Comment. A commenter recommends the rules require the Center to respond within 14 calendar days notifying a payor of acceptance, rejection, or other issues to allow the payor to correct any system issues going forward rather than having to spend limited resources recreating old submissions.

Agency Response. The department agrees and changes the language in proposed §21.5405(g) to provide a 14-day timeline for the Center to inform the payor of the data quality assessments and specify any required data corrections and resubmissions.

Comment on §21.5406.

Comment. A commenter expresses appreciation for the inclusion of health insurance providers in the stakeholder advisory group established in §21.5406.

Agency Response. The department thanks the commenter and believes this accomplishes the goal of the statute.

Insurance Code §38.403 provides that members of the stakeholder advisory group serve fixed terms as prescribed by rules adopted by the Commissioner.

Insurance Code §38.404 provides that payors must submit the required data at a schedule and frequency determined by the Center and adopted by the Commissioner by rule.

Insurance Code §38.409 provides that the Commissioner adopt rules specifying the types of data a payor is required to provide to the Center and also specifying the schedule, frequency, and manner in which a payor must provide data to the Center.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

§21.5401. Applicability:

(a) This subchapter applies to a payor that issues, sponsors, or administers a plan subject to reporting under subsection (b) of this section.

(b) Payors must submit data files as required by this subchapter with respect to each of the following types of health benefit plans or dental benefit plans issued in Texas:

(1) a health benefit plan as defined by Insurance Code §1501.002, concerning Definitions;

(2) an individual health care plan that is subject to Insurance Code §1271.004, concerning Individual Health Care Plan;

(3) an individual health insurance policy providing major medical expense coverage that is subject to Insurance Code Chapter 1201, concerning Accident and Health Insurance;

(4) a health benefit plan as defined by §21.2702 of this title (relating to Definitions);

(5) a student health plan that provides major medical coverage, consistent with the definition of student health insurance coverage in 45 CFR §14.71.145, concerning Student Health Insurance Coverage;

(6) short-term limited-duration insurance as defined by Insurance Code §1509.001, concerning Definition;

(7) individual or group dental insurance coverage that is subject to Insurance Code Chapter 1201 or Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance;

(8) dental coverage provided through a single service HMO that is subject to Chapter 11, Subchapter W, of this title (relating to Single Service HMOs);

(9) a Medicare supplement benefit plan under Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, if the payor elects to submit such data;

(10) a health benefit plan as defined by Insurance Code Chapter 846, concerning Multiple Employer Welfare Arrangements;

(11) basic coverage under Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act;

(12) a basic plan under Insurance Code Chapter 1575, concerning Texas Public School Employees Group Benefits Program;

(13) a health coverage plan under Insurance Code Chapter 1579, concerning Texas School Employees Uniform Group Health Coverage;

(14) basic coverage under Insurance Code Chapter 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System;

(15) a county employee health benefit plan established under Local Government Code Chapter 157, concerning Assistance, Benefits, and Working Conditions of County Officers and Employees;

(16) group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program;

(17) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program;

(18) a Medicaid managed care plan operated under Government Code Chapter 533, concerning Medicaid Managed Care Program;

(19) the child health plan program operated under Health and Safety Code Chapter 62;

(20) the health benefits plan for children operated under Health and Safety Code Chapter 63;

(21) a Medicare Advantage Plan providing health benefits under Medicare Part C as defined in 42 USC §1395w-21, et seq.;

(22) a Medicare Part D voluntary prescription drug benefit plan providing benefits as defined in 42 USC §1395w-101, et seq.; and

(23) a health benefit plan or dental plan subject to the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.) if the plan sponsor or administrator elects to submit such data.

(c) Data files required by this subchapter must include information with respect to all Texas resident members, as defined in §21.5402(16) of this title. Information on persons who are not Texas resident members is not required.

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

(1) Allowed amount--Has the meaning assigned by Insurance Code §38.402, concerning Definitions.

(2) Center--The Center for Health Care Data at The University of Texas Health Science Center at Houston.

(3) Data--Has the meaning assigned by Insurance Code §38.402.

(4) Data files--Files submitted under this subchapter, including dental claims data files, enrollment and eligibility data files, medical claims data files, pharmacy claims data files, and provider files.

(5) Database--Has the meaning assigned by Insurance Code §38.402.

(6) Dental claims data file--A file that includes data as specified in the Texas APCD CDL about any dental claim or encounter for which some action has been taken on the claim during the reporting period, including payment, denial, adjustment, or other modification.

(7) Enrollment and eligibility data file--A file that provides identifying data as specified in the Texas APCD CDL about a person who is enrolled and eligible to receive health care coverage from a payor, whether or not the member used services during the reporting period, with one record per member, per month, per plan.

(8) Medical claims data file--A file that includes data as specified in the Texas APCD CDL about medical claims and other en-
counter information for which some action has been taken on the claim during the reporting period, including payment, denial, adjustment, or other modification.

(9) Payor--Has the meaning assigned by Insurance Code §38.402.

(10) Pharmacy claims data file--A file that includes data as specified in the Texas APCD CDL about all claims filed by pharmacies, including mail order and retail dispensaries, for prescriptions that were dispensed, processed, and paid during the reporting period.

(11) Provider file--A file that includes information as specified in the Texas APCD CDL about all providers (regardless of network status) that submitted claims that are included in the medical claims data file, dental claims data file, or pharmacy claims data file, with a separate record provided for each unique physical location for a provider who practices in multiple locations.

(12) Qualified research entity--Has the meaning assigned by Insurance Code §38.402.

(13) Stakeholder advisory group--Has the meaning assigned by Insurance Code §38.402.

(14) Submission guide--The document entitled "The Texas All-Payer Claims Database Data Submission Guide," created by the Center, that outlines administrative procedures and provides technical guidance for submitting data files.

(15) Texas APCD CDL--The standardized format, or common data layout (CDL), for All-Payer Claims Database (APCD) data files published by the Center and based on the "All-Payer Claims Database Common Data Layout" established by the National Association of Health Data Organizations and used with permission.

(16) Texas resident member--Any policyholder or certificate holder (subscriber) of a plan issued in Texas whose residence is within the state of Texas and all covered dependents, regardless of where the dependent resides.

§21.5403. Texas APCD Common Data Layout and Submission Guide.

(a) Payors must submit complete and accurate data files for all applicable plans as required by this subchapter and consistent with the Texas APCD CDL v1.09, released May 20, 2022. The Texas APCD CDL is available on the Center's website and:

1. is modeled on the "All-Payer Claims Database Common Data Layout" published by the National Association of Health Data Organizations and used with permission;

2. identifies which data elements payors are required to submit in each data file and which data elements are optional, consistent with Insurance Code §38.404(c), concerning Establishment and Administration of Database; and

3. identifies the record specifications, definitions, code tables, and threshold levels for each required data element.

(b) The Center may issue technical guidance that provides flexibility regarding the existing requirements contained in the Texas APCD CDL, such as removing required data elements, clarifying specifications, increasing the maximum length, or decreasing the minimum threshold. However, such guidance may not modify statutory requirements, impose more stringent requirements, or increase the scope of the data being collected.

(c) The Center will establish, evaluate, and update data collection procedures within a submission guide, consistent with Insurance Code §38.404(f), concerning Establishment and Administration of Database. Notwithstanding subsection (b) of this section, in the event of an inconsistency between this subchapter and the submission guide, this subchapter controls.

§21.5404. Data Submission Requirements.

(a) Payors must submit the data files required by subsection (c) of this section to the Center according to the schedule provided in §21.5405 of this title (relating to Timing and Frequency of Data Submissions). Payors are responsible for submitting or arranging to submit all applicable data under this subchapter, including data with respect to benefits that are administered or adjudicated by another contracted or delegated entity, such as carved-out behavioral health benefits or pharmacy benefits administered by a pharmacy benefit manager. Payors may arrange for a third-party administrator or delegated or contracted entity to submit data on behalf of the payor, but may not submit data that duplicates data submitted by a third party.

1. The Texas Health and Human Services Commission may submit data on behalf of all applicable payors participating in a plan or program identified in §21.5401(b)(17) - (b)(20) of this title (relating to Applicability).

2. A payor that acts as an administrator on behalf of a health benefit plan or dental plan for which reporting is optional per Insurance Code §38.407, concerning Certain Entities Not Required to Submit Data, may ask the plan sponsor whether it elects or declines to participate in or submit data to the Center and may include data for such plans within the payor's data submission. Both the inquiry to and response from the plan sponsor should be in writing.

3. A payor providing Medicare Supplement benefit plans may elect to submit Medicare Supplement benefit plan data to the Center.

(b) Payors or their designees must register with the Center each year to submit data, consistent with the instructions and procedures contained in the submission guide. Payors must communicate any changes to registration information by contacting the Center within 30 days using the contact information provided in the submission guide. Upon registration, the Center will assign a unique payor code and submitter code to be used in naming the data files and provide the credentials and information required to submit data files.

(c) Payors must submit the following files, consistent with the requirements of the Texas APCD CDL:

1. enrollment and eligibility data files;

2. medical claims data files;

3. pharmacy claims data files;

4. dental claims data files; and

5. provider files.

(d) Payors must package all files being submitted into zip files that are encrypted according to the standard provided in the submission guide. Payors must submit the encrypted zip files to the Center using one of the following file submission methods:

1. save the files on a Universal Serial Bus (USB) flash drive and use a secure courier to deliver the USB drive to the database according to delivery instructions provided in the submission guide;

2. transmit the files to the Center's Managed File Transfer servers using the Secure File Transport Protocol (SFTP) and the credentials and transmittal information provided upon registration;

3. upload files from an internet browser using the Hypertext Transfer Protocol Secure (HTTPS) protocol and the credentials and transmittal information provided upon registration;
transmit the files using a subsequent electronic method as provided in the data submission guide.

Payors must name data files and zip files consistent with the file naming conventions specified by the Center in the submission guide.

Payors must format all data files as standard 8-bit UCS Transformation Format (UTF-8) encoded text files with a ".txt" file extension and adhere to the following standards:

1. Use a single line per record and do not include carriage returns or line feed characters within the record;
2. Records must be delimited by the carriage return and line feed character combination;
3. All data fields are variable field length, subject to the constraints identified in the Texas APCD CDL, and must be delimited using the pipe (|) character (ASCII=124), which must not appear in the data itself;
4. Text fields must not be demarcated or enclosed in single or double quotes;
5. The first row of each data file must contain the names of data columns as specified by the Texas APCD CDL;
6. Numerical fields (e.g., ID numbers, account numbers, etc.) must not contain spaces, hyphens, or other punctuation marks, or be padded with leading or trailing zeroes;
7. Currency and unit fields must contain decimal points when appropriate;
8. If a data field is not to be populated, a null value must be used, consisting of an empty set of consecutive pipe delimiters (||) with no content between them.

Data files must include information consistent with the Texas APCD CDL that enables the data to be analyzed based on the market category, product category, coverage type, and other factors relevant for distinguishing types of plans.

Payors must include data in medical, pharmacy, and dental claims data files for a given reporting period based on the date the claim is adjudicated, not the date of Service associated with the claim. For example, a service provided in March, but adjudicated in April, would be included in the April data report. Likewise, any claim adjustments must be included in the appropriate data file based on the date the adjustment was made and include a reference that links the original claim to all subsequent actions associated with that claim. Payors must report medical, pharmacy, and dental claims data at the visit, service, or prescription level. Payors must also include claims for capitated services with all medical, pharmacy, and dental claims data file submissions.

Payors must include all payment fields specified as required in the Texas APCD CDL. With respect to medical, pharmacy, and dental claims data file submissions, payors must also:

1. Include coinsurance and copayment data in two separate fields;
2. Clearly identify claims where multiple parties have financial responsibility by including a Coordination of Benefits, or COB, notation; and
3. Include specified types of denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. The data submission guide will specify the types of denied claims that must be included on the basis of the claim adjustment reason code associated with the denial. In general, denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. Denied claims are required when they accurately reflect care that was delivered to an eligible member but not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. Payors are not required to include data for rejected claims or claims that are denied because the patient was not an eligible member.

Every data file submission must include a control report that specifies the count of records and, as applicable, the total allowed amount and total paid amount.

Unless otherwise specified, payors must use the code sources listed and described in the Texas APCD CDL within the member eligibility and enrollment data file and medical, pharmacy, and dental claims data file and provider file submissions. When standardized values for data fields are available and stated within the Texas APCD CDL, a payor may not submit data that uses a unique coding system.

Payors must use the member’s social security number as a unique member identifier (ID) or assign an alternative unique member ID as provided in this subsection.

1. If a payor collects the social security number for the subscriber only, the payor must assign a discrete two-digit suffix for each member under the subscriber’s contract.
2. If a payor does not collect the subscriber’s social security number, the payor must assign a unique member ID to the subscriber and the member in its place. The payor may also use a discrete two-digit suffix with the unique member ID to associate members under the same contract with the subscriber.
3. A payor must use the same unique member ID for the member’s entire period of coverage under a particular plan. If a change in the unique member ID or the use of two different unique member IDs for the same individual is unavoidable, the payor must provide documentation, if available, linking the member IDs in the form and method provided by the Center.

When standardized values for data variables are available and stated within the Texas APCD CDL, no specific or unique coding systems will be permitted as part of the health care claims data set submission.

Within the enrollment and eligibility data files, payors must report member enrollment and eligibility information at the individual member level. If a member is covered as both a subscriber and a dependent on two different policies during the same month, the payor must submit two member enrollment and eligibility records. If a member has two different policies for two different coverage types, the payor must submit two member enrollment and eligibility records.

Payors must include a header and trailer record in each data file submission according to the formats described in the Texas APCD CDL. The header record is the first record of each separate file submission, and the trailer record is the last.

§21.5405. Timing and Frequency of Data Submissions.

Payors must submit monthly data files according to the following schedule:

1. January data must be submitted no later than May 7 of that year;
2. February data must be submitted no later than June 7 of that year;
(3) March data must be submitted no later than July 7 of that year;
(4) April data must be submitted no later than August 7 of that year;
(5) May data must be submitted no later than September 7 of that year;
(6) June data must be submitted no later than October 7 of that year;
(7) July data must be submitted no later than November 7 of that year;
(8) August data must be submitted no later than December 7 of that year;
(9) September data must be submitted no later than January 7 of the following year;
(10) October data must be submitted no later than February 7 of the following year;
(11) November data must be submitted no later than March 7 of the following year; and
(12) December data must be submitted no later than April 7 of the following year;

(b) Except as provided in subsections (c) and (d) of this section, payors must submit test data files, historical data files, and monthly data files according to the dates specified by the Center, subject to the following requirements:

(1) the Center will provide notice of the timeline for payors to submit registration and test data no later than 90 days before the data is due, and test data will be due no sooner than October 1, 2022;

(2) the Center will provide notice of the timeline for submitting historical data, which must include data for reporting periods spanning from January 1, 2019, to the most recent monthly reporting period, no later than 120 days before the data is due, and historical data will be due no sooner than January 1, 2023; and

(3) the Center will provide notice of the timeline for submitting monthly data no later than 180 days before the commencement of the monthly data submission, and the first monthly data submission date will be no sooner than March 1, 2023.

(c) A payor with fewer than 10,000 covered lives in plans that are subject to reporting under this subchapter as of December 31 of the previous year must begin reporting no later than 12 months after the dates otherwise required, as specified by the Center, consistent with subsection (a) of this section. The payor must register with the Center to document the payor's eligibility for this extension.

(d) A payor may request a temporary exception from one or more requirements of this subchapter or the Texas APCD CDL by submitting a request to the Center no less than 30 calendar days before the date the payor is otherwise required to comply with the requirement. Except as provided in paragraph (2) of this subsection, the Center may grant an exception if the payor demonstrates that compliance would impose an unreasonable cost or burden relative to the public value that would be gained from full compliance.

(1) An exception may not last more than 12 consecutive months.

(2) An exception may not be granted from any requirement contained in Insurance Code Chapter 38, Subchapter I.

(3) The Center may request additional information from a payor in order to make a determination on an exception request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received.

(4) A request for an exception that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (3) of this subsection, the 14-day timeline begins the day after the payor submits such information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an exception may be deemed withdrawn by the Center at the end of the 14-day period.

(e) A payor that is unable to meet the reporting schedule provided by this section may submit a request for an extension to the Center before the reporting due date. The Center may grant a request for good cause at its discretion.

(1) The Center may request additional information from a payor in order to make a determination on an extension request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received.

(2) A request for an extension that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (1) of this subsection, the 14-day timeline begins the day after the payor submits such information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an extension may be deemed withdrawn by the Center at the end of the 14-day period.

(f) The Center will assess each data submission to ensure the data files are complete, accurate, and correctly formatted.

(g) The Center will communicate receipt of data within 14 calendar days, inform the payor of the data quality assessments, and specify any required data corrections and resubmissions.

(h) Upon receipt of a resubmission request, the payor must respond within 14 calendar days with either a revised and corrected data file or an extension request.

(i) If a payor fails to submit required data or fails to correct submissions rejected due to errors or omissions, the Center will provide written notice to the payor. If the payor fails to provide the required information within 30 calendar days following receipt of said written notice, the Center will notify the department of the failure to report. The department may pursue compliance with this subchapter via any appropriate corrective action, sanction, or penalty that is within the authority of the department.

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 May 27, 2022.
TRD-202202056
PART 6. OFFICE OF INJURED EMPLOYEE COUNSEL

CHAPTER 276. GENERAL ADMINISTRATION

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §276.1

INTRODUCTION. The Office of Injured Employee Counsel (OIEC) adopts an amendment to existing rule at 28 Texas Administrative Code (TAC), Chapter 276, Subchapter A, §276.1. The proposed amendment updates the rule to ensure efficient agency operations and maintain consistency with statute and rules.

The amendment is adopted without changes to the proposed amendment published in the April 22, 2022, issue of the Texas Register (47 TegReg 2110). OIEC adopts the amendment to §276.1. The rule will not be republished.

REASONED JUSTIFICATION. OIEC identified a number of rules that required updates during the agency's rule review under Texas Government Code §2001.039, which requires a state agency to review each of its rules every four years. The agency identified rules that are outdated, inconsistent with statutory language, or fail to clarify the language and purpose of statutes.

The adopted amendment to §276.1, Definitions, removes the requirement for ombudsmen to have an adjuster's license. The requirement of an adjuster's license is not required under the Labor Code. This change also makes the rule consistent with §276.10.

SUMMARY OF COMMENTS. OIEC did not receive any comments on the proposed amendment.

STATUTORY AUTHORITY. The Public Counsel adopts the amendment to §276.1 as authorized under Labor Code §404.006 to adopt rules as necessary to implement Chapter 404 of the Labor Code.

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 May 27, 2022.

TRD-202202054
Benjamin de Leon
Regional Staff Attorney
Office of Injured Employee Counsel
Effective date: June 16, 2022
Proposal publication date: April 22, 2022
For further information, please call: (512) 804-4194

28 TAC §276.5

INTRODUCTION. The Office of Injured Employee Counsel (OIEC) adopts an amendment to an existing rule at 28 Texas Administrative Code (TAC), Chapter 276, Subchapter A, §276.5. The proposed amendment updates the rule to maintain consistency with statute and OIEC rules.

The amendment is adopted without changes to the proposed amendment published in the April 22, 2022, issue of the Texas Register (47 TegReg 2111). The rule will not be republished.

REASONED JUSTIFICATION. OIEC identified a number of rules that required updates during the agency's rule review under Texas Government Code §2001.039, which requires a state agency to review each of its rules every four years. The agency identified rules that are outdated, inconsistent with statutory language, or fail to clarify the language and purpose of statutes.

The adopted amendment to §276.5, Employer's Notification of Ombudsman Program to Employees, removes a reference to an adjuster's license located in the attached graphic found in §276.5(c) titled: "NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL". An adjuster's license is not required under the Labor Code. This change also makes the rule consistent with §§276.1 and 276.10.

SUMMARY OF COMMENTS. OIEC did not receive any comments on the proposed amendments.

STATUTORY AUTHORITY. The Public Counsel adopts the amendment to §276.5 as authorized under Labor Code §404.006 to adopt rules as necessary to implement Chapter 404 of the Labor Code.

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 May 27, 2022.

TRD-202202052
Benjamin de Leon
Regional Staff Attorney
Office of Injured Employee Counsel
Effective date: June 16, 2022
Proposal publication date: April 22, 2022
For further information, please call: (512) 804-4194
The adopted amendment to §276.6, Notice of Injured Employee Rights and Responsibilities, updates the rule with the most current information about the Office of Injured Employee Counsel. This change is part of a general effort to remove complexity from and add accuracy and clarity to agency rules.

SUMMARY OF COMMENTS. OIEC did not receive any comments on the proposed amendment.

STATUTORY AUTHORITY. The Public Counsel adopts the amendment to §276.6 as authorized under Labor Code §404.006 to adopt rules as necessary to implement Chapter 404 of the Labor Code.


(a) The Public Counsel adopts by reference the Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System (Notice) in accordance with Labor Code §404.109.

(b) The Notice shall be distributed by the Texas Department of Insurance, Division of Workers' Compensation (Division).

(c) The Notice may be obtained from the:

(1) Office of Injured Employee Counsel's website at www.oiec.texas.gov or at the physical location located at 1601 Congress Avenue, Austin, Texas 78701; or

(2) Texas Department of Insurance, Division of Workers' Compensation website at www.tdi.texas.gov or at the physical location located at 1601 Congress Avenue, Austin, Texas 78701.

(d) This section may not be construed as establishing an entitlement to benefits to which the claimant is not otherwise entitled under Labor Code Title 5.

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 May 27, 2022.

TRD-202202053
Benjamin de Leon
Regional Staff Attorney
Office of Injured Employee Counsel
Effective date: September 1, 2022
Proposal publication date: April 22, 2022
For further information, please call: (512) 804-4194

SUBCHAPTER B. OMBUDSMAN PROGRAM

28 TAC §276.12

INTRODUCTION. The Office of Injured Employee Counsel (OIEC) adopts the repeal of existing rule 28 Texas Administrative Code (TAC), Chapter 276, Subchapter B, §276.12. The information in this rule is found in the Texas Labor Code and in OIEC policy. The rule is not necessary and should be repealed.

The repeal is adopted without changes as published in the April 22, 2022, issue of the Texas Register (47 TegReg 2113). OIEC adopts the repeal of §276.12. The rule will not be republished.

REASONED JUSTIFICATION. OIEC identified a number of rules that required updates during the agency's rule review under Texas Government Code §2001.039, which requires a state agency to review each of its rules every four years. The agency identified rules that are outdated, inconsistent with statutory language, or fail to clarify the language and purpose of statutes.

The adopted repeal of §276.12, Procedures for Private Meetings with Unrepresented Injured Employees Prior to a Workers' Compensation Proceeding, eliminates a requirement that is already found in Texas Labor Code §404.151, which addresses the procedures for meetings with unrepresented injured employees prior to an informal or formal hearing. In addition, existing OIEC policy addresses the rule content. As a result, the agency rule is not necessary.

SUMMARY OF COMMENTS. OIEC did not receive any comments on the proposed repeal.

STATUTORY AUTHORITY. The Public Counsel adopts the repeal of §276.12 as authorized under Labor Code §404.006 to adopt rules as necessary to implement Chapter 404 of the Labor Code.

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 May 27, 2022.

TRD-202202055
Benjamin de Leon
Regional Staff Attorney
Office of Injured Employee Counsel
Effective date: June 16, 2022
Proposal publication date: April 22, 2022
For further information, please call: (512) 804-4194

47 TexReg 3486 June 10, 2022 Texas Register