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

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

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 742. MINIMUM STANDARDS FOR LISTED FAMILY HOMES

SUBCHAPTER D. NOTIFICATIONS AND LIABILITY INSURANCE REQUIREMENTS

26 TAC §742.402

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §742.402, concerning Disclosed Revocations and Parental Notice Requirements.

BACKGROUND AND PURPOSE

The proposal is necessary to comply with Senate Bill (SB) 225, 87th Legislature, Regular Session, 2021.

SB 225 added Texas Human Resources Code §42.0562, which requires the collection of information on any child care home employee who has had a revocation of a state-issued license, registration, certificate, permit, or other occupational authorization by a licensing authority.

HHSC Child Care Regulation (CCR) proposes a new rule to meet the requirements of Texas Human Resources Code §42.0562 and to extend those requirements to listed family home permit holders, controlling persons, employees, and prospective employees. The new rule also requires the listed family home to notify a parent for each enrolled child if a revocation is disclosed.

SECTION-BY-SECTION SUMMARY

Proposed new §742.402 requires (1) each permit holder, controlling person, employee, and prospective employee of a listed family home to complete a form disclosing any revocation of state-issued license, registration, certificate, permit, or other occupational authorization that allowed the practice or engagement in a particular business, occupation, or profession before the revocation; (2) a listed family home to notify, in writing, parents of children enrolled in the home if any person disclosed a revocation and what license, registration, or other occupational authorization was revoked; (3) a listed family home to keep the disclosure form and parental notice on file; and (4) parental notice only if the person who discloses the revocation is hired or continues to be affiliated with the listed family home.

FISCAL NOTE

Victoria Grady, Deputy Chief of Finance, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will create a new regulation;

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule is necessary to protect the health, safety, and welfare of the residents of Texas; does not impose a cost on regulated persons; and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Deputy Executive Commissioner for Child Care Regulation, has determined that for each year of the first five years the rule is in effect the public benefit will be increased protections for children in listed family homes.

Victoria Grady has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule be-

cause the rule does not require any significant time or resources that would result in a cost to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal, including information related to the cost, benefit, or effect of the proposed rule, as well as any applicable data, research, or analysis, may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhs.texas.gov*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 26R072" in the subject line.

STATUTORY AUTHORITY

The new rule is authorized by Texas Government Code §524.0151, 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, as well as Texas Government Code §524.0005, which provides the executive commissioner with broad rule-making authority. In addition, §742.402 is authorized by Texas Human Resources Code §42.042, which requires the executive commissioner to adopt rules to carry out the provisions of Chapter 42.

The proposal implements Texas Human Resources Code §42.0562 and §42.042.

§742.402. Disclosed Revocations and Parental Notice Requirements.

(a) Each listed family home permit holder, controlling person, employee, and prospective employee must complete a form disclosing any revocation of a state-issued license, registration, certificate, permit, or other occupational authorization to practice or engage in a particular business, occupation, or profession. The disclosure form must include the:

(1) full legal name of the person or business entity, if different;

(2) name of the licensing authority and the type of license, registration, certificate, permit, or occupational authorization revoked;

(3) date of revocation; and

(4) signature of the person completing the form and date the form was completed.

(b) When a revocation is disclosed as described in subsection (a) of this section, the listed family home must provide written notice to parents of all enrolled children.

(1) For the purposes of this section, a parent is a person who has legal responsibility for or legal custody of a child, including the managing conservator or legal guardian.

(2) The notice must state that a person associated with the operation has had a revocation and specify the type of license, registration, certificate, permit, or other occupational authorization revoked.

(3) A parent for each enrolled child must sign and date the written notice.

(c) The listed family home must keep the disclosure form and the signed parental notice on file for review by Child Care Regulation.

(d) The parental notice described in subsection (b) of this section is not required if the person who discloses the revocation is not hired or is no longer affiliated with the listed family home.

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

Filed with the Office of the Secretary of State on July 15, 2026.

TRD-202602924
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 438-3269

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CHAPTER 747. MINIMUM STANDARDS FOR CHILD CARE [~~CHILD-CARE~~] HOMES

SUBCHAPTER B. ADMINISTRATION AND COMMUNICATION

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §747.207 concerning What are my responsibilities as the primary caregiver; and new §747.311, concerning Disclosed Revocations and Parental Notice Requirements.

BACKGROUND AND PURPOSE

The proposal is necessary to comply with Senate Bill (SB) 225, 87th Legislature, Regular Session, 2021.

SB 225 added Texas Human Resources Code §42.0562, which requires the collection of information on any child care home employee who has had a revocation of a state-issued license, registration, certificate, permit, or other occupational authorization by a licensing authority.

The proposal also amends a rule to require that a child care home's primary caregiver comply with Texas Workforce Commission Child Care Services (CCS) requirements when receiving subsidies. The proposed amendment strengthens rules related to a child care home's compliance with the CCS program requirements if receiving subsidies.

HHSC Child Care Regulation (CCR) proposes a new rule to meet the requirements of Texas Human Resources Code §42.0562 and to extend those requirements to child care home permit holders, controlling persons, employees, and prospective employees. The new rule also requires the child care home to notify a parent for each enrolled child if a revocation is disclosed.

In addition, CCR is making non-substantive changes, including the removal of the hyphen between "child" and "care."

SECTION-BY-SECTION SUMMARY

The proposed amendment to §747.207 (1) amends the rule title; (2) adds language requiring compliance with CCS program requirements if receiving CCS subsidies; and (3) makes non-substantive changes for better readability and understanding.

Proposed new §747.311 requires (1) each permit holder, controlling person, employee, and prospective employee of a child care home to complete a form disclosing any revocation of state-issued license, registration, or other occupational authorization that allowed the practice or engagement in a particular business, occupation, or profession before the revocation; (2) a child care home to notify, in writing, parents of children enrolled in the child care home if any person disclosed a revocation and what license, registration, or other occupational authorization was revoked; (3) a child care home to keep the disclosure form and parental notice on file; and (4) parental notice only if the person who discloses the revocation is hired or continues to be affiliated with the child care home.

FISCAL NOTE

Victoria Grady, Deputy Chief of Finance, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

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

(2) implementation of the proposed rules will not affect the number of HHSC employee positions;

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

(4) the proposed rules will not affect fees paid to HHSC;

(5) the proposed rules will create a new regulation;

(6) the proposed rules will expand existing regulations;

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

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

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

Victoria Grady has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities required to comply with the rules.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas; do not impose a cost on regulated persons; and are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Deputy Executive Commissioner for Child Care Regulation, has determined that for each year of the first five years the rules are in effect the public benefit will be increased protections for children in child care homes and greater accountability for child care homes receiving CCS subsidies.

Victoria Grady has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not require any significant time or resources that would result in a cost to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal, including information related to the cost, benefit, or effect of the proposed rules, as well as any applicable data, research, or analysis, may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhs.texas.gov*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 26R072" in the subject line.

DIVISION 1. PRIMARY CAREGIVER RESPONSIBILITIES

26 TAC §747.207

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, 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, as well as Texas Government Code §524.0005, which provides the executive commissioner with broad rule-making authority. In addition, §747.207 and §747.311 are authorized by Texas Human Resources Code §42.042, which requires the executive commissioner to adopt rules to carry out the provisions of Chapter 42.

The proposal implements Texas Human Resources Code §42.0562 and §42.042.

§747.207. Primary Caregiver Responsibilities. [~~What are my responsibilities as the primary caregiver?~~]

The primary caregiver must [~~You are responsible for~~]:

(1) develop [~~Developing~~] and follow the [~~implementing your child-care home's~~] operational policies, as specified in this chapter [~~, which comply with or exceed Division 4 of this subchapter (relating to Operational Policies)~~];

(2) ensure [~~Ensuring~~] all assistant caregivers and substitute caregivers follow the [~~comply with the relevant~~] minimum standards [~~for those caregivers~~], as specified in this chapter, and receive [~~are provided~~] assignments that match each caregiver's [~~their~~] skills, abilities, and training;

(3) ensure [~~Ensuring~~] all household members follow [~~comply with~~] the minimum standards [~~that apply to household members~~], as specified in this chapter;

(4) report any [~~Reporting~~] suspected abuse, neglect, or exploitation directly to the Texas Abuse and Neglect Hotline, as required by Texas Family Code §261.101 [~~§261.1401~~]. The [~~You may not delegate your~~] responsibility to make a report cannot be delegated, and the primary caregiver [~~you~~] may not require a household member or employee to seek approval to make [~~file~~] a report or to notify the primary caregiver [~~you~~] that a report was made;

(5) allow a parent to [~~Ensuring parents can~~] visit the child care [~~your child-care~~] home any time during operating hours, without [~~all hours of operation to observe their child, program activities, the home, the grounds, and the equipment, without having to secure~~] prior approval;

(6) request [~~Initiating~~] background checks as specified in Chapter 745, Subchapter F of this title (relating to Background Checks);

(7) keep [~~Ensuring~~] all information about [~~related to~~] background checks [~~is kept~~] confidential and protect background check information from disclosure [~~not disclosed~~] to unauthorized persons, as required by law [~~the Human Resources Code, §40.005(d) and (e)~~];

(8) follow [~~Complying with the~~] liability insurance requirements in this division;

(9) ensure the number of children in care, both at the child care home and away from the home, such as during a field trip, does not exceed the licensed or registered capacity;

(10) [~~(9)~~] comply [~~Complying~~] with[~~:~~]

[~~(A)~~] [~~The child-care licensing law, found in~~] Chapter 42 of the Human Resources Code, [~~;~~]

[~~(B)~~] all [~~All~~] the minimum standards, and [~~that apply to your licensed or registered child-care home, as specified in this chapter;~~]

[~~(C)~~] any [~~All~~] other [~~applicable laws and rules in the~~] Texas Administrative Code rules that apply; and

[~~(10) Ensuring the total number of children in care at the home or away from the home, such as during a field trip, never exceeds the capacity of the home as specified on the license or registration.~~]

(11) comply with all Texas Workforce Commission Child Care Services (CCS) requirements when receiving CCS subsidies. Failure to follow CCS requirements, including knowingly or negligently failing to meet any provider requirements or responsibilities outlined in Title 40, Texas Administrative Code Chapter 809, is considered a violation of the Texas Health and Human Services Commission minimum standards.

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

Filed with the Office of the Secretary of State on July 15, 2026.

TRD-202602925
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 438-3269

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DIVISION 2. REQUIRED NOTIFICATIONS

26 TAC §747.311

STATUTORY AUTHORITY

The new rule is authorized by Texas Government Code §524.0151, 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, as well as Texas Government Code §524.0005, which provides the executive commissioner with broad rule-making authority. In addition, §747.207 and §747.311 are authorized by Texas Human Resources Code §42.042, which requires the executive commissioner to adopt rules to carry out the provisions of Chapter 42.

The proposal implements Texas Human Resources Code §42.0562 and §42.042.

§747.311. Disclosed Revocations and Parental Notice Requirements.

(a) Each child care home permit holder, controlling person, employee, and prospective employee must complete a form disclosing any revocation of a state-issued license, registration, certificate, permit, or other occupational authorization to practice or engage in a particular business, occupation, or profession. The disclosure form must include the:

(1) full legal name of the person or business entity, if different;

(2) name of the licensing authority and the type of license, registration, certificate, permit, or occupational authorization revoked;

(3) date of revocation; and

(4) signature of the person completing the form and date the form was completed.

(b) When a revocation is disclosed as described in subsection (a) of this section, the child care home must provide written notice to parents of all enrolled children.

(1) For the purposes of this section, a parent is a person who has legal responsibility for or legal custody of a child, including the managing conservator or legal guardian.

(2) The notice must state that a person associated with the operation has had a revocation and specify the type of license, registration, certificate, permit, or other occupational authorization revoked.

(3) A parent for each enrolled child must sign and date the written notice.

(c) The child care home must keep the disclosure form and the signed parental notice on file for review by Child Care Regulation.

(d) The parental notice described in subsection (b) of this section is not required if the person who discloses the revocation is not hired or is no longer affiliated with the child care home.

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

Filed with the Office of the Secretary of State on July 15, 2026.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-3269

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 1. GENERAL ADMINISTRATION
SUBCHAPTER C. ASSESSMENT OF MAINTENANCE TAXES AND FEES

28 TAC §1.414

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §1.414 concerning the assessment of maintenance taxes, surcharges and fees collected from the sale of insurance policies. The amendments to §1.414 implement Senate Bill 1455, 89th Legislature, 2025.

EXPLANATION. Amending §1.414 is necessary to implement SB 1455, which amended the Insurance Code and Labor Code to replace the collection of maintenance taxes for workers' compensation insurance with the collection of workers' compensation surcharges.

The amendments to §1.414 replace "maintenance tax" with "surcharge" and add "surcharge" to subsections pertaining to workers' compensation to conform with the terminology change in SB 1455.

In addition, the proposed amendments include nonsubstantive rule drafting and formatting changes for plain language and to conform the section to the agency's current style and to improve the rule's clarity. These changes include lowercasing "Commissioner" and adding the title of statutory citations for transparency.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Amy Maddox, chief financial officer of the Financial Services Office in the Administrative Operations Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments, other than that imposed by statute. Ms. Maddox made this determination because the proposed amendment does not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendment.

Ms. Maddox does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Maddox expects that administering the proposed amendment will have the public benefit of ensuring that TDI's rules conform to SB 1455 and allow for Texas-based workers' compensation insurers to be more competitive out of state.

Ms. Maddox expects that the proposed amendment will not increase the cost of compliance with §1.414 because it does not impose requirements beyond those in the statute. SB 1455 requires that the same maintenance taxes paid as before will now be classified as surcharges for workers' compensation insurance. As a result, the cost associated with the change of terminology required by SB 1455 does not result from the enforcement or administration of the proposed amendment.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. Proposed §1.414 does not change the amount insurers will pay or cause any business operations to change for regulated entities. It only changes the term "maintenance taxes" to "surcharges." As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. In addition, no rule amendments are required under Government Code §2001.0045 because the proposed §1.414 is necessary to implement legislation. The proposed rule implements SB 1455.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on August 31, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests

public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2870. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on August 25, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.035. Visit www.tdi.texas.gov/alert/event/index.html for more information on the proposed rule, hearing, and comment submission.

STATUTORY AUTHORITY. TDI proposes amendments to §1.414 under Insurance Code §251.001 and §36.001.

Insurance Code §251.001 requires the commissioner to annually determine the rate of assessment of each maintenance tax or workers' compensation surcharge imposed under Title 3, Subtitle C of the Insurance Code.

Insurance Code §36.001 authorizes the commissioner to adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of the state.

CROSS-REFERENCE TO STATUTE. Section 1.414 implements SB 1455.

§1.414. Assessment of Maintenance Taxes, Surcharges, and Fees.

(a) Each calendar year by commissioner [~~Commissioner~~] order the department will assess rates for maintenance taxes, surcharges and fees on the gross premiums of insurers for the following lines of insurance:

(1) motor vehicle insurance, under Insurance Code §254.002, concerning Maximum Rate; Annual Adjustment;

(2) casualty insurance and fidelity, guaranty, and surety bonds, under Insurance Code §253.002, concerning Maximum Rate; Annual Adjustment;

(3) fire insurance and allied lines, including inland marine, under Insurance Code §252.002, concerning Maximum Rate; Annual Adjustment;

(4) workers' compensation insurance, under Insurance Code §255.002, concerning Maximum Rate; Annual Adjustment;

(5) workers' compensation insurance, under Labor Code §403.003, concerning Rate of Surcharge;

(6) workers' compensation insurance, under Labor Code §405.003, concerning Funding; Surcharge and Recovery of Surcharge by Insurers;

(7) workers' compensation insurance, under Labor Code §407A.301, concerning Surcharge for Division and Research Functions of Department;

(8) workers' compensation insurance, under Labor Code §407A.302, concerning Surcharge for Department; and

(9) title insurance, under Insurance Code §271.005, concerning Maximum Rate; Annual Adjustment.

(b) Each calendar year by commissioner [~~Commissioner~~] order the department will assess the rate for the maintenance tax to be assessed on gross premiums of insurers for life, health, and accident insurance and the gross considerations for annuity and endowment contracts, under Insurance Code §257.002, concerning Maximum Rate; Annual Adjustment.

(c) Each calendar year by commissioner [~~Commissioner~~] order the department will assess rates for maintenance taxes for the following entities:

(1) under Insurance Code §258.003, concerning Maximum Rate; Annual Adjustment, an amount per enrollee for:

(A) single service health maintenance organizations;

(B) multiservice health maintenance organizations; and

(C) limited service health maintenance organizations; and

(2) under Insurance Code §259.003, concerning Maximum Rate; Annual Adjustment, a rate of the correctly reported gross amount of administrative or service fees for third-party administrators.

(d) Each calendar year by commissioner [~~Commissioner~~] order the department will assess a surcharge rate [~~for maintenance tax~~] under Labor Code §405.003 for each certified self-insurer, to fund the Workers' Compensation Research and Evaluation Group. The rate will be calculated under Labor Code §407.103(b), concerning Self-Insurer Surcharge; Effect on General Surcharge, and it will be billed to the certified self-insurer by the Division of Workers' Compensation.

(e) Each calendar year by commissioner [~~Commissioner~~] order the department will assess a surcharge rate [~~for maintenance tax~~] under Labor Code §405.003 and §407A.301 for each workers' compensation self-insurance group, to fund the Workers' Compensation Research and Evaluation Group. The rate will be calculated under Labor Code §407.103(b).

(f) Each calendar year by commissioner [~~Commissioner~~] order the department will assess a surcharge rate [~~for maintenance tax~~] under Labor Code §407.103 and §407.104, concerning Collection of Surcharges and Fees; Administrative Violation, for each certified self-insurer. The rate will be calculated under Labor Code §407.103(b), and it will be billed to the certified self-insurer by the Division of Workers' Compensation.

(g) The maintenance tax and surcharge revenue need is calculated as the amount of revenue needed to reach the targeted year-end fund balance, considering [~~taking into account~~] the beginning balance, other expected [~~non-maintenance tax~~] revenues, and estimated expenditures. For each line of insurance:

(1) the assessment rate is calculated by dividing the revenue need by the estimated premium volume or assessment base; and

(2) if the calculated rate is above the statutory rate, the rate is set at the statutory maximum and any revenue shortfall is spread to the other maintenance tax or surcharge lines, increasing the revenue need and tax rates for the remaining lines.

(h) The taxes, surcharges and fees assessed by the commissioner [~~Commissioner~~] order issued under subsections (a), (b), (c), and (e) of this section will be payable and due to the Comptroller of Public Accounts on March 1 each year.

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

Filed with the Office of the Secretary of State on July 16, 2026.

TRD-202602936

Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 676-6555

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CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER G. WORKERS' COMPENSATION INSURANCE

DIVISION 2. GROUP SELF-INSURANCE COVERAGE

28 TAC §§5.6401 - 5.6411, 5.6413

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§5.6401 - 5.6411 and 5.6413, concerning group self-insurance coverage. Amendments to §5.6401 and §5.6403 implement Senate Bill 264, 89th Legislature, 2025.

EXPLANATION. Amending §5.6401 and §5.6403 is necessary to implement SB 264, which added Labor Code §407A.0521, concerning New Certificates of Approval Prohibited. Section 407A.0521 prohibits the issuance of a certificate of approval to a proposed group on or after September 1, 2025, though it provides that the commissioner may amend a certificate of approval issued to a group before September 1, 2025.

The proposed amendments to §§5.6402, 5.6404 - 5.6411, and 5.6413 include nonsubstantive rule drafting and formatting changes for plain language to conform the sections to the agency's current style and to improve clarity. These changes include changing "shall" to "must," "will," or "may"; "pursuant to" to "under"; "percent" to "%"; and lowercasing "commissioner." Amendments also add chapter and section titles and correct grammatical errors such as fixing unhyphenated adjectives, adding missing commas, and removing unnecessary articles.

Descriptions of the sections' proposed amendments follow.

Section 5.6401. An amendment to §5.6401 removes a reference to applicants, since under Labor Code §407A.0521 applications for new self-insurance group certificates may no longer be approved. Amendments also include nonsubstantive rule drafting and formatting changes.

Section 5.6402. Amendments to §5.6402 include nonsubstantive rule drafting and formatting changes.

Section 5.6403. Amendments to §5.6403 include disallowing unincorporated associations or business trusts that propose to organize as workers' compensation self-insurance groups to file applications for certificates of approval; stating that the commissioner will no longer issue new certificates of approval to proposed groups; stating the commissioner may amend a certificate of approval issued to a group before September 1, 2025; and nonsubstantive rule drafting and formatting changes.

Section 5.6404. Amendments to §5.6404 include nonsubstantive rule drafting and formatting changes.

Section 5.6405. Amendments to §5.6405 include replacing outdated references to provisions from the uncodified Insurance Code and nonsubstantive rule drafting and formatting changes.

Section 5.6406. Amendments to §5.6406 include nonsubstantive rule drafting and formatting changes.

Section 5.6407. Amendments to §5.6407 include nonsubstantive rule drafting and formatting changes. No changes are proposed to Figure 28 TAC §5.6407(b).

Section 5.6408. Amendments to §5.6408 include nonsubstantive rule drafting and formatting changes for plain language. No changes are proposed to Figure 28 TAC §5.6408(c).

Section 5.6409. Amendments to §5.6409 include nonsubstantive rule drafting and formatting changes.

Section 5.6410. Amendments to §5.6410 include replacing outdated references to provisions from the uncodified Insurance Code and nonsubstantive rule drafting and formatting changes.

Section 5.6411. Amendments to §5.6411 include nonsubstantive rule drafting and formatting changes.

Section 5.64013. Amendments to §5.6413 include nonsubstantive rule drafting and formatting changes.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Jamie Walker, deputy commissioner of the Financial Regulation Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments, other than that imposed by statute. Ms. Walker made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Walker does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Walker expects that administering them will have the public benefits of ensuring that TDI's rules conform to Labor Code §407A.0521 and ensuring that TDI's rules are accurate and transparent by adding titles to citations and eliminating errors in punctuation and grammar.

Ms. Walker expects that the proposed amendments will not increase the cost of compliance with Labor Code §407A.0521 because it does not impose requirements beyond those in statute. Labor Code §407A.0521 prohibits the commissioner from issuing a certificate of approval to a proposed group on or after September 1, 2025. As a result, any cost associated with the rule does not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities because the amendments are largely nonsubstantive in nature and do not impose requirements beyond those in statute. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. In addition, no additional rule amendments are required under Government Code §2001.0045 because the proposed Texas Self-Insurance

Group Guaranty Fund Rule is necessary to implement legislation. The proposed rule implements Labor Code §407A.0521, as added by SB 264.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on August 31, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2869 at 10:00 a.m., central time, on August 25, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.035. Details of how to view and participate virtually in the public hearing will be made available on TDI's website at www.tdi.texas.gov/alert/event/index.html.

STATUTORY AUTHORITY. TDI proposes amendments to §§5.6401 - 5.6411 and 5.6413 under Labor Code §407A.008 and Insurance Code §4151.006 and §36.001.

Labor Code §407A.008 authorizes the commissioner to adopt rules as necessary to implement Labor Code Chapter 407A.

Insurance Code §4151.006 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 4151.

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

CROSS-REFERENCE TO STATUTE. Section 5.6401 and §5.6403 implement Labor Code §407A.0521. Sections 5.6402, 5.6403, and 5.6411 implement Insurance Code §4151.006. Sections 5.6401 - 5.6411 and 5.6413 implement Labor Code §407A.008 and Insurance Code §36.001.

§5.6401. Purpose and Scope.

This division establishes the licensing, contracting, reporting, and financial requirements, procedures, responsibilities, and obligations applicable to [~~applicants and~~] workers' compensation self-insurance groups holding a certificate of approval issued under [~~the~~] Labor Code Chapter 407A, concerning Group Self-Insurance Coverage.

§5.6402. Definitions.

(a) The following words and terms, when used in this division, [~~shall~~] have the following meanings[~~,~~] unless the context clearly indicates otherwise.

(1) Actuary--A member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserves opinions by the Casualty Practice Council of the American Academy of Actuaries.

(2) Administrator--An individual, partnership, or corporation engaged by the board of trustees of a group to implement the policies established by the board of trustees and to provide day-to-day management of the group, as defined in [~~the~~] Labor Code §407A.001(a)(1), concerning Definitions. Day-to-day management may include, but is not limited to, claims adjustment; safety engineering; compilation of statistics and the preparation of premium, loss, and tax reports; preparation of other required self-insurance reports; development of members' assessments and fees; and administration of a claim fund. For purposes of this division, administrator includes and has the same meaning as managing company, as that term is defined in [~~the~~] Labor Code §407A.001(a)(5-a). Any reference to the term administrator in this division in all contexts necessarily includes and references both administrator and managing company.

(3) Books and records [~~Records~~]--All books, accounts, records, documents, written agreements, contracts, papers, correspondence, claims files, receipts, bills, notes, pleadings, investigatory files, or any other written or electronic material relating to the business of a group.

(4) Certified public accountant [~~Public Accountant~~]--An accountant or firm in good standing with the American Institute of Certified Public Accountants and the Texas State Board of Public Accountancy and who conforms to the Code of Professional Ethics of the American Institute of Certified Public Accountants.

(5) Commissioner--The commissioner of insurance [~~Commissioner of Insurance~~].

(6) Department--The Texas Department of Insurance.

(7) Group--An unincorporated association or business trust composed of five or more private employers that meet all of the requirements of [~~the~~] Labor Code Chapter 407A, concerning Group Self-Insurance Coverage, and this division.

(8) Managing company--As defined in paragraph (2) of this subsection.

(9) Modified schedule rating premium--As defined in [~~the~~] Labor Code §407A.001(a)(6).

(10) Person--An individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.

(11) Same or similar--As set forth in [~~the~~] Labor Code §407A.001(a)(7).

(12) Service company--A person that directly or indirectly provides services to or on behalf of a group, other than the services provided by an administrator, including, but not limited to:

(A) claims adjustment;

(B) safety engineering;

(C) compilation of statistics and the preparation of premium, loss, and tax reports;

(D) preparation of other required self-insurance reports;

(E) development of members' assessments and fees; and

(F) administration of a claim fund.

(13) Third-party [~~Third party~~] administrator--An administrator or service company, as those terms are defined under this division, that holds itself out or acts as an administrator, as that term is defined in [~~the~~] Insurance Code §4151.001(1), concerning Definitions.

(b) A group must [~~shall~~] engage only one administrator to implement the policies established by the board of trustees and to provide day-to-day management of the group. A group may engage more than one service company to provide services to the group.

(c) An individual, partnership, or corporation may act as an administrator for more than one group.

(d) An individual, partnership, or corporation may act as an administrator for one group and as a service company for another group.

(e) An individual, partnership, or corporation may not act as both an administrator and a service company for the same group at the same time.

§5.6403. Application for Initial Certificate of Approval.

(a) Consistent with Labor Code §407A.0521, concerning New Certificates of Approval Prohibited, [~~An~~] unincorporated associations [~~association~~] or business trusts [~~trust composed of five or more private employers~~] that propose [~~proposes~~] to organize as [~~a~~] workers' compensation self-insurance groups may no longer file applications for certificates [~~group shall file with the department an application for a certificate~~] of approval with the department.

(1) Consistent with Labor Code §407A.0521, the commissioner will no longer issue new certificates of approval to proposed groups.

(2) As permitted by Labor Code §407A.0521, the commissioner may amend a certificate of approval that was issued to a group before September 1, 2025.

(b) Contents of the application must include the information required by Labor Code §407A.051, concerning Application for Initial Certificate of Approval; Approval Requirements.

(c) In addition to the information required under subsection (b) of this section, an applicant must [~~shall~~] also provide the following:

(1) A statement that demonstrates that the members of the group are in the same or similar type of business as required by Labor Code §407A.002(a)(1), concerning Application of Chapter; Establishment of Private Group.

(A) The statement should demonstrate that the members of the group have the same governing classification.

(B) If the members of the proposed group have different governing classifications, the statement should demonstrate how the business pursuits of the members of the group are similar enough in operation in the commissioner's [~~Commissioner of Insurance's~~] discretion to be grouped together.

(2) To aid the department in making the determination that the trade or professional association meets the requirements of Labor Code §407A.002(a)(2) that the trade of professional association has been in existence in this state for purposes other than insurance for five years before the establishment of the group, provide copies of documents relating to the organization, governance, and operation of the association and a narrative describing the association's activities [~~of the association~~]. Annual reports, conventions, seminars, dues requirements, newsletters, and other evidence acceptable to the commissioner [~~Commissioner of Insurance~~] may be submitted to aid the department in making its determination.

(3) In addition to the copy of the group's bylaws [~~of the group~~] required by Labor Code §407A.051(c)(6), submit copies of documents relating to the organization, governance, and operation of the group.

(4) Financial statement projections on a quarterly basis [~~Projected financial statements~~] for [~~the~~] 24 months [~~month period~~] from the group's start of operations including a [~~using quarterly~~] balance sheet [~~projections~~] based on the group's fiscal year, [~~quarterly~~] cash flow schedules reflecting expenditures by category, [~~quarterly~~] revenue and expenses, [~~expense projections~~] and an actuarial opinion [~~projection~~] of the group's total projected incurred liabilities for workers' compensation that [~~which~~] demonstrate compliance with Labor Code §407A.051(c)(10). The actuarial opinion must [~~which requires the group to~~] show the group's [~~its~~] financial ability to pay the workers' compensation obligations of the employers who are members of the group. The [~~and Labor Code §407A.053(c) which requires the~~] group must [~~to~~] post security equal to the greater of $300,000 or 25% of the group's total incurred liabilities for workers' compensation in compliance with Labor Code §407A.053(c), concerning Financial Requirements. The projections must [~~shall~~] include an estimate of the employees to be covered on which the projections and actuarial assumptions are based. The projections must reflect the identity, qualifications, and credentials of the persons making the projections.

(5) A written commitment, binder, or policy or contract of excess insurance that meets the requirements of §5.6405 of this title [~~division~~] (relating to Excess Insurance).

(6) A fidelity bond for an administrator in the amount of $250,000. The fidelity bond must meet the requirements of §5.6408 of this title [~~division~~] (relating to Fidelity and Performance Bonds).

(7) A fidelity bond for a service company identified under [~~pursuant to~~] paragraph (12)(A) or (B) of this subsection, if there is one, in the amount of $250,000. The fidelity bond must meet the requirements of §5.6408 of this title [~~division~~].

(8) A performance bond for a service company identified under [~~pursuant to~~] paragraph (12)(A) of this subsection that provides claims service to or on behalf of a group, if there is one, in the amount of $250,000. This performance bond is in addition to the fidelity bond required in paragraph (7) of this subsection for a service company. The performance bond must [~~shall~~] be in the form prescribed in §5.6408 of this title [~~division~~].

(9) An indemnity agreement executed by the members of the group binding the members, jointly and severally, for the obligations of the group. At a minimum, the agreement must [~~shall~~] include

the provisions described in §5.6406 of this title [division] (relating to Indemnity Agreement).

(10) An acknowledgment [acknowledgement], in the form prescribed in §5.6407 of this title [division] (relating to Acknowledgment [Acknowledgement] of Indemnity Agreement), executed by each member of the group that it is aware that it can be called upon to pay the workers' compensation claims of another member of the group under [pursuant to the] Labor Code Chapter 407A, concerning Group Self-Insurance Coverage.

(11) The statement required by §5.6404 of this title [division] (relating to Notification to the Department and Responsibility for Continued Compliance).

(12) A business plan or plan of operation that describes the group's business activities, safety program, and organization. The plan must also include:

(A) the identity of the administrator of the group and any third-party [third party] administrator that provides services to or on behalf of the group;

(B) excluding any person identified under [pursuant to] subparagraph (C) of this paragraph, the identity of any service company that performs one or more of the following services:

(i) provides cash and asset management services to a group, including any person that has access to or disbursement authority over any of the group's assets and accounts;

(ii) maintains the group's accounting records or organizational documents;

(iii) stores or maintains the group's electronic books and records, including a person identified by a group under §5.6409(b)(3) of this title [division] (relating to Books and Records); or

(iv) provides management of a function [for which] the group retains ultimate responsibility for under the Insurance Code, [the] Labor Code, or rules adopted under those codes [thereunder];

(C) the identity of:

(i) the accountant of the group; and

(ii) the actuary of the group.

(D) a general description of the experience, qualifications, facilities, and personnel of a person identified under [pursuant to] subparagraph (A) or (B) of this paragraph; and

(E) the identity of the affiliates of a person identified under [pursuant to] subparagraph (A) or (B) of this paragraph. A group may identify such affiliates in an organizational chart.

(13) A copy of each written agreement required under §5.6411 of this title [division] (relating to Contract Provisions).

(14) A statement that a third-party [third party] administrator identified under [pursuant to] paragraph (12)(A) of this subsection either holds the required authorization from the department or has applied for the required authorization from the department and that the group will verify that such authorization has been granted by the department before the group allows the third-party [third party] administrator to provide services to or on behalf of the group.

(d) The group must also submit [the following]:

(1) proof that it has received payment or a promise to pay from each member of 25% of its first-year [first year] estimated modified schedule rating premium. If the group approves a member's submission of a promise to pay the 25% of premium, the employer must submit payment of the amount promised no later than 10 days after the effective date of the member's coverage with the group;[,] or

(2) a certification by a certified public accountant and an actuary that assets and reserves of the trust satisfy the requirement of [the] Labor Code §407A.051(c)(11)(B).

(e) Each member of the initial board of trustees of a group, subsequent members of the board of trustees of a group, and the executive officers of a person identified under [pursuant to] subsection (c)(12)(A) or (B) of this section must [shall] provide to the department a completed biographical affidavit in accordance with §7.1604(b)(1)(C) of this title (relating to Application for Certificate of Authority [Denial, Suspension, Cancellation, or Revocation]). A biographical affidavit is not required if a biographical affidavit from the individual has been filed with the department within the prior three years and contains substantially accurate information. A biographical affidavit must demonstrate that the affiant has sufficient experience, ability, standing, and good record to make success of a group probable.

(f) Each member of the initial board of trustees of a group, subsequent members of the board of trustees of a group, and the executive officers of a person identified under [pursuant to] subsection (c)(12)(A) or (B) of this section must [shall] comply with the requirements of Chapter 1, Subchapter D, of this title (relating to Effect of Criminal Conduct).

(g) A person subject to this division and to the requirements of [the] Insurance Code §4151.055, concerning Fidelity Bond Required, may satisfy the requirements of §4151.055 by obtaining a fidelity bond that meets the requirements of subsection (c)(6) or (7) of this section, as applicable.

(h) Under [Pursuant to the] Labor Code §407A.051(b)(7), the commissioner may require the submission of any other relevant information reasonably required to determine whether to approve or disapprove an application for a certificate of approval.

§5.6404. Notification to the Department and Responsibility for Continued Compliance.

(a) No later than 30 days after the effective date of the change, a group must [shall] provide written notice to the department identifying:

(1) any change in the information filed by the group under [the] Labor Code §407A.051(c), concerning Application for Initial Certificate of Approval; Approval Requirements, and §5.6403 of this title [division] (relating to Application for Initial Certificate of Approval); and

(2) any change in the group's manner of compliance with [the] Labor Code §407A.051(c) and §5.6403 of this title [division].

(b) A group must meet the requirements of [the] Labor Code §407A.051(c) and §5.6403 of this title [division] as those requirements apply to any change of information identified by a group under [pursuant to] subsection (a) of this section.

(c) A group must [shall] provide written notice to the department no later than 10 days of first becoming aware that any hazardous financial condition exists, or that, in the opinion of its administrator, any hazardous financial condition is likely to occur. For purposes of this subsection only, hazardous financial conditions include the conditions described in [the] Labor Code §407A.355(a) and (b), concerning Deficits; Insolvencies, and any event, series of events, or negative trend that may affect the group's ability to continue as a viable group.

(d) A group must [shall] acknowledge its responsibilities under this section by executing a statement that it will meet the notifica-

tion requirements of subsections (a) and (c) of this section and filing it with the department.

(e) A group is required to maintain at all times the qualifications necessary to obtain a certificate of approval issued under [~~the~~] Labor Code Chapter 407A, concerning Group Self-Insurance Coverage [~~at all times~~].

§5.6405. Excess Insurance.

(a) Unless otherwise approved by the commissioner, a group must [~~shall~~] obtain excess insurance for losses that exceed a group's retention in an amount that will pay all benefits required under the Labor Code and rules adopted thereunder for a compensable claim.

(b) The group must [~~shall~~] obtain and maintain excess insurance coverage from an insurer that has a certificate of authority from the department [~~Texas Department of Insurance~~] or from an eligible surplus lines insurer in compliance with Insurance Code Chapter 981, concerning Surplus Lines Insurance, [~~of the Texas Insurance Code~~] and related provisions of the Texas Administrative Code, provided that:

(1) the surplus lines insurer is also certified as a trusteed reinsurer by the department [~~Texas Department of Insurance~~], in accordance with [~~Insurance Code, Article 5.75-1(b)(3) (effective April 1, 2007, Article 5.75-1(b)(3) is repealed and re-adopted as~~] Insurance Code §§493.102, concerning Credit for Reinsurance Generally; 493.152, concerning Composition of Trust; 493.153, concerning Form of Trust; 493.154, concerning Terms of Trust; [-] 493.155, concerning Reports and Certification; and 493.157, concerning Authorized Reinsurance; Credit and Accounting [~~495 157~~)];

(2) the surplus lines insurer maintains a financial strength rating of "A-" or better, as determined by A.M. Best Company;

(3) the surplus lines insurer provides a clean, irrevocable, and unconditional letter of credit in favor of the group as beneficiary and held by the group, subject to withdrawal solely by and under the exclusive control of the group, to secure the payment of losses, including losses, loss adjustment expenses, incurred but not reported losses, and any other obligation of the surplus lines insurer under the terms and conditions of the excess insurance policy, whether paid or unpaid by the group:

(A) in no less than the greater of:

(i) the amount of actuarially projected losses to ultimate; or

(ii) the amount of actual losses to ultimate;

(B) issued by a qualified United States financial institution as defined in [~~Insurance Code, Article 5.75-1(e) (effective April 1, 2007, Article 5.75-1(e) is repealed and re-adopted as~~] Insurance Code §§493.002, concerning Applicability of Chapter; 493.102, concerning Credit for Reinsurance Generally, and 493.104, concerning Credit for Funds Securing Reinsurance Obligations[~~)~~]; and

(C) provided the letter of credit is in a form acceptable to the department [~~Texas Department of Insurance~~] and meets the requirements in 28 TAC §7.610 (relating to Letter of Credit Requirements), except for those requirements that apply solely to reinsurance agreements;

(4) the group timely collects recoverables and receivables from the surplus lines insurer, but in no event, later than 90 days, including, if needed, drawing down on the letter of credit;

(5) the group submits the surplus lines policy forms, renewal forms, certificates, endorsements and amendments applicable thereto, and any agreements between the surplus lines insurer and the group to the department [~~Texas Department of Insurance~~] for review prior to use and the group may not accept or enter into any agreement or arrangement with the surplus lines insurer that has not been reviewed by the department [~~Texas Department of Insurance~~];

(6) the group demonstrates to the satisfaction of the department [~~Texas Department of Insurance~~] that the group meets the requirements of subsection (b) of this section before obtaining and in order to maintain excess insurance coverage from an eligible surplus lines insurer; and

(7) the group notifies the commissioner [~~Commissioner~~] in writing no less than five calendar days after receiving notice of cancellation or nonrenewal of the excess insurance policy and no less than 30 calendar days before [~~prior to~~] the effective date of any proposed change in the excess insurance policy, by endorsement or otherwise.

(c) A group may petition the department to obtain excess insurance in an amount that is different than the amount required by subsection (a) of this section. In determining whether to grant a group's petition, the commissioner will [~~shall~~] consider the current market conditions; a group's size, types of employment, years in existence, and risk exposure; other forms, if any, of additional financial security available to the group; and any other relevant factor. In no event, however, may [~~shall~~] a group's excess insurance coverage be less than $10 million per occurrence.

(d) To assist the commissioner in making the determination under subsection (c) of this section, the group must [~~shall~~], at a minimum, submit an analysis prepared by an actuary of the appropriate level of specific excess insurance for the group.

§5.6406. Indemnity Agreement.

The indemnity agreement required by Labor Code §407A.051(c)(14), concerning Application for Initial Certificate of Approval; Approval Requirements, and §407A.056, concerning Indemnity Agreement Requirements, must be executed by all employers in the group and must [~~shall~~] contain the following provisions.[~~:~~]

(1) THIS IS A LEGAL DOCUMENT THAT BINDS THE SIGNATORIES TO SPECIFIC DUTIES AND RESPONSIBILITIES REGARDING GROUP FINANCIAL ARRANGEMENTS FOR COVERING WORKERS' COMPENSATION INJURIES AND OCCUPATIONAL DISEASE AND EMPLOYERS LIABILITY INSURANCE COVERAGE IN THE STATE OF TEXAS.

(2) JOINT AND SEVERAL LIABILITY: THIS PARAGRAPH REQUIRES THE EMPLOYER TO JOIN IN PAYING WORKERS' COMPENSATION LOSSES OF THE GROUP IN THE EVENT THE GROUP'S ASSETS ARE NOT SUFFICIENT TO COVER THE LIABILITIES. The Employer will be jointly and severally obligated with each other member of the group to meet the workers' compensation and employer's liability insurance coverage obligations of the group and to make any and all payments to the group, which may be necessary to meet the group's obligations under applicable Texas law and regulations and also in accordance with the group's Bylaws; including agreeing that if the assets of the group are at any time insufficient to enable the group to discharge the group's legal liabilities and other obligations and maintain the reserves required of it under applicable Texas statutes and regulations, and the group is unable to otherwise make up the deficiency in accordance with Texas laws, regulations, and the group's Bylaws, then the Employer will be jointly and severally liable to pay an assessment by the group in an amount necessary to make up the deficiency.

(3) The Employer remains jointly and severally liable even if the Employer is cancelled by the group or elects to terminate membership in the group. The Employer will remain jointly and severally liable for the workers' compensation and employer's liability insurance

coverage obligations for the group and its members that were incurred during the Employer's period of membership.

(4) The insolvency or bankruptcy of the Employer will not relieve the group, the Employer, or any member from liability for the payment of any benefits incurred during the insolvency or bankrupt member's period of membership.

(5) The Employer is not buying a policy of insurance. The employer is entering into an agreement which is evidence that the employer is a subscriber to the Texas workers' compensation system.

(6) Because the sums required to fulfill workers' compensation and employer's liability insurance coverage obligation of the group cannot be known precisely in advance, the premium and other assessments, reserve requirements, and other financial requirements for the group's operation will initially be established by estimates.

§5.6407. Acknowledgment [~~Acknowledgement~~] of Indemnity Agreement.

(a) Each member must [~~shall~~] execute the acknowledgment [~~acknowledgement~~] set forth in subsection (b) of this section. The acknowledgment must [~~acknowledgement shall~~] be printed in black ink on an 8-1/2-inch [8 ~~1/2~~ ~~inch~~] by 11-inch [~~11 inch~~] sheet of white paper in at least 11-point [~~11 point~~] type.

(b) The acknowledgment [~~acknowledgement~~] form is as follows:

Figure: 28 TAC §5.6407(b) (No change.)

§5.6408. Fidelity and Performance Bonds.

(a) Fidelity bonds required of an administrator under [~~the~~] Labor Code §407A.051(c)(12), concerning Application for Initial Certificate of Approval; Approval Requirements, and §5.6403(c)(6) of this title [~~division~~] (relating to Application for Initial Certificate of Approval) and a service company under [~~the~~] Labor Code §407A.051(c)(13) and §5.6403(c)(7) of this title (relating to Acknowledgment of Indemnity Agreement) [~~division~~] must protect against loss caused directly by an act of fraud or dishonesty by the employees of the administrator or service company and such fidelity bond must [~~shall~~] include the group as a loss payee.

(b) A performance bond required under [~~the~~] Labor Code §407A.057(a), concerning Additional Performance Bond Requirements, and §5.6403(c)(8) of this title (relating to Fidelity and Performance Bonds) [~~division~~] for a service company providing claims services to or on behalf of a group must [~~shall~~] be in substantially the form set forth in subsection (c) of this section.

(c) A performance bond required under [~~the~~] Labor Code §407A.057(a) and §5.6403(c)(8) of this title must [~~division shall~~] contain the following text and must [~~shall~~] be in the following format:

Figure: 28 TAC §5.6408(c) (No change.)

(d) Administrators and service companies may [~~only~~] obtain a fidelity or performance bond only from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with [~~the~~] Insurance Code Chapter 981, concerning Surplus Lines Insurance, and regulations adopted under it [~~thereunder~~].

(e) An administrator or service company that has a fidelity or performance bond canceled [~~cancelled~~] or terminated and not replaced with new coverage that meets the requirements of [~~the~~] Labor Code Chapter 407A, concerning Group Self-Insurance Coverage, and this division and that is effective concurrently upon the date of the cancellation or termination must [~~shall~~]:

(1) immediately inform the commissioner in writing, which in no event may [~~shall~~] be later than five business days from the date the administrator or service company first becomes aware of the cancellation or termination; and

(2) immediately inform the group in writing, which in no event may [~~shall~~] be later than five business days from the date the administrator or service company first becomes aware of the cancellation or termination.

§5.6409. Books and Records.

(a) Except as otherwise provided in this division, this section applies to all books and records of a group, regardless of whether the books and records are located in [~~the State of Texas~~] or outside [~~the State~~] of Texas.

(b) A group's books and records must be located within the United States of America and its territories at all times, but may be located outside [~~the State~~] of Texas, provided that the group provides prior written notice to the department that:

(1) states [~~provides~~] the specific address outside [~~the State~~] of Texas where the group's books and records will be located;

(2) identifies the types of books and records that will be located outside [~~the State~~] of Texas, including those that will be maintained in an electronic format;

(3) if applicable, identifies the vendor of a leased or purchased software or electronic platform that [~~who~~] will provide services to the group related to the maintenance of the group's books and records; and

(4) if applicable, includes the group's continuity plan in the event of cancellation or termination of the arrangement with a vendor identified by the group under [~~pursuant to~~] paragraph (3) of this subsection.

(c) All books and records of a group must [~~shall~~] be:

(1) electronically or physically accessible to the department upon the department's request; and

(2) maintained in a manner that provides an audit trail between the group's general ledger and the group's source documents.

(d) A group's electronic books and records must be maintained with reasonable controls to ensure the integrity, accuracy, and reliability of the electronic storage system and to prevent the deterioration of the electronic books and records.

(e) A group must ensure a weekly backup of its electronic books and records.

(f) A group must be able to access a complete and current set of its electronic books and records or a complete and current backup of its electronic books and records from a location in [~~the State of~~] Texas at all times.

(g) This section does not in any way limit the commissioner's authority under [~~the~~] Labor Code §407A.252, concerning Examination, and §407A.355, concerning Deficits; Insolvencies.

(h) To the extent of a conflict between this section and [~~the~~] Labor Code §407A.252 or §407A.355, [~~the~~] Labor Code §407A.252 or §407A.355 prevails.

(i) A group holding a certificate of approval issued before [~~prior to~~] the effective date of this section must [~~shall~~] comply with this section's provisions [~~the provisions of this section~~] no later than 30 days after this section's [~~the~~] effective date [~~of this section~~].

§5.6410. Investments.

(a) The board of trustees must [~~shall~~] maintain responsibility for all money collected or disbursed from the group.

(b) The board must [~~shall~~] annually adopt a written investment plan consistent with the requirements for the investments authorized under Insurance Code [~~Article 2.10 and~~] §822.204, concerning Form of Capital and Surplus, for minimum capital and surplus and reserves. The investment plan must [~~shall~~] meet the requirements of Insurance Code §822.204 [~~Article 2.10(a)~~].

(c) With the prior written approval of the commissioner [~~Commissioner~~], a group may invest up to 5% of its assets in a manner other than that authorized under this section.

(d) The group must [~~shall~~] hold all investments in accordance with [~~Texas~~] Insurance Code Chapter 422, concerning Asset Protection Act [~~Article 21.39B~~].

§5.6411. Contract Provisions.

(a) A group must [~~shall~~] execute a written agreement with a person identified under [~~pursuant to~~] §5.6403(c)(12)(A) or (B) of this title [~~division~~] (relating to Application for Initial Certificate of Approval) that meets the requirements of this section.

(b) If a person identified under [~~pursuant to~~] §5.6403(c)(12)(A) or (B) of this title [~~division~~] delegates any of the services that it has agreed to provide on behalf of a group to another person, the delegating person must [~~shall~~] execute a written agreement with the person to whom the services are delegated. The written agreement must meet the requirements of this section.

(c) A group retains ultimate accountability and responsibility for compliance with all statutory and regulatory requirements, and no written agreement may be construed to limit, in any way, the group's ultimate accountability and responsibility.

(d) A written agreement entered into under [~~pursuant to~~] subsection (a) or (b) of this section must [~~shall~~] include:

(1) a requirement that the administrator, service company, or third-party [~~third party~~] administrator must comply with the applicable requirements of the Insurance Code, [~~and the~~] Labor Code, and rules adopted under them [~~thereunder~~], including holding the appropriate licenses or certificates of authority under the Insurance Code or [~~the~~] Labor Code;

(2) a requirement that the administrator, service company, or third-party [~~third party~~] administrator must permit the commissioner or the group to examine at any time:

(A) its financial solvency; and

(B) its ability to perform its responsibilities under the written agreement;

(3) a description of the duties or services that the administrator, service company, or third-party [~~third party~~] administrator is expected to provide and any applicable instructions related to the performance of those services, including references to a group's claims handling practices or procedures; and

(4) a provision relating to continuity of services, including run-off [~~run off~~] fee schedules and the transfer of the books and records of a group from one administrator, service company, or third-party [~~third party~~] administrator to another administrator, service company, or third-party [~~third party~~] administrator.

(e) A written agreement entered into under [~~pursuant to~~] subsection (a) or (b) of this section must [~~shall~~] also ensure that the books and records of the group:

(1) remain the property of the group at all times;

(2) are available to the group or its designee at any time while in the custody of an administrator, service company, or third-party [~~third party~~] administrator; and

(3) will be timely transferred to the group or its designee:

(A) upon request of the group;

(B) at the termination or cancellation of a written agreement entered into by an administrator, service company, or third-party [~~third party~~] administrator under [~~pursuant to~~] subsection (a) or (b) of this section; and

(C) in compliance with all applicable statutory and rule requirements.

(f) A written agreement required under subsection (a) or (b) of this section must meet the requirements of this section no later than June 1, 2009.

§5.6413. Membership Cancellation or Termination.

(a) A group is required to notify the commissioner under [~~pursuant to the~~] Labor Code §407A.201(c), concerning Admission of Employer as Member, only if the group experiences a reduction in membership, caused by either cancellation or termination, resulting in a cumulative reduction of 10% [~~10 percent~~] or more of its annual written premium, not later than the 10th day after the date on which the cumulative reduction in membership takes effect.

(b) The notification required by subsection (a) of this section must include:

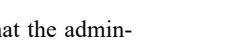
(1) an explanation of the reason for the cancellation or termination of each member of the group; and

(2) a statement indicating how the group anticipates addressing the membership loss, including whether [~~or not~~] assessments of the remaining members of the group will be necessary.

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

Filed with the Office of the Secretary of State on July 14, 2026.

TRD-202602896
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 676-6555



CHAPTER 6. CAPTIVE INSURANCE
SUBCHAPTER G. TAXES

28 TAC §6.601

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §6.601, concerning the waiver of workers' compensation surcharge. The amendments to §6.601 implement Senate Bill 1455, 89th Legislature, 2025.

EXPLANATION. Amending §6.601 is necessary to implement SB 1455, which amended the Insurance Code and Labor Code to replace the collection of maintenance taxes for workers' compensation insurance policies with the collection of workers' compensation surcharges.

The amendments to §6.601 add to its title "Surcharges and Fees" to more fully reflect the text of the section, and add "surcharges" to follow "taxes" in addressing what a redomesticating foreign or alien captive insurance company may request the commissioner to waive under subsection (d) and add the phrase "workers' compensation surcharges" to the items in the list that follow it. The amendments also make nonsubstantive changes for plain language and to adhere to current agency style.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Amy Maddox, chief financial officer of the Financial Services Office in the Administrative Operations Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments, other than that imposed by statute. Ms. Maddox made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Maddox does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Maddox expects that administering the proposed amendments will have the public benefits of ensuring that TDI's rules conform to SB 1455 and allow Texas-based workers' compensation insurers to be more competitive out of state.

Ms. Maddox expects that the proposed amendments will not increase the cost of compliance with §6.601 because it does not impose requirements beyond those in the statute. SB 1455 requires that the same maintenance taxes paid as before will now be classified as surcharges for workers' compensation insurance. As a result, the cost associated with the change of terminology required by SB 1455, does not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. SB 1455 does not change the amount of money insurers must pay under the statute. It only changed the name of maintenance taxes to surcharges. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. In addition, no rule amendments are required under Government Code §2001.0045 because the proposed amendments to §6.601 are necessary to implement legislation. The proposed rule implements Insurance Code §§201.001(a), 201.051(a) and (d), 251.001(a), 251.002 - 251.004, 255.001 - 255.005, 281.006; and Labor Code §§402.076(b), 403.001 - 403.005, 405.003, 403.0055, 407.103 - 407.104, 407A.252(b), and 407A.301 - 407A.303, as added by SB 1455.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on August 31, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2870. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on August 25, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.035. Visit www.tdi.texas.gov/alert/event/index.html for more information on the proposed rule, hearing, and comment submission.

STATUTORY AUTHORITY. TDI proposes amendments to §6.601 under Insurance Code §§251.001, 964.069, 2051.201, and 36.001.

Insurance Code §251.001 requires the commissioner to annually determine the rate of assessment of each maintenance tax or workers' compensation surcharge imposed under Title 3, Subtitle C of the Insurance Code.

Insurance Code §964.069 authorizes the commissioner to adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 964.

Insurance Code §2051.201 authorizes the commissioner to adopt and enforce rules to carry out provisions of law referenced in §2051.002, which includes Insurance Code Chapter 251 as that chapter relates to workers' compensation insurance.

Insurance Code §36.001 authorizes the commissioner to adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of the state.

CROSS-REFERENCE TO STATUTE. Section 6.601 implements SB 1455 and Insurance Code §964.071.

§6.601. Waiver of Taxes, Surcharges, and Fees.

(a) A foreign or alien captive insurance company redomesticating from another jurisdiction may request that the commissioner postpone or waive [~~the imposition of~~] any tax or fee imposed under the Insurance Code for a period not to exceed two tax reporting years from the date of redomestication.

(b) The request must be in writing and submitted to the department with the application.

(c) The request must state and provide support of the benefit that licensing the captive insurance company will have for Texas, including, as applicable, employment of Texas residents, the development of real estate in Texas, economic activity in Texas, and additional taxes that will be paid in Texas.

(d) The commissioner may, in writing, grant or deny the waiver request, in whole or in part, at the commissioner's sole discretion, including granting a waiver for all or part of the two-year period and all or part of one or more of the following taxes or fees:

(1) the maintenance tax;

(2) the premium tax; [~~or~~]

(3) licensing fees; or [~~.~~]

(4) workers' compensation surcharges.

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

Filed with the Office of the Secretary of State on July 16, 2026.

TRD-202602937
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 676-6555

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CHAPTER 21. TRADE PRACTICES

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§21.109, 21.120, 21.701, 21.705, 21.3003, 21.4003, 21.4502, 21.4703, 21.5501, and 21.5503 concerning trade practices. The amendments implement House Bills 721, 1620, and 2221, and Senate Bills 1236 and 1332, 89th Legislature, 2025; House Bill 4611, 88th Legislature, 2023; and House Bill 2090, 87th Legislature, 2021.

EXPLANATION. Amendments to §§21.109, 21.701, 21.3003, 21.4003, 21.4502, 21.4703, and 21.5501 are necessary to implement the following legislation. From the 89th Legislature:

- HB 721 revises the applicability of Insurance Code Chapter 1662 to remove regional and local health care programs that operate under Health and Safety Code Chapter 75.

- HB 2221 moves requirements concerning unlawful rebates and inducements to new Insurance Code Chapter 1702.

- SB 1236 requires the inclusion of unique group numbers on pharmacy benefit ID cards.

- SB 1332 permits health benefit plans to waive a group policyholder's liability under the circumstances outlined in the bill.

From the 88th Legislature, HB 4611 reorganized Medicaid managed care provisions in the Government Code by repealing Chapter 533 and adding new Chapter 540.

From the 87th Legislature, HB 2090 created price transparency requirements for certain health benefit plans.

To implement other provisions of SB 1236, HB 2221, and HB 1620, TDI proposed to amend 28 TAC Chapters 3 (51 TexReg 3043), 11 (51 TexReg 3058), and 26 (51 TexReg 3081) in the May 8, 2026 issue of the *Texas Register*; and 28 TAC Chapter 19 (51 TexReg 3320) in the May 15, 2026 issue of the *Texas Register*.

Descriptions of the sections' proposed amendments follow.

Section §21.109. To implement HB 2221, the proposed amendments to §§21.109(a)(1) and 21.109(a)(3) replace the term "health related services or health related information" with "loss-control or value-added products or services" to conform with terminology used in new Insurance Code Chapter 1702.

The proposed amendments to §21.109(a)(2) reference the definition for "loss-control or value-added products or services" and add a citation to Insurance Code §1702.002. The amendments also remove subparagraphs (A) and (B) of §21.109(a)(2), which contain definitions for "health-related services" and "health-related information." Those terms are no longer relevant, since HB 2221 repealed Insurance Code §541.058.

Section §21.120. The proposed amendments to §21.120(a) update and clarify instructions for submission of advertising filings. The requirement to include a transmittal letter addressed to TDI's mailing address is removed and replaced with instructions to submit an advertisement consistent with filing procedures in 28 TAC Chapter 3, Subchapter A. Those rules were modernized in 2025 and clarify that advertising filings are submitted through the System for Electronic Rates and Forms Filing (SERFF). The amendments to subsection (a) clarify that the contents specified in paragraphs (1) - (6) must be included in the filing, rather than in a transmittal letter. Consistent with 28 TAC §3.11, this eliminates unnecessary duplication because some of the information may be captured in SERFF data fields.

TDI proposes to remove current §21.120(b), since the department no longer requires advertisements to be filed in duplicate. The remaining subsections are redesignated to reflect this removal.

The proposed amendments to current §21.120(d), redesignated as §21.120(c), modify the subsection to align with filing rules in 28 TAC Chapter 3, Subchapter A. The term "the same as" is replaced with "an exact copy," with reference to the definitions in 28 TAC Chapter 3, Subchapter A. The amendments clarify that the process to submit a substantially similar advertising file is to classify the filing as informational when submitting in SERFF. The requirement to include a signed statement is amended to require a signed certification, with reference to the requirements in 28 TAC Chapter 3, Subchapter A. The term "SERFF filing number" replaces the reference to the department's filing number.

Section §21.701. The proposed amendments to §21.701 implement HB 2221 by replacing the reference to Insurance Code §541.057 with Insurance Code §1702.103 and §1702.153, since §541.057 was repealed by HB 2221.

Section §21.705. The proposed amendments to §21.705 update the types of HIV tests that may be used for underwriting purposes by replacing references to outdated tests with tests rec-

ommended by the Centers for Disease Control and Prevention (CDC).

Section §21.3003. The proposed amendments to §21.3003 correct a citation in subsection (a)(3) by replacing the reference to Insurance Code Chapter 1251, Subchapter E with Subchapter G, which addresses continuation of coverage for dependents. This change aligns the citation with the original version of the rule, which referenced Article 3.51-6, §3B.

Amendments to §21.3003(b)(3) improve readability by breaking the paragraph into subparagraphs (A) and (B) to separately address group and individual health benefit plans and add a reference to the group number requirements in new subsection (e).

TDI proposes new §21.3003(e) and (f) to implement SB 1236. New subsection (e) requires that a group number on an identification card must distinguish between lines of business, such that a group number provided to an enrollee in a plan subject to Insurance Code Chapter 1369, Subchapter D, cannot be assigned to an enrollee in a plan that is not subject to Subchapter D. Additionally, unique group numbers must be assigned for each line of business specified in Insurance Code §1251.151(b), which addresses employer plans for state employees, teachers, and university employees, as well as Medicaid and CHIP. Since these plans are exempt from many of the requirements in Insurance Code Chapter 1369, using the same group numbers could create confusion.

New §21.3003(f) requires a health benefit plan issuer to provide a method to identify, based on the group number provided on the identification card, whether an enrollee is covered by a plan that is subject to Insurance Code Chapter 1369, Subchapter D. For example, the issuer could include an identifier within the group numbering convention, or the issuer could maintain a list of group numbers that are associated with applicable health benefit plans. New §21.3003(f) requires the issuer to make the identification method publicly available on its website.

Section §21.4003. The proposed amendment to §21.4003 implements SB 1332 by adding new subsection (c). The new subsection clarifies that if a health carrier chooses to waive an employer's liability for a terminated employee's premium as allowed by Insurance Code §843.210(e) and §1301.0061(e), the carrier must do so in a manner that ensures equal treatment of similarly situated employer groups.

Also, an amendment to §21.4003(a)(3)(B) updates examples of what might constitute immediate written notification.

Section §21.4502. The proposed amendment to §21.4502(c)(4) removes the outdated reference to Government Code 533 and replaces it with Government Code Chapter 540, consistent with HB 4611.

Also, an amendment to §21.4502(f) corrects a citation by adding the words "Insurance Code."

Section §21.4703. The proposed amendments to §21.4703 replace the reference to Insurance Code §541.056(a) with §1702.102, consistent with HB 2221.

Section §21.5501. The proposed amendments to §21.5501 implement HB 721. The proposal deletes paragraph (3) of §21.5501(a) and adds new paragraph (5) to §21.5501(b), to clarify that the rules in Subchapter UU no longer apply to a regional or local health care program. To conform to HB 4611, an amendment is proposed to revise the Government Code reference in §21.5501(b)(4) from Chapter 533 to Chapter 540. Additionally, the proposal removes §21.5501(c) - (e), which address the initial implementation deadlines, because those are no longer relevant.

Section §21.5503. The proposal amends §21.5503(a), (b), and (d), updating data schemas for the "in-network rates," "allowed-amounts," "table-of-contents" and files. The version 2.0 schemas replace the version 1.1 schemas and conform to schema updates published October 1, 2025, by the Centers for Medicare and Medicaid Services (CMS) https://github.com/CMSgov/price-transparency-guide. The schema updates focus on improving the organization of machine-readable files and reducing duplication. The schema for the "prescription-drugs" file in subsection (c) is not being updated, because CMS, after initially delaying enforcement, has not finalized a schema for prescription drugs. The proposal deletes subsection (e) because CMS no longer publishes a separate provider reference file schema.

TDI has posted a redline copy of the data schemas on the department's website that illustrates the changes between version 1.1 and version 2.0. Changes include adding and removing data fields; making some fields required that were previously optional; and updating definitions to modify or clarify instructions.

A non-exhaustive summary of the changes made in version 2.0 of the data schemas follows:

- New required fields "last_updated_on" and "version" are added to the Table of Contents File Schema. The "version" field is changed to being a required field in the In-Network File Schema and the Out-Of-Network Allowed Amount File Schema.

- New fields "issuer_name" and "plan_sponsor_name" are added, and the definition of the "plan_name" field is updated to remove the name of the plan sponsor and insurance company, which are now included as separate fields. These changes are made within the Reporting Plans Object of the Table of Contents File Schema, and the In-Network and Out-Of-Network Allowed Amount File Schemas. Explanations of the use of the new fields are included in Additional Notes sections.

- The definition of the "plan_id" field is updated to specify the instructions with reference to the "plan_id_type", use a HIOS identifier that is 10 digits instead of 14, and specify that the employer identification number is associated with a plan sponsor. This change is made within the Reporting Plans Object of the Table of Contents File Schema, and the In-Network and Out-Of-Network Allowed Amount File Schemas.

- Within the File Location Object of the Table of Contents File Schema, the definition of the "location" field is updated to reference the full HTTPS URL.

- Within the In-Network Object of the In-Network File Schema, a "severity_of_illness" field is added and "description" is now a required field. The definition of the "covered_services" field updated to align with the renaming of the Covered Services Object.

- Within the In-Network File Schema, the Covered Services Object is renamed as the Contained Billing Code Object, and the Bundle Code Object is removed.

The "billing_code_type_version" definition is updated to specify instructions if there is no version available for the "billing_code_type". This change is made in the In-Network and Contained Billing Code Objects of the In-Network File Schema and the Out-Of-Network Object of the Out-Of-Network Allowed Amount File Schema.

- Within the Negotiated Rate Details Object of the In-Network File Schema, the "provider_groups" field is removed and the "provider_references" field is changed to be required. The "Additional Notes Concerning provider_groups, provider_references" section is also removed.

- Within the Providers Object of the In-Network File Schema, the definition of the "npi" field is expanded to include both Type 1 and Type 2 NPIs and associated reporting instructions.

Within the Tax Identifier Object of the In-Network File Schema, a new "business_name" field is added. The Additional Notes section is expanded to include instructions depending on whether a contractual arrangement is made at the NPI or TIN level.

- Within the Provider Reference Object of the In-Network File Schema, the "location" field is removed and a required "network_name" field is added. The "provider_groups" field is changed to be required. The "Additional Notes Concerning provider_group, location" section is removed.

- Within the Negotiated Price Object of the In-Network File Schema, the "negotiated_rate" field definition is updated to allow a percentage amount. The "service_code" field is changed to required. A new required "setting" field is added. The definition of the "additional_information" field is expanded to instruct users to submit a question through Github before using this field. The Additional Notes section is expanded to address additional allowable values for the "negotiated_type" field, and to address the use of a custom value to avoid listing all possible service codes in some circumstances.

Nonsubstantive updates are made to the formatting and hyperlinks within the schema document.

In addition, proposed amendments to the sections include nonsubstantive editorial and formatting changes to conform the sections to the agency's current drafting style and plain language preferences to improve clarity. These changes appear throughout the amended sections and include adding titles to statutory citations, updating cross-references to other rules, nonsubstantive text edits, and other grammatical, punctuational, and format changes.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the proposed amendments, other than that imposed by the statute. Ms. Bowden made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Bowden expects that administering the proposed amendments will have the public benefit of ensuring that TDI's rules conform to HBs 1620 and 2221, and SBs 1236 and 1332.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance. Any costs for those required to comply with the proposed amendments are attributable to HBs 1620 and 2221, and SBs 1236 and 1332. The proposed amendments do not impose requirements beyond those in the statute.

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

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. In addition, no additional rule amendments would be required under Government Code §2001.0045 because the proposed amendments are necessary to implement legislation. The proposed rule amendments implement the following bills from the 89th legislative session: HB 1620, HB 2221, SB 1236 and SB 1332.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will expand, limit, or repeal an existing regulation;

- will increase or decrease the number of individuals subject to the rule's applicability;

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on August 31, 2026. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2871 at 10:00 a.m., central time, on August 25, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.035. Details of how to view and participate virtually in the public hearing will be made available on TDI's website at www.tdi.texas.gov/alert/event/index.html.

SUBCHAPTER B. ADVERTISING, CERTAIN TRADE PRACTICES, AND SOLICITATION

DIVISION 1. INSURANCE ADVERTISING

28 TAC §21.109, §21.120

STATUTORY AUTHORITY. TDI proposes amendments to §21.109 and §21.120 under Insurance Code §§541.401, 562.106, 1702.006, and 36.001.

Insurance Code §541.401 authorizes the commissioner to adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §562.106 provides that if the commissioner reasonably believes that a program operator or marketer may not be operating in compliance with Insurance Code Chapter 562, the commissioner by order may require the program operator or marketer to submit to the commissioner any advertisement, solicitation, or marketing material, discount card, agreement, or other document requested by the commissioner.

Insurance Code §1702.006 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. Section 21.109 implements Insurance Code Chapter 1702.

§21.109. Unlawful Inducement.

(a) An advertisement may not state or imply anything offering or tending to offer a good, service, or other guarantee or contractual right of pecuniary value outside of the express terms of the policy offered by the advertisement.

(1) This subsection does not prohibit, in connection with an accident and health insurance policy or health maintenance organization contract, the provision of loss-control or value-added products or services [~~health-related services or health-related information~~], or the disclosure in advertising of the availability of such additional services and information, to prospective policy or certificate holders, or prospective enrollees or contract holders. If there is a separate charge required to access such additional services or information, an advertisement referencing the services or information must disclose that fact.

(2) In this subsection, the term "loss-control or value-added products or services" is defined in accordance with Insurance Code §1702.002, concerning Regulation of Certain Trade Practices.[~~:~~]

[~~(A) Health-related services" are defined in accordance with the Insurance Code §541.058.~~]

[~~(B) "Health-related information" is defined in accordance with the Insurance Code §541.058.~~]

(3) An advertisement referencing noncontractual loss-control or value-added products or services [~~health-related services or health-related information~~] must disclose that such services or information are not a part of the policy, may be discontinued at any time, and, as appropriate, may be subject to geographic availability.

(b) No insurer or agent may state or imply as an inducement to the purchase of insurance a guarantee of return of premium based on [~~upon~~] the quality of its policy other than where such guarantee is required by law or stated within the policy of insurance offered.

(c) An advertisement may offer an incentive to inquire about a policy or obtain a quote if [~~provided that~~] it includes a clear and conspicuous disclosure that no purchase is required [~~in order~~] to receive the incentive.

(d) No advertisement may state or imply any advantage, right, or preference that [~~which~~] if granted or performed would be a violation of the public policy or any law of this state or of the United States of America.

(e) An advertisement may not state or imply any deviation in normal or usual cost that is not in fact legally allowable.

(f) An advertisement may not state or imply an advantage by purchase of insurance to be gained by an organization because of past or prospective donation to be made by an insurer, agent, or representative out of proceeds of purchase.

§21.120. Insurance Advertising.

(a) Any advertisement required to be submitted or submitted voluntarily by an insurer licensed to do business in Texas must be submitted to TDI consistent with filing procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). The filing [~~accompanied by a transmittal letter addressed to the Texas Department of Insurance, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. The transmittal letter~~] must contain the following information:

(1) the identifying form number of each form submitted, including a separate identifying form number for each webpage [~~Internet page~~] and pop-up having a distinct URL;

(2) the type of advertisement submitted, i.e., institutional advertisement, invitation to inquire, or invitation to contract;

(3) the form number [~~numbers~~] of each [~~the~~] approved policy or [~~and/or~~] rider [~~form(s)~~] advertised;

(4) the method or media used for dissemination of the advertisement;

(5) the form number [~~number(s)~~] for all other advertising material to be used with each advertisement [~~the advertisement(s)~~] being submitted; and

(6) an attachment explaining all variable material; the variable material must be identified with brackets on the advertisement [~~advertisement(s)~~].

[~~(b) All advertisements must be submitted in duplicate.~~]

(b) [~~(c)~~] Advertisements may be submitted in printers' proof or as "pasteups."

(c) [~~(d)~~] An advertisement subject to requirements regarding filing of the advertisement with the department for review under the Insurance Code or this title [~~Texas Administrative Code, Title 28, and~~] that is an exact copy [~~the same as~~] or substantially similar to an advertisement previously reviewed and accepted by the department, is not required to be filed for review. For the purposes of this subsection, "exact copy" and "substantially similar" have the meanings assigned in §3.2 of this title (relating to Definitions). [~~means the new advertisement does not introduce any substantive content not previously reviewed, nor does it eliminate any content satisfying required disclosures or that would render the advertisement noncompliant with §21.112 of this title (relating to General Prohibition).~~] A person or entity wishing to introduce a "substantially similar" advertisement must submit an informational filing in SERFF that includes a signed certification for a substantially similar filing consistent with the requirements in Chapter 3, Subchapter A, of this title. The filing [~~file a signed written statement with the department at the address identified in subsection (a) of this section. Such statement~~] must identify or illustrate the changes to be introduced, and list each [~~the~~] previously reviewed and accepted form [~~form(s)~~] in which those changes would appear, includ-

ing the form [~~number(s)~~] and the SERFF filing number [~~department's filing number(s) under which~~] those forms were previously reviewed and accepted under.

(d) [~~(c)~~] The following rules require that advertisements be filed with the department for review at or before [~~prior to~~] use:

(1) §3.1744 of this title (relating to Advertising, Sales, and Solicitation Materials; Filing Prior to Use), regarding life settlement contracts;

(2) §3.3313 of this title (relating to Filing Requirements for Advertising), regarding Medicare supplement insurance;

(3) §3.3838 of this title (relating to Filing Requirements for Advertising), regarding long-term care insurance; and

(4) §11.603 of this title (relating to Filings), regarding certain Medicare HMO contracts.

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

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Jessica Barta
General Counsel
Texas Department of Insurance
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SUBCHAPTER H. UNFAIR DISCRIMINATION

28 TAC §21.701, §21.705

STATUTORY AUTHORITY. TDI proposes amendments to §21.701 and §21.705 under Insurance Code §545.003, §1702.006, and §36.001.

Insurance Code §545.003 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 545 and rules to be followed for an HIV-related test requested or required by an issuer.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. Section 21.701 implements Insurance Code §544.002, §545.056, and Chapter 1702.

§21.701. Purpose.

The purpose of these sections is to identify specific acts or practices that [~~which~~] are prohibited by Insurance Code §1702.103 and §1702.153, concerning Prohibited Distinctions and Discrimination [~~541.057~~] and §544.002, concerning Unfair Discrimination.

§21.705. Nondiscriminatory Testing for Human Immunodeficiency Virus.

A proposed insured for life or health and accident insurance, or for coverage by a company licensed under Insurance Code Chapter 842, or with a licensed health maintenance organization may be required to be tested for the presence of the human immunodeficiency virus (HIV). Requiring such testing is not unfair discrimination provided:

(1) the testing is required on a nondiscriminatory basis for all individuals in the same class; [~~and~~]

(2) no proposed insured is denied coverage or rated a substandard risk on the basis of such testing unless:

(A) the proposed insured is tested to determine the existence of HIV antibodies or antigens in the blood using a test that is included in the current Centers for Disease Control and Prevention (CDC) recommended laboratory HIV testing algorithm for serum or plasma specimens; and [~~an initial enzyme linked immunosorbent assay (ELISA) test is administered to the proposed insured, and it indicates the presence of HIV antibodies;~~]

(B) the test is considered positive only if testing results meet the most current CDC recommended HIV testing algorithm or a more reliable confirmatory test or test protocol [~~a second ELISA test is conducted and it indicates the presence of HIV antibodies~~]; and

[~~(C) a Western Blot test is conducted and it confirms the results of the two ELISA tests.~~]

(3) the tests and testing procedures used have been approved by the United States Food and Drug Administration (FDA) and otherwise comply with applicable Texas and federal laws.

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

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SUBCHAPTER V. PHARMACY BENEFITS DIVISION 2. IDENTIFICATION CARDS

28 TAC §21.3003

STATUTORY AUTHORITY.

TDI proposes amendments to §21.3003 under Insurance Code §1369.154 and §36.001.

Insurance Code §1369.154 requires the commissioner to adopt rules necessary to implement Insurance Code Chapter 1369, Subchapter D.

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

CROSS-REFERENCE TO STATUTE.

Section 21.3003 implements Insurance Code §1369.153.

§21.3003. Standard Identification Cards.

(a) The issuer of a health benefit plan that provides pharmacy benefits, or a pharmacy benefit manager or administrator issuing standard identification cards to enrollees must issue standard identification cards as follows:

(1) For a subscriber who is an enrollee, and who has no enrolled dependents, a single card must be issued to the subscriber, with additional cards available on request.

(2) For a subscriber who is an enrollee, and who has enrolled dependents, either:

(A) a card must be issued to the subscriber and to each of the enrolled dependents, with additional cards available on request; or

(B) two cards must be issued to the subscriber for use by the subscriber and all enrolled dependents, with additional cards available on request.

(3) For coverage under an individual health benefit plan in which the subscriber is not an enrollee, or for coverage under a health benefit plan that is continued by an enrollee under Insurance Code Chapter 1251, Subchapter G [E], concerning Continuation of Group Coverage for Certain Family Members and Dependents, either:

(A) a card must be issued to each enrollee, with additional cards available on request; or

(B) two cards must be issued for use by all enrollees, with additional cards available on request.

(b) Each standard identification card issued must, at all times the card is in effect, include current information on the front of each identification card as follows:

(1) the enrolled subscriber's or enrolled dependents' names and identification codes, as follows:

(A) for cards issued under subsection (a)(1) of this section, the enrolled subscriber's name and identification code;

(B) for cards issued under subsection (a)(2)(A) of this section, the enrolled subscriber's name and identification code on the enrolled subscriber's card, and on each enrolled dependent's card, the name and identification code of the enrolled dependent to whom the card will be issued;

(C) for cards issued under subsection (a)(2)(B) of this section, the name and identification code of the enrolled subscriber and the names and identification codes of all the enrolled dependents;

(D) for cards issued under subsection (a)(3)(A) of this section, on each enrolled dependent's card, the name and identification code of the enrolled dependent to whom the card will be issued;

(E) for cards issued under subsection (a)(3)(B) of this section, the names and identification codes of all enrolled dependents;

(2) the name or logo of the issuer, or of the administrator or pharmacy benefit manager that is administering the pharmacy benefits, if different from the health benefit plan issuer;

(3) as applicable:[;]

(A) for a group health benefit plan, the applicable group number, subject to the requirements in subsection (e) of this section [applicable to the enrollee(s) covered by a group health benefit plan]; or

(B) for an individual health benefit plan, the applicable policy number or evidence of coverage number [applicable to the enrollee(s) covered by an individual health benefit plan];

(4) the effective date of coverage;

(5) as applicable, the corresponding copayment or coinsurance for generic and brand-name drugs; provided that, if the health benefit plan uses a drug formulary with benefit levels in addition to generic and brand-name prescription drugs, the card must include the corresponding copayments or coinsurance for each tier level of the drug formulary. In addition to disclosure of each benefit level, the card may include a term like "variable" for cost-sharing structures [such as "variable," to reflect benefit designs] not fully revealed by the drug formulary tier disclosure;

(6) as applicable, the International Identification Number, also known as the Banking Identification Number, assigned to the administrator or pharmacy benefit manager by the American National Standards Institute; and

(7) for a plan issued under Insurance Code Chapters 843, concerning Health Maintenance Organizations, or 1301, concerning Preferred Provider Benefit Plans, with the letters "TDI" or "DOI" prominently displayed.

(c) In addition to the information required under subsection (b) of this section, the issuer of a health benefit plan must include on the identification card of each enrollee a telephone number of an appropriate person to call to obtain [for purposes of obtaining] information about [relating to] the pharmacy benefits provided under the health benefit plan.

(d) Nothing in this section prohibits the issuer of a health benefit plan, or an administrator or pharmacy benefit manager, from issuing a standard identification card containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required by subsections (b) and (c) of this section is printed on the card.

(e) Consistent with Insurance Code §1369.153, concerning Information Required on Identification Card, a group number on an identification card must distinguish between lines of business, as follows.

(1) A unique group number must be assigned for each line of business specified in Insurance Code §1369.151(b), concerning Applicability of Subchapter.

(2) A group number provided to an enrollee in a health benefit plan subject to Insurance Code Chapter 1369, Subchapter D, concerning Pharmacy Benefit Cards, may not be assigned to an enrollee in a health benefit plan that is not subject to that subchapter.

(f) An issuer of a health benefit plan must provide a method to identify, based on the group number provided on the identification card, whether an enrollee is covered by a health benefit plan that is subject to Insurance Code Chapter 1369, Subchapter D. The issuer must make the identification method available on its publicly accessible website.

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

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SUBCHAPTER FF. OBLIGATION TO CONTINUE PREMIUM PAYMENT AND

COVERAGE AFTER NOTICE OF LOST GROUP ELIGIBILITY

28 TAC §21.4003

STATUTORY AUTHORITY. TDI proposes amendments to §21.4003 under Insurance Code §§843.151, 1301.007, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios, mileage requirements, travel time, and appointment waiting times.

Insurance Code §1301.007 provides that the commissioner adopt rules as necessary to implement Insurance Code Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider benefits and basic level of benefits to residents of this state.

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

CROSS-REFERENCE TO STATUTE. Section 21.4003 implements Insurance Code Chapter 1301.

§21.4003. Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations.

(a) Liability for Premiums for Individuals Who Are No Longer Part of the Covered Group.

(1) A contract between a health carrier and a group policyholder or group contract holder under a health benefit plan contract must provide that:

(A) the group policyholder or group contract holder, as described in the Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance, is liable for an individual insured's or enrollee's premiums from the time the individual is no longer part of the group eligible for coverage under the plan until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage under the plan; and

(B) the individual remains covered under the plan until the end of the period specified in subparagraph (A) of this paragraph.

(2) If a health carrier agrees that a group policyholder or group contract holder may tender the notice referenced in paragraph (1)(A) of this subsection by mail, the date the group policyholder or group contract holder tenders the notice to the postal service is the date the group policyholder or group contract holder notifies the health carrier. Evidence of written notifications may be maintained in a mail log [~~in order~~] to provide proof of submission and establish date of receipt.

(3) If an individual or an enrollee ceases to be a part of the group eligible for coverage within seven calendar days before [~~prior to~~] the end of the month, the group policyholder or group contract holder will be deemed to have notified the health carrier in the month in which the individual or enrollee ceases to be part of the group if the health carrier receives notification within the first three days of the subsequent month, not including Saturdays, Sundays, and legal holidays. If the notification is sent during this additional three-day notification period, the policyholder or contract holder must transmit the notification of an individual's loss of eligibility during the previous month by a method:

(A) agreed on [~~upon~~] by the group policyholder or group contract holder and the carrier, and

(B) that provides immediate written notification, such as a web portal, text message, email, or fax [~~an internet portal, electronic mail, or telefacsimile~~]. Immediate written notification sent via electronic means will be presumed received on the date it is submitted; hand-delivered notification will be presumed received on the date the delivery receipt is signed.

(4) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if a group policyholder or group contract holder notifies a health carrier that an individual will no longer be part of the group eligible for coverage at least 30 days before [~~prior to~~] the date the individual will no longer be part of the group eligible for coverage.

(5) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if the individual elects to terminate coverage under the plan and obtains coverage under a successor health benefit plan that takes effect at any time after termination of group eligibility and before the end of the coverage and premium payment period required by the Insurance Code §843.210, concerning Terms of Enrollee Eligibility, and §1301.0061, concerning Terms of Enrollee Eligibility, and subsection (a) of this section. A health carrier may require a group policyholder or group contract holder seeking to avoid payment of additional premium for an individual no longer part of the group eligible for coverage to verify the successor coverage and to agree to be responsible for payment of premium if the individual's successor health benefit plan does not cover the individual from the termination of the health carrier's coverage until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage. In addition, the group policyholder or group contract holder and the health carrier remain responsible for compliance with the Insurance Code §843.210 and §1301.0061 if the individual's successor health benefit plan does not cover the individual from the termination of the health carrier's coverage until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage.

(6) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section under coverage a health carrier extends to an individual in compliance with 29 USC [~~U.S.C.~~] §1161 et seq. (COBRA), the Insurance Code Chapter 1251 Subchapter F, concerning Continuation or Conversion Privilege on Termination of Coverage Under Group Policy, or any other federal or state continuation of coverage requirement that allows an individual insured or enrollee, upon termination of eligibility from a group, to pay premium and extend the period of group health benefit plan coverage after the individual has left employment or otherwise no longer qualifies as a member of the group.

(7) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if a group policyholder or group contract holder does not contribute to the payment of any individual insured's or enrollee's premium.

(8) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of

this section in the event of the individual insured's or enrollee's death after the later of the date of the individual insured's or enrollee's:

(A) death; or

(B) receipt of the last covered service under the plan.

(b) Notice of Liability for Premiums for Individuals Who Are No Longer Part of the Covered Group.

(1) A health carrier that enters into or renews a health benefit plan contract with a group policyholder or group contract holder shall provide written notice to the group policyholder or group contract holder that the group policyholder or group contract holder is liable for premiums for an individual who is no longer part of the group until the health carrier receives notification of termination of the individual's eligibility for coverage as follows:

(A) as required by the Insurance Code §843.210(c) and §1301.0061(c), if the health carrier charges the group policyholder or group contract holder on a monthly basis for premiums, the health carrier shall provide the notice in each monthly statement sent to the group policyholder or group contract holder;

(B) if the health carrier charges the group policyholder or group contract holder on other than a monthly basis for premiums, the health carrier shall provide the written notice at inception or renewal of the policy or contract, as applicable, and, thereafter, at the time of each billing, and

(C) as required by the Insurance Code §843.210(d) and §1301.0061(d), the notice required under subparagraphs (A) and (B) of this paragraph must include a description of methods preferred by the health carrier for notification by a group policyholder or group contract holder of an individual's termination from coverage eligibility.

(2) Notwithstanding the requirements of paragraph (1) of this subsection, a health carrier is not required to send notice of group policyholder or contract holder liability for premiums more often than monthly.

(c) Equal Treatment of Employers. If a health carrier chooses to waive premiums as permitted under Insurance Code §843.210(e) and §1301.0061(e), the health carrier must do so in a manner that ensures equal treatment of similarly situated employer groups.

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

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Jessica Barta
General Counsel
Texas Department of Insurance
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SUBCHAPTER KK. HEALTH CARE REIMBURSEMENT RATE INFORMATION

28 TAC §21.4502

STATUTORY AUTHORITY. TDI proposes amendments to §21.4502 under Insurance Code §38.354 and §36.001.

Insurance Code §38.354 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 38, Subchapter H.

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

CROSS-REFERENCE TO STATUTE. Section §21.4502 implements HB 4611.

§21.4502. Applicability.

(a) This subchapter applies to the issuer of an applicable health benefit plan as defined in §21.4503 of this title (relating to Definitions) and as provided by Insurance Code §38.353(a), concerning Applicability of Subchapter:

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; and

(6) a health maintenance organization (HMO).

(b) As provided in Insurance Code §38.353(b), and notwithstanding any provision in Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M System or any other law, this subchapter applies to:

(1) a basic coverage plan under Insurance Code Chapter 1551;

(2) a basic plan under Insurance Code Chapter 1575;

(3) a primary care coverage plan under Insurance Code Chapter 1579; and

(4) basic coverage under Insurance Code Chapter 1601.

(c) Under Insurance Code §38.353(d), this subchapter does not apply to:

(1) standard health benefit plans provided under Insurance Code Chapter 1507, concerning Consumer Choice of Benefits Health Insurance Plans;

(2) children's [~~childrens~~'] health benefit plans provided under Insurance Code Chapter 1502, concerning Health Benefit Plans for Children;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under Government Code Chapter 540, concerning Medicaid Managed Care Program [~~533~~];

(5) Medicaid programs operated under Human Resources Code Chapter 32, concerning Medical Assistance Program; or

(6) the state child health plan operated under Health and Safety Code Chapters 62, concerning Child Health Plan for Certain Low-Income Children; or 63, concerning Health Benefits Plan for Certain Children.

(d) Notwithstanding subsection (c)(1) of this section, an applicable health benefit plan issuer is not prohibited from electively including data concerning reimbursement rates for standard health benefit plans provided under Insurance Code Chapter 1507 in its submission

of the report required in §21.4506 of this title (relating to Submission of Report) for purposes of administrative convenience. Data from all other plans identified in subsection (c) of this section must be excluded from the report.

(e) An applicable health benefit plan issuer with fewer than 20,000 covered lives in comprehensive health coverage as reported on Part 1 of the National Association of Insurance Commissioners Supplemental Health Care Exhibit as of the end of the applicable reporting period is not required to submit a report under §21.4506.

(f) Under Insurance Code §38.353(e), this subchapter does not apply to:

(1) a Medicare supplemental policy as defined by §1882(g)(1), Social Security Act (42 USC [~~U.S.C.~~] §1395ss), concerning Certification of Medicare Supplement Health Insurance Policies; or

(2) a Medicare Advantage plan offered under a contract with the federal Centers for Medicare and Medicaid Services.

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

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SUBCHAPTER MM. WELLNESS PROGRAMS

28 TAC §21.4703

STATUTORY AUTHORITY. TDI proposes amendments to §21.4703 under Insurance Code §541.401, §1702.006, and §36.001.

Insurance Code 541.401 provides that the commissioner may adopt and enforce rules necessary to accomplish the purpose of Insurance Code Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules to implement Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. Section 21.4703 implements Insurance Code Chapters 544 and 1702.

§21.4703. Wellness Programs Exception.

(a) Notwithstanding the provisions of Insurance Code Chapter 1501, concerning Health Insurance Portability and Availability Act; §1702.102, concerning Prohibited Rebates and Inducements; [~~§541.056(a) and~~] §544.052, concerning Unfair Discrimination; and the provisions of Chapter 26, Subchapter A, of this title, concerning Definitions, Severability, and Small Employer Health Regulations, an individual or group health benefit plan issuer, an accident and health insurance issuer, or a health maintenance organization may vary the amount of premium or contribution it requires similarly situated individuals to pay, or vary benefits, or both, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706 (relating to Wellness Programs With Participation as Sole Basis for Reward Eligibility), 21.4707 (relating to Activity-Only Wellness Programs), or 21.4708 (relating to Outcome-Based Wellness Programs) of this title.

(b) Notwithstanding the provisions of Insurance Code §1702.102 [~~§541.056(a)~~] and §544.052, an insurer issuing an accident and health insurance policy may vary the amount of premium or contribution it requires similarly situated individuals or individuals of the same class and of essentially the same hazard to pay, or vary benefits, or both, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title.

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

Filed with the Office of the Secretary of State on July 16, 2026.

TRD-202602934
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 676-6555

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SUBCHAPTER UU. MACHINE-READABLE FILES

28 TAC §21.5501, §21.5503

STATUTORY AUTHORITY. TDI proposes amendments to §21.5501 and §21.5503 under Insurance Code §1662.004 and §36.001.

Insurance Code §1662.004 authorizes the commissioner to adopt rules necessary to implement Insurance Code Chapter 1662.

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

CROSS-REFERENCE TO STATUTE. Sections 21.5501 and 21.5503 implement Insurance Code Chapter 1662.

§21.5501. Applicability and Effective Date.

(a) Except as provided in subsections (b) and (c) of this section, this subchapter applies to issuers of health benefit plans as specified in Insurance Code §1662.003, concerning Applicability of Chapter, that provide major medical coverage for which federal reporting requirements under 26 CFR [~~C.F.R.~~] Part 54, concerning Pension Excise Taxes; 29 CFR [~~C.F.R.~~] Part 2590, concerning Rules and Regulations for Group Health Plans; 45 CFR [~~C.F.R.~~] Part 147, concerning Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets; and 45 CFR [~~C.F.R.~~] Part 158, concerning Issuer Use of Premium Revenue: Reporting and Rebate Requirements, do not apply, including:

(1) issuers providing short-term limited-duration insurance, as defined in Insurance Code Chapter 1509, concerning Short-Term Limited-Duration Insurance; and

(2) issuers providing grandfathered health plan coverage, as defined in 45 CFR [C.F.R.] §147.140, concerning Preservation of Right to Maintain Existing Coverage.[; and]

[(3) a regional or local health care program operated under Health and Safety Code §75.104, concerning Health Care Services.]

(b) This subchapter does not apply to the following types of plans:

(1) a plan that is not considered creditable coverage as specified under Insurance Code §1205.004(b), concerning Creditable Coverage;

(2) the child health plan program operated under Health and Safety Code Chapter 62, concerning Child Health Plan for Certain Low-Income Children;

(3) the health benefits plan for children operated under Health and Safety Code Chapter 63, concerning Health Benefits Plan for Certain Children; [and]

(4) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program, including the Medicaid managed care program operated under Government Code Chapter 540 [533], concerning Medicaid Managed Care Program; and

(5) a regional or local health care program operated under Health and Safety Code §75.104, concerning Health Care Services.

[(c) Except as provided by subsections (d) and (e) of this section, with respect to an applicable health benefit plan, an issuer must begin publishing machine-readable files as required under this subchapter in the month in which the plan year or policy year begins.]

[(d) A health benefit plan issuer with fewer than 1,000 total enrollees in all health benefit plans subject to reporting as of December 31, 2021, must begin publishing machine-readable files as required under this subchapter no later than January 1, 2024.]

[(e) Except as provided by subsection (d) of this section, an issuer is required to begin publishing machine-readable files no sooner than 180 days after the effective date of this section and no later than the earliest date specified in paragraphs (1) and (2) of this subsection:]

[(1) the date that the federal Departments of Labor, Health and Human Services, and Treasury begin enforcing the federal Transparency in Coverage rules specific to the publication of machine-readable files for prescription drug pricing, in-network rates, and out-of-network allowed amounts and billed charges, if the date of enforcement occurs after the 180th day following the effective date of this section; or]

[(2) January 1, 2024.]

§21.5503. Data Schemas.

(a) In-network negotiated rate file schema. For the "in-network-rates" file published under this subchapter, an issuer must include data elements consistent with the In-Network File Schema contained in Machine-Readable Files: Data Schemas (version 2.0) [(version 1.1)], published on the department's website.

(b) Out-of-network allowed amount file schema. For the "allowed-amounts" file published under this subchapter, an issuer must include data elements consistent with the Out-of-Network Allowed Amount File Schema contained in Machine-Readable Files: Data Schemas (version 2.0) [(version 1.1)], published on the department's website.

(c) In-network prescription drugs file schema. For the "prescription-drugs" file published under this subchapter, an issuer must include data elements consistent with the Rx File Schema contained in Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

(d) Table of contents file schema. If an issuer chooses to include multiple plans in a single file, as permitted under §21.5502(h) of this title (relating to Form and Method of Publishing Machine-Readable Files), the issuer must publish a "table-of-contents" file, consistent with the Table of Contents File Schema contained in Machine-Readable Files: Data Schemas (version 2.0) [(version 1.1)], published on the department's website.

[(e) Provider reference file schema. If an issuer chooses to include an external file of provider references, the issuer must include a "Provider Reference" file, consistent with the Provider Reference File Schema contained in the Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.]

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

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

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PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 137. DISABILITY MANAGEMENT
SUBCHAPTER B. RETURN TO WORK

28 TAC §137.10

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) proposes to amend 28 TAC §137.10, concerning return-to-work guidelines. Section 137.10 implements Texas Labor Code §413.011. The DWC medical advisor recommends the amendments to the commissioner of workers' compensation under Labor Code §413.0511(b).

EXPLANATION. The amendments adopt a different set of guidelines for disability duration values. The current rule requires the use of Medical Disability Advisor, while the proposed change would require the use of ODG by MCG, published by MCG Health (ODG by MCG). Amending §137.10 is necessary to instruct insurance carriers, health care providers, and employers to use the disability duration values in the current edition of the ODG by MCG instead of those in the MDGuidelines (formerly known as Medical Disability Advisor), as guidelines for the evaluation of expected or average return-to-work timeframes. The amendments also update DWC's website address and the section's effective date, and include nonsubstantive editorial

changes that make updates for plain language and agency style to improve the rule's clarity.

Labor Code §413.011(e) requires the commissioner to adopt treatment guidelines and return-to-work guidelines by rule. Section 413.011(f) requires that those guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control, and to enhance a timely and appropriate return to work.

To fulfill their role in the Texas workers' compensation system, designated doctors are required to subscribe to these guidelines, which includes purchasing access to them. The current adopted treatment guidelines are published by ODG by MCG, and include access to return-to-work guidelines. Designated doctors cannot currently use ODG by MCG's return-to-work guidelines because the current adopted return-to-work guidelines are published by MDGuidelines. MDGuidelines will change its pricing model and raise its rates substantially starting on October 1, 2026. Since the ODG by MCG treatment guidelines subscription already includes access to return-to-work guidelines, the amendments will allow system participants to use the ODG by MCG services they already subscribe to instead of maintaining a separate, costly subscription to MDGuidelines. Amending the rule to update the reference from Medical Disability Advisor to ODG by MCG is necessary to ensure continued participation in the workers' compensation system by avoiding unnecessary administrative and monetary burdens on doctors in the system. The change will promote efficiency by allowing system participants to benefit from a single subscription instead of maintaining two separate subscriptions to substantially similar services. Avoiding those unnecessary costs also complies with the requirement in Labor Code §413.011 that the commissioner's adopted return-to-work guidelines help achieve effective medical cost control.

The return-to-work guidelines in ODG by MCG are comparable to those in MDGuidelines, and moving to the guidelines in ODG by MCG makes sense administratively, economically, and clinically. Both sets of guidelines derive disability duration values from the same foundational methodology—population-based epidemiological data stratified by diagnosis, job classification, and physical demand characteristics. The underlying evidence base for expected return-to-work timeframes does not differ materially between the two sets of guidelines. In practice, duration values calculated using both sets of guidelines have been substantively equivalent across the overwhelming majority of diagnostic categories in Texas workers' compensation claims. As a result, replacing the return-to-work guidelines with those in ODG by MCG removes an unnecessary cost and duplication of resources without any loss of clinical accuracy or adjudicative reliability. In addition, because treatment and expected disability duration are evaluated together, using the ODG by MCG for both treatment, as is currently the case, and return-to-work disability duration calculations, as DWC proposes here, allows system participants to apply a single, integrated, evidence-based resource across both the treatment and return-to-work functions, which more accurately reflects actual clinical decision making.

DWC invited public comments on an informal draft posted on DWC's website on May 6, 2026. DWC considered the comments it received on the draft when drafting this proposal.

As part of the implementation plan for this rule, DWC intends to train system participants on the use of the return-to-work guidelines in ODG by MCG.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Deputy Commissioner for Operations Mary Landrum has determined that during each year of the first five years the proposed changes are in effect, there will be no or minimal measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. This determination was made because the proposed changes do not add to or decrease state revenues or expenditures, and because local and state government entities are only involved in enforcing or complying with the proposed changes when acting in the capacity of a workers' compensation insurance carrier. Those entities will be impacted in the same way as an insurance carrier and will realize the same benefits from the proposed changes.

Deputy Commissioner Landrum does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed changes are in effect, Deputy Commissioner Landrum expects that enforcing and administering the proposed changes will have the public benefits of reducing administrative burdens and unnecessary costs to system participants, promoting stability and consistency in the workers' compensation system, and enhancing retention of doctors in the system, as well as ensuring that DWC's rules conform to Labor Code §413.011 and are current and accurate, which promotes transparent and efficient regulation.

Deputy Commissioner Landrum expects that the proposed changes will not increase the cost to comply with Labor Code §413.011 because they do not impose requirements beyond those in the statute, and do not create more burdensome obligations than the current rule. Instead, Deputy Commissioner Landrum expects that the proposed changes will lessen the cost of compliance. Labor Code §413.011(e) requires the commissioner to adopt return-to-work guidelines by rule. Section 413.011(f) requires that those guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control, and to enhance a timely and appropriate return to work. As a result, the cost associated with moving from the disability duration values in the MDGuidelines to those in the ODG by MCG does not result from the enforcement or administration of the proposed changes. In fact, the proposed changes should reduce the cost of participation in the system because designated doctors will no longer be required to subscribe to two different services that provide return-to-work guidelines. And adopting the proposed changes before October 1, 2026, when MDGuidelines has scheduled a substantial rate increase, will allow system participants to avoid that additional cost.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. DWC has determined that the proposed changes will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities because the proposed changes are designed to reduce the cost of compliance by eliminating an unnecessary subscription, and to make editorial revisions, updates to obsolete references, and updates for plain language and agency style. The proposed changes do not change the people the rule affects or impose additional costs. As a result, and in accordance with Government Code §2006.002(c), DWC is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. DWC has determined that this proposal does not

impose a possible cost on regulated persons. In contrast, DWC expects that the reduced monetary and administrative burden from the amendments will reduce costs to regulated persons. As a result, no additional rule amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. DWC has determined that for each year of the first five years that the proposed changes are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

DWC made these determinations because the proposed changes eliminate an unnecessary subscription, enhance efficiency and clarity, and make editorial changes for plain language and agency style. They do not change the people the rule affects or impose additional costs.

TAKINGS IMPACT ASSESSMENT. DWC has determined that no private real property interests are affected by this proposal, and this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR INFORMATION AND PUBLIC COMMENT. DWC requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. DWC will consider any written comments on the proposal that DWC receives no later than 5:00 p.m., Central time, on August 31, 2026. Send your comments to RuleComments@tdi.texas.gov; or to Texas Department of Insurance, Division of Workers' Compensation, Legal and Communications Services, MC-LS, P.O. Box 12050, Austin, Texas 78711-2050.

DWC will also consider written and oral comments on the proposal at a public hearing at 11 a.m., Central time, on August 24, 2026. The hearing will take place remotely. DWC will publish details of how to view and participate in the hearing on the agency website at www.tdi.texas.gov//alert/event/index.html.

STATUTORY AUTHORITY. DWC proposes §137.10 under Labor Code §§413.011, 402.00111, 402.00116, and 402.061.

Labor Code §413.011(e) requires the commissioner to adopt treatment guidelines and return-to-work guidelines by rule. Section 413.011(f) states that the medical policies or guidelines the commissioner adopts in subsection (e) must be: (1) designed to ensure the quality of medical care and to achieve effective medical cost control; (2) designed to enhance a timely and appropriate return to work; and (3) consistent with §§413.013, 413.020, 413.052, and 413.053.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

CROSS-REFERENCE TO STATUTE. Section 137.10 implements Labor Code §413.011, recodified from V.A.C.S. Arts. 8308-8.01(a) and (g), and 8308-8.21(a) and (b), by House Bill (HB) 752, 73rd Legislature, Regular Session (1993); and amended by HB 7, 79th Legislature, Regular Session (2005).

§137.10. Return to Work Guidelines.

(a) Insurance carriers, health care providers, and employers must [~~shall~~] use the disability duration values in the current edition of the ODG by MCG guidelines published by MCG Health at www.mcg.com/odg (ODG by MCG, referred to in this title as Division return to work guidelines) [~~*The Medical Disability Advisor, Workplace Guidelines for Disability Duration*~~, ~~excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd. (Division return to work guidelines)~~], as guidelines for the evaluation of expected or average return to work time frames.

(b) Information on how to obtain or inspect copies of the Division return to work guidelines is [~~may be found~~] on the Division's website: www.tdi.texas.gov/wc/ [~~*www.tdi.state.tx.us*~~].

(c) - (f) (No change.)

(g) This section applies to any determination of an injured employee's ability to return to work conducted on or after October 1, 2026 [~~is effective on or after May 1, 2007~~].

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

Filed with the Office of the Secretary of State on July 14, 2026.

TRD-202602898
Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 804-4703

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 7. TEXAS COMMISSION ON LAW ENFORCEMENT

CHAPTER 221. PROFICIENCY CERTIFICATES

37 TAC §221.21

The Texas Commission on Law Enforcement (Commission) proposes amended 37 Texas Administrative Code §221.21, Firearms Proficiency for Community Supervision Officers. This proposed amended rule would remove the requirements for

community supervision and corrections department officers and parole officers to recertify firearms proficiency every year and to renew the certificate every two years. This would realign the rule with the provisions of Texas Occupations Code §1701.257 and allow the Texas Department of Criminal Justice to determine any recertification or requalification requirements.

Mr. John P. Beauchamp, General Counsel, has determined that for each year of the first five years this proposed amended rule will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of enforcing or administering the proposed amendment.

Mr. Beauchamp has determined that for each year of the first five years this proposed amended rule will be in effect, there will be a positive benefit to the public by conforming with Texas Occupations Code §1701.257. There will be no anticipated economic costs to persons required to comply with the proposed amendment.

Mr. Beauchamp has determined that for each year of the first five years this proposed amended rule will be in effect, there will be no adverse economic effects to small businesses, microbusinesses, or rural communities as a result of implementing the proposed amendment.

Mr. Beauchamp has determined that for each year of the first five years this proposed amended rule will be in effect, there will be no effects to a local economy as a result of implementing the proposed amendment.

Mr. Beauchamp has determined the following:

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

(2) implementation of the proposed rule does not require the creation of new employee positions or the elimination of existing employee positions;

(3) implementation of the proposed rule does not require an increase or decrease in future legislative appropriations to the agency;

(4) the proposed rule does not require an increase in fees paid to the agency, but does result in a decrease in fees paid to the agency by removing the certificate renewal requirement;

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

(6) the proposed rule does not expand or repeal an existing regulation, but does limit an existing regulation by removing the firearms recertification and certificate renewal requirements;

(7) the proposed rule does not increase or decrease the number of individuals subject to the rule's applicability; and

(8) the proposed rule does not positively or adversely affect this state's economy.

The Commission is requesting comments regarding the proposed amended rule and information related to the cost, benefit, or effect of the proposed amended rule, including any applicable data, research, or analysis, from any person required to comply with the proposed amended rule or any other interested person. The comment period will last 30 days following the publication of this proposal in the *Texas Register*. Comments and information may be submitted electronically to public.comment@tcole.texas.gov or in writing to Mr. John P. Beauchamp, General Counsel, Texas Commission on Law Enforcement, 6330 E. Highway 290, Suite 200, Austin, Texas 78723-1035.

The amended rule is proposed pursuant to Texas Occupations Code §1701.151, General Powers of Commission; Rulemaking Authority, and Texas Occupations Code §1701.257, Firearms Training Program for Supervision Officers. Texas Occupations Code §1701.151 authorizes the Commission to adopt rules for the administration of Occupations Code Chapter 1701. Texas Occupations Code §1701.257 requires the Commission to administer a training program and issue certificates relating to firearms proficiency for community supervision and corrections department officers or parole officers.

The amended rule as proposed affects or implements Texas Occupations Code §1701.151, General Powers of Commission; Rulemaking Authority, and Texas Occupations Code §1701.257, Firearms Training Program for Supervision Officers. No other code, article, or statute is affected by this proposal.

§221.21. Firearms Proficiency for Community Supervision Officers.

(a) To qualify for a firearms proficiency certificate for community supervision and parole officers, an applicant must meet the following requirements including:

(1) currently employed as a community supervision officer by a Community Supervision and Corrections Department (CSCD), or parole officer employed by the Texas Department of Criminal Justice (TDCJ); and

(2) successful completion of the commission's current firearms training program for community supervision officers.

~~[(b) The holder of a certificate issued under this section must meet the firearms proficiency requirements at least once every 12 months.]~~

~~[(c) Certificates issued under this section expire two years from date of issuance. Within forty-five days of the expiration of a certificate, a supervision officer may apply for the issuance of a renewal. Supervision officers must meet the requirements in subsections (a)(1) and (b) of this section in order to renew the certificate.]~~

(b) ~~[(d)]~~ The effective date of this section is November 1, 2026 [~~July 15, 2010~~].

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

Filed with the Office of the Secretary of State on July 17, 2026.

TRD-202602939
Gregory Stevens
Executive Director
Texas Commission on Law Enforcement
Earliest possible date of adoption: August 30, 2026
For further information, please call: (512) 936-7700

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PART 11. TEXAS JUVENILE JUSTICE DEPARTMENT

CHAPTER 380. RULES FOR STATE-OPERATED PROGRAMS AND FACILITIES

SUBCHAPTER F. SECURITY AND CONTROL

37 TAC §380.9723

The Texas Juvenile Justice Department (TJJD) proposes to amend 37 TAC, Part 11, §380.9723, Use of Force.

SUMMARY OF CHANGES

The proposed amendments to §380.9723 revise the rule to allow the use of oleoresin capsicum (OC) spray in TJJD-operated medium-restriction facilities in addition to high-restriction facilities. The amendment is intended to provide medium-restriction facilities with an additional approved intervention option for limited, unsafe situations when non-physical interventions and other physical interventions have failed or are not practical.

The proposed amendments are intended to support facility safety and operational security while preserving the rule's existing requirements that force be reasonable, limited to approved techniques, and used only by trained staff in accordance with the totality of the circumstances.

FISCAL NOTE

Emily Anderson, Deputy Executive Director: Support Operations and Finance, has determined that, for each year of the first five years the amended section is in effect, there will be no significant fiscal impact for state government or local governments as a result of enforcing or administering the section.

PUBLIC BENEFITS/COSTS

Cameron Taylor, Policy Director, has determined that for each year of the first five years the amended section is in effect, the public benefit anticipated as a result of administering the section will be to help enhance TJJD operational and public safety.

Ms. Anderson has also determined that there will be no effect on small businesses, micro-businesses, or rural communities. There is no anticipated economic cost to persons who are required to comply with the amended section as proposed. No private real property rights are affected by adoption of the section.

GOVERNMENT GROWTH IMPACT

TJJD has determined that, during the first five years the amended section is in effect, the section will have the following impacts.

(1) The proposed section does not create or eliminate a government program.

(2) The proposed section does not require the creation or elimination of employee positions at TJJD.

(3) The proposed section does not require an increase or decrease in future legislative appropriations to TJJD.

(4) The proposed section does not impact fees paid to TJJD.

(5) The proposed section does not create a new regulation.

(6) The proposed section does not expand, limit, or repeal an existing regulation.

(7) The proposed section does not increase or decrease the number of individuals subject to the section's applicability.

(8) The proposed section will not positively or adversely affect this state's economy.

PUBLIC COMMENTS

Comments on the proposal may be submitted within 30 days after publication of this notice to Texas Juvenile Justice Department, Policy and Standards Section, P.O. Box 12757, Austin, Texas 78711, or via email to policy.proposals@tjjd.texas.gov.

STATUTORY AUTHORITY

The amended section is proposed under §242.003, Human Resources Code, which requires the Board to adopt rules appropriate to properly accomplish TJJD's functions and to adopt rules for governing TJJD schools, facilities, and programs.

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

§380.9723. Use of Force.

(a) Purpose. This rule establishes the procedures for staff intervention when youth behavior threatens safety and order.

(b) Applicability.

(1) This rule applies to all facilities, offices, and programs operated by the Texas Juvenile Justice Department (TJJD), unless specifically stated otherwise in this rule.

(2) This rule does not apply to peace officers employed and commissioned by TJJD or by the TJJD Office of Inspector General.

(3) This rule does not apply to the use of four-point mechanical restraints for medical or mental health purposes. See §380.9198 of this title.

(c) General Provisions.

(1) Non-physical interventions are preferred and must be used to the extent practical to manage youth behavior.

(2) TJJD authorizes its staff to use reasonable force as a last resort to maintain safety and order. Only staff who are trained in agency-approved techniques are authorized to use force.

(3) The use of force as punishment or for convenience of staff is strictly prohibited.

(4) Approved use of force techniques are those determined by TJJD to minimize risk of harm to youth and staff.

(5) Staff must release youth from manual or mechanical restraint as soon as the purpose for the restraint has been achieved.

(6) If a staff member observes a use of force in violation of policy, he/she must take action, as practical, to protect the youth from harm.

(7) Staff must report any violations of this policy as soon as possible, but no later than the end of the current shift.

(8) Violations of this policy may result in disciplinary action up to and including termination of employment.

(9) After any manual restraint or use of oleoresin capsicum (OC) spray in a high restriction facility, a youth must be assessed by medical staff as soon as reasonably possible under the totality of the circumstances. [~~After any manual restraint in a medium restriction facility, medical staff must be consulted as soon reasonably possible. Any injuries must be documented in the medical record along with an explanation from the youth describing how the injuries occurred. Photographs must be taken of all injuries.~~]

(10) After any manual restraint in a medium restriction facility, medical staff must be consulted as soon as reasonably possible.

(11) Any injuries must be documented in the medical record along with an explanation from the youth describing how the injuries occurred. Photographs must be taken of all injuries.

(12) [~~(10)~~] Only restraint equipment approved by the executive director or his/her designee may be used in TJJD facilities. All

restraint equipment must be used in a manner consistent with its design and intended purpose.

(13) [~~(11)~~] Only the facility administrator, staff having authority to act as the facility administrator, or a higher-level authority in the facility administrator's chain of supervision may declare that a particular situation is a riot, consistent with the definition of a riot.

(d) References.

(1) For procedures and programs designed to allow youth time to regain self-control, see §§380.9520, 380.9739, and 380.9740 of this title.

(2) For criteria and procedures on administering a psychotropic drug in a psychiatric emergency when a youth will not give consent for the administration, see §380.9192 of this title.

(3) For procedures relating to youth searches, see §380.9709 of this title.

(e) Definitions.

(1) Barricade--any of the following, if used by a youth to prevent and/or obstruct staff from gaining access to the youth: a locked, jammed, or blocked door, dorm furniture, boxes, desks, chairs, computers, folding tables, stacked mattresses, or any other similar item that obstructs passage.

(2) Handle With Care®--an agency-trained physical intervention system.

(3) Imminent Harm--a reasonable belief that harm to persons or property is about to occur, unless immediate action is taken.

(4) Medical Provider--has the meaning assigned by §380.9175 of this title.

(5) Positional Asphyxia--the reduction in oxygen in the bloodstream and tissues due to an impairment of a person's respiratory system caused by body positioning or the application of external weight/pressure.

(6) Practical--a reasonable belief that something is capable of being done.

(7) Reasonable Belief--a belief that would be held by a similarly trained staff considering the totality of the circumstances.

(8) Reasonable Force--the least amount of force that a trained staff, in like circumstances, would reasonably believe to be necessary to maintain order and safety as authorized under this rule.

(9) Serious Bodily Injury--an injury that creates a substantial risk of death, serious permanent disfigurement, or extended loss or impairment of the function of any bodily member or organ.

(10) Substantial Property Damage--at least $500 in damage to state property or another's personal property.

(11) Totality of the Circumstances--facts and circumstances known by the actor at the time of the incident.

(12) Use of Force--physical measures used to direct, compel, or restrain bodily movement of a non-compliant youth.

(13) Riot--a situation in which three or more youths intentionally participate in conduct that threatens imminent harm to persons or property and that substantially obstructs the performance of facility operations or a program therein.

(f) Non-Physical Interventions. Alternatives to force must be used whenever practical to assist a youth in maintaining or regaining self-control. Staff are prohibited from using humiliating punishment, including verbal harassment to manage youth behavior. Staff are trained in the use of the following non-physical intervention techniques:

(1) Staff presence--this includes mere presence of staff to include non-verbal gestures made with eyes, hands, head, or body utilizing proximity, standing, eye contact and/or facial expressions; and/or involving additional staff to intervene.

(2) Verbal de-escalation--this includes verbal prompting, directive statements, and redirecting youth attention and/or behavior.

(3) Use of problem-solving groups.

(g) Physical Interventions. When reasonable force is necessary, staff are authorized to use the following methods:

(1) Physical Escort--touching of the arm, elbow, shoulder, or back for the purpose of directing the youth from one location to another.

(2) Mechanical Restraint--use of a mechanical device applied to a youth as a means of restricting a youth's freedom of action.

(3) Manual Restraint--use of hands-on techniques as a means of restricting a youth's freedom of action.

(4) Planned Team Restraint--restraint of a youth who is in a locked or barricaded room or security vehicle by a pre-assembled team.

(5) OC Spray--oleoresin capsicum spray, also known as pepper spray. Oleoresin capsicum is a mixture of essential oil and resin found in nature and derived from any plant of the genus capsicum, such as jalapeño, cayenne, or habanero.

(h) Criteria for Use of Force. Except as otherwise indicated in this rule, reasonable force is authorized under the following circumstances:

(1) protection of youth from imminent self-harm;

(2) protection of self from imminent harm;

(3) protection of other youth or third parties from imminent harm;

(4) protection of property from imminent, substantial damage;

(5) prevention of escape or fleeing apprehension;

(6) movement of a youth referred to the security unit, other temporary isolation room, or alternative classroom;

(7) movement of a resistant youth within the security unit when the youth's behavior is substantially disruptive and the youth refuses to stop the behavior;

(8) movement of a resistant youth from a dangerous situation;

(9) to conduct a search of a resistant youth reasonably believed to be in possession of a weapon, an item that can be adapted for use as a weapon, a controlled substance, or other item(s) that breech the security of the facility;

(10) to conduct a search of a resistant youth entering the security unit; or

(11) to administer medical treatment to a resistant youth when failure to do so could have serious health implications and a medical provider has ordered a restraint.

(i) Determining the Intervention or the Reasonable Force to be Used. In determining the type of intervention or the reasonable

force to be used, staff must consider whether action needs to be taken immediately or can be delayed until additional staff can organize a team response. However, only a medical provider may determine the type of intervention or the reasonable force to be used in administering medical treatment to a resistant youth.

(j) Approved Use of Force Techniques. Use of force techniques that may be used are limited to:

(1) agency-trained:

(A) physical escort;

(B) Handle With Care® methods of manual restraint;

(C) mechanical restraints;

(D) OC spray, under certain limited circumstances; and

(2) other non-prohibited methods of manual restraint that under the totality of circumstances existing at the time:

(A) are more practical than the agency-trained Handle With Care® methods of restraint, taking into account the youth's and staff's particular vulnerability to harm;

(B) involve a use of force that is measured and progressive to a degree no greater than that reasonably believed necessary to achieve the objective; and

(C) do not unduly risk serious harm or needless pain to the youth or staff.

(k) Prohibited Restraint Techniques.

(1) Prohibited restraint techniques include the following:

(A) restricting respiration in any way, such as applying a chokehold or pressure to a youth's back or chest or placing a youth in a position that is capable of causing positional asphyxia;

(B) using any method that is capable of causing loss of consciousness or harm to the neck;

(C) pinning down with knees to the torso, head, and/or neck;

(D) slapping, punching, kicking, or hitting;

(E) using pressure-point, pain-compliance, and joint-manipulation techniques other than an approved Handle With Care® method for release of a chokehold, bite, or hair pull;

(F) modifying restraint equipment;

(G) applying any cuffing technique that connects handcuffs behind the back to ankle restraints;

(H) dragging or lifting of the youth by the hair or ear or by any type of mechanical restraints;

(I) lifting a youth's arms behind the back, while in mechanical restraints, in a manner that is capable of causing injury to the shoulder;

(J) using other youth or untrained staff to assist with the restraint;

(K) securing a youth to another youth or to a fixed object, other than to an agency-approved full-body restraint device; or

(L) administering a drug for controlling acute episodic behavior as a means of physical restraint, except when the youth's behavior is attributable to mental illness and the drug is authorized by a licensed psychiatric provider or physician and administered by a licensed medical professional.

(2) A physical contact that would otherwise be prohibited by subsection (k)(1) of this section, does not include one that is only accidental and momentary.

(l) Requirements for Planned Team Restraint Situations.

(1) Criteria for Use. Planned team restraint is authorized only to:

(A) stop the youth from engaging in self-harm;

(B) prevent substantial property damage; or

(C) recover a weapon or item that has been adapted for use as a weapon and is capable of causing death or serious bodily injury.

(2) Requirements for Use.

(A) Prior to approval of planned team restraint, the facility administrator or administrative duty officer must personally observe the situation. Only the facility administrator or administrative duty officer may authorize a planned team restraint.

(B) All planned team restraints must be videotaped when practical, including a recording of a verbal description of the youth's conduct and all warnings provided the youth according to the agency-approved script.

(C) Only staff trained in planned team restraint may participate in the team that is assembled for the room entry.

(D) The youth must be warned to discontinue the misconduct at least two times after the team is assembled and before the room entry. The team must provide continuous opportunities for compliance during the room entry.

(E) Use of the riot shield during a planned team restraint is limited to cases in which a youth has a weapon or a youth's behavior indicates there is a significant risk of harm to the staff members involved in the restraint.

(m) Requirements for Use of Mechanical Restraints.

(1) Guidelines for Use.

(A) Mechanical restraint equipment must not be secured so tightly as to interfere with circulation or so loosely as to permit chafing of the skin.

(B) When mechanical restraints are employed on a youth in a prone position, the youth is placed on his/her side as soon as practical in order to help ensure adequate respiration and circulation. The youth must be allowed to sit up as soon as his/her behavior is under control.

(C) A mechanical restraint for other than transportation, riot control, or medical purposes must be terminated as soon as the purpose for which the youth was restrained under subsection (h) of this section has been achieved, but in any event within 30 minutes, unless an extension is granted. Extensions may be granted by the facility administrator or designee for up to two-hour intervals until termination of restraint.

(D) A mechanical restraint for medical purposes must be terminated as soon as the purpose for which the youth was restrained has been achieved or upon expiration of the medical provider's order, whichever occurs first.

(E) When mechanical restraints are applied, staff must:

(i) check the youth for adequate respiration and circulation every 15 minutes;

(ii) provide regularly scheduled meals and drinks;

(iii) provide opportunity for elimination of bodily waste at least once every two hours; and

(iv) provide continuous visual supervision and appropriate assistance until the mechanical restraint is terminated.

(F) Mechanical ankle and wrist restraints attached to a waist belt by a lead chain may be used when transporting a youth to a security unit, within a security unit, and from a security unit in order to prevent harm to the youth or others. These restraints may not be attached in a manner that prevents the youth from being able to stand upright. Mechanical restraints may remain on the youth for the duration of the activity if circumstances warrant such restraints.

(2) Restrictions on Use During or After Childbirth.

(A) TJJD staff may not use mechanical restraints to control the movement of a youth who is in labor, during delivery, or during recovery from delivery unless the executive director or designee determines that the use of restraints is necessary to:

(i) ensure the safety and security of the youth, the infant, a staff member, or a member of the public; or

(ii) prevent a substantial risk that the youth will attempt to escape.

(B) If restraint is approved by the executive director or designee, staff must use the least restrictive type and method of restraint necessary to achieve the purpose of the restraint.

(3) Mechanical Restraint Use by TJJD Transportation Staff. Mechanical ankle and wrist restraints attached to a waist belt by a lead chain must be used during secure transportation by designated TJJD transportation staff. Exceptions may be made for youth being transported following release on parole from a residential facility or when medically necessary.

(4) Mechanical Restraint Use by Other Transporters.

(A) Mechanical ankle and wrist restraints attached to a waist belt by a lead chain must be used during transportation when a youth is being transported to a high restriction facility.

(B) Mechanical ankle and wrist restraints attached to a waist belt by a lead chain may be used when transporting a youth off-campus.

(n) Requirements for Use of OC Spray.

(1) Authorization and Training for Use of OC Spray.

(A) OC spray is permitted only in TJJD-operated high-restriction and medium-restriction [~~high restriction~~] facilities.

(B) Unless reasonably believed necessary to prevent loss of life or serious bodily injury, authorization to use OC spray must be obtained from the facility administrator, assistant superintendent, or administrative duty officer prior to each use.

(C) The only staff authorized to routinely carry OC spray on-person are the facility administrator, assistant superintendent, administrative duty officer, juvenile correctional officer shift supervisor (one per shift), dorm supervisor, and security personnel whose primary responsibility is to patrol the campus and respond to security-related incidents. Any staff positions in addition to those listed must be authorized in writing by the executive director or his/her designee.

(D) Only staff who have been trained by TJJD in the use of OC spray are authorized to use it. TJJD's OC spray training curriculum must include a requirement that each staff member be sprayed with OC if:

(i) the staff member is receiving his/her first OC spray training as a TJJD employee; and

(ii) exposure to OC is not medically contraindicated.

(2) Criteria for Use.

(A) Except as provided in subparagraph (B) of this paragraph, OC spray is authorized for use only when non-physical interventions and other physical interventions have failed or are not practical, and it is reasonably believed necessary to:

(i) quell a riot or major campus disruption;

(ii) resolve a hostage situation;

(iii) remove youth from behind a barricade in a riot or self-harm situation;

(iv) secure an object that is being used as a weapon and that is capable of causing serious bodily injury;

(v) protect youth, staff, or others from imminent serious bodily injury; or

(vi) prevent escape.

(B) Unless reasonably believed necessary to prevent loss of life or serious bodily injury, OC spray is not authorized for use on a youth when a medical provider has diagnosed the youth with a chronic, serious respiratory problem or other serious health condition identified by TJJD (e.g., significant eye problems, known history of severe allergic reaction to OC, or severe dermatological problems).

(3) Guidelines for Use.

(A) OC spray canisters must be carefully controlled at all times.

(B) Any youth affected by OC spray must be decontaminated with cool water as soon as the purpose of the restraint has been achieved.

(C) Immediately following decontamination from OC spray, medical staff must be contacted to examine and, if necessary, treat and monitor all youth and staff affected by OC spray.

(D) Each individually assigned canister of OC must be weighed at the time it is assigned and after each use.

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

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