ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE SUBCHAPTER R. TELECOMMUNICATIONS IN MANAGED CARE SERVICE COORDINATION AND ASSESSMENTS

1 TAC §§353.1502, 353.1504, 353.1506

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to §353.1502, concerning Definitions; §353.1504, concerning Use of Telecommunications in Service Coordination and Service Management; and §353.1506, concerning Additional Requirements for Assessments and Service Management in STAR Health.

Section 353.1502 is adopted with changes to the proposed text as published in the December 20, 2024, issue of the *Texas Register* (49 TexReg 10167). This rule will be republished.

Section 353.1504 and §353.1506 are adopted without changes to the proposed text as published in the December 20, 2024, issue of the *Texas Register* (49 TexReg 10167). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments are necessary to comply with House Bill 4, 87th Legislature, Regular Session, 2021, which requires telecommunications allowances to the new service coordination levels for STAR Health. The amendments reflect the STAR Health programmatic changes by incorporating service coordination levels and replacing the term "service management" with "service coordination." These changes allow the STAR Health managed care organization to conduct assessments and provide service coordination services using telecommunications or information technology when it is clinically effective and cost-effective to do so.

COMMENTS

The 31-day comment period ended January 20, 2025.

During this period, HHSC did not receive any comments regarding the proposed rules.

HHSC revised §353.1502(13) to make the definition of "HHSC" more consistent with the definition used in other HHSC rules.

STATUTORY AUTHORITY

The amendments are adopted under 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 system; Texas Government Code §531.033, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration in Texas and to establish methods of administration and adopt necessary rules for the proper and efficient operation of the medical assistance program.

§353.1502. Definitions.

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

(1) Assessments--Managed care organization (MCO) evaluation of a member's medical and functional service needs, including community-based long-term services and supports, behavioral health services, therapies (e.g., physical, occupational, speech), and nursing services. This includes the MCO's completion of program-specific instruments and forms.

(2) Audio-only--Synchronous interactive, two-way audio communication that uses only sound and that meets the privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include face-to-face communication.

(3) Audio-visual--Synchronous interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audio-visual does not include audio-only or in-person communication.

(4) C.F.R.--Code of Federal Regulations.

(5) Change in condition--A significant change in a member's health, caregiver support, or functional status that will not normally resolve itself without further intervention and requires review of and revision to the member's current service plan or individual service plan.

(6) Community-based long-term services and supports (LTSS)--Services provided to a qualified member in the member's home or another community-based setting necessary to allow the member to remain in the most integrated setting possible. Community-based LTSS includes Medicaid state plan services available to all members, as well as services available to members who qualify for the Home and Community Based Services (HCBS) Program or Medicaid 1915(c) waiver programs, including the STAR+PLUS Home and Community-Based Services (HCBS) Program and the Medically Dependent Children Program. Community-based LTSS is available to both HCBS -eligible and non-HCBS eligible members. Community-based LTSS in Medicaid managed care varies by program model.

(7) Community First Choice (CFC)--A Medicaid state plan benefit described in 1 TAC Chapter 354, Subchapter A, Division 27 (relating to Community First Choice).

(8) Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, nonemergency medical transportation services, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and the Texas Health and Human Services Commission, including:

(A) all services or items comprising "medical assistance" as defined in Human Resources Code §32.003; and

(B) all value-added services under such contract.

(9) Declared state of disaster--A State of Disaster declared by the governor in accordance with Texas Government Code §418.014.

(10) Face-to-face--In-person or audio-visual communication that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include audio-only communication.

(11) Functionally necessary covered services--Community-based long-term services and supports provided to assist members with activities of daily living based on a functional assessment of the member's activities of daily living and a determination of the amount of supplemental supports necessary for the member to remain independent or in the most integrated setting.

(12) Healthcare service plan--An individualized plan developed with and for a member with special healthcare needs in the STAR Health program. The healthcare service plan includes the following:

(A) the member's history;

(B) a summary of current medical and social needs and concerns;

(C) short and long-term needs and goals; and

(D) a treatment plan to address the member's physical, psychological, and emotional healthcare problems and needs, including:

(i) a list of required services;

(ii) the frequency of each service;

(iii) a description of who will provide each service; and

(iv) for a member in the Early Childhood Intervention program, the individual family service plan.

(13) HHSC--The Texas Health and Human Services Commission or its designee.

(14) HIPAA--Health Insurance Portability and Accountability Act. Collectively, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§1320d et seq., and regulations adopted under that act, as modified by the Health Information Technology for Economic and Clinical Health Act (HITECH) (P.L. 111-105), and regulations adopted under that act at 45 CFR Parts 160 and 164.

(15) Individual service plan (ISP)--An individualized and person-centered plan in which a member enrolled in the STAR Kids, STAR Health or STAR+PLUS HCBS program operated by an MCO, with assistance as needed, identifies and documents the member's preferences, strengths, and health and wellness needs in order to develop short term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services. The ISP is supported by the results of a member's program-specific assessment and must meet the requirements of 42 C.F.R. §441.301.

(16) Information technology--Includes text, email, fax, secure transmission of clinical information, and HIPAA-compliant telecommunication tools such as health plan websites where a member or the member's legally authorized representative can access the member's healthcare information, including service plans.

(17) In-person (or in person)--Within the physical presence of another person. In-person or in person does not include audio-visual or audio-only communication.

(18) Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, and may, depending on the circumstances, include a parent, guardian, or managing conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. §435.923.

(19) Managed care organization (MCO)--An entity licensed and approved by the Texas Department of Insurance with which HHSC contracts to provide Medicaid services and that complies with Chapter 353 of this title (relating to Medicaid Managed Care).

(20) Medical consenter--The person who may consent to medical care for a member under Texas Family Code Chapter 266.

(21) Medically Dependent Children Program (MDCP)--A 1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(22) Medically necessary--Has the meaning as defined in §353.2 of this chapter (relating to Definitions).

(23) Medical Necessity Level of Care (MN/LOC)--An assessment instrument used to determine medical necessity for a nursing facility as defined by 26 TAC §554.2601. An MN/LOC is required for STAR+PLUS HCBS Program and CFC eligibility.

(24) Member--A person who is eligible for benefits under Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(25) Minimum data set (MDS)--Has the meaning as defined in 26 TAC §554.101.

(26) Nursing facility--An entity that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242.

(27) Nursing facility level of care--The determination that the level of care required to adequately serve a member is at or above the level of care provided by a nursing facility.

(28) Person-centered care--An approach to care that focuses on members as individuals and supports caregivers working most closely with members. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment.

(29) Resident Assessment Instrument (RAI)--Has the meaning as defined in 26 TAC §554.101.

(30) Resource Utilization Group (RUG)--A categorization method, consisting of multiple categories based on the minimum data set core elements in a resident assessment instrument, that is used to determine a recipient's service and care requirements for a nursing facility. A RUG determination is necessary for MDCP and the STAR+PLUS HCBS Program eligibility because these programs require a nursing facility level of care.

(31) Service coordination--A specialized care management service that is performed or arranged by the MCO to identify needs, including physical health, mental health services and long term support services, facilitate development of a service plan or individualized service plan to address those identified needs, and coordination of services among the member's primary care provider, specialty providers, and non-medical providers to ensure timely access to covered services, non-capitated services, and community services.

(32) Service coordinator--The person with primary responsibility for providing service coordination to Medicaid managed care members.

(33) Service plan (SP)--An individualized and person-centered plan in which a member, with assistance as needed, identifies and documents the member's preferences, strengths, and needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services. The service plan is supported by the results of the member's program-specific assessment. In STAR+PLUS, a service plan applies to members who are not enrolled in the STAR+PLUS HCBS Program.

(34) STAR+PLUS Home and Community-Based Services (HCBS) Program--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(35) Telecommunications--An exchange of information by electronic and electrical means.

(36) Telephonic--Audio-only communication using a telephone. Telephonic communication does not include audio-visual communication.

(37) Verbal consent--The spoken agreement of a member, a member's legally authorized representative, or a member's medical consenter.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501005
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 14, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 438-2910

♦ ♦ ♦

CHAPTER 355. REIMBURSEMENT RATES
SUBCHAPTER D. REIMBURSEMENT METHODOLOGY FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS (ICF/IID)

1 TAC §355.456

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.456, concerning Reimbursement Methodology.

Section 355.456 is adopted without changes to the proposed text as published in the November 15, 2024, issue of the *Texas Register* (49 TexReg 9134). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

The adoption updates the reimbursement methodology for the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) high medical needs add-on rates based on the Patient Driven Payment Model Long-Term Care (PDPM LTC) for nursing facilities. The current reimbursement methodology for the ICF/IID high medical needs add-on is based on the Resource Utilization Group version 3 (RUG-III) classification system and associated costs. The 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 25) directed HHSC to "develop and implement a Texas version of the Patient Driven Payment Model methodology for the reimbursement of long-term stay nursing facility services in the Medicaid program." The PDPM LTC methodology implements a new nursing facility classification system for Medicaid residents. This amendment uses PDPM LTC classifications to establish the reimbursement methodology for the ICF/IID high medical needs add-ons.

COMMENTS

The 31-day comment period ended December 16, 2024.

During this period, HHSC did not receive any comments regarding the proposed rule.

STATUTORY AUTHORITY

The amendment is adopted under 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; and Texas Human Resources Code §32.021 and Texas Government Code §532.0051(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501003

Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 14, 2025
Proposal publication date: November 15, 2024
For further information, please call: (512) 867-7817

♦ ♦ ♦

SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

1 TAC §355.503, §355.507

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to §355.503, concerning Reimbursement Methodology for Long-Term Services and Supports State Plan and Home and Community-Based Services Waiver Program Services Delivered through the STAR+PLUS Managed Care Program, and §355.507, concerning Reimbursement Methodology for Long-Term Services and Supports State Plan and Medically Dependent Children Waiver Program Services Delivered through the STAR Kids and STAR Health Managed Care Programs.

Section 355.503 and §355.507 are adopted without changes to the proposed text as published in the November 1, 2024, issue of the *Texas Register* (49 TexReg 8635). The rules will not be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the proposal is to clarify the reimbursement methodologies for the Long-term Services and Supports (LTSS) state plan and waiver services delivered through managed care. HHSC maintains fee schedules for LTSS programs and services delivered in STAR+PLUS or STAR Kids programs that represent the rates HHSC would pay contracted providers for these services if the services were delivered under a fee-for-service delivery model. The adoption ensures that HHSC has an established rate methodology for all the services delivered in managed care based on the STAR+PLUS and STAR Kids LTSS billing matrices. The adoption relabels and adds language to the rules to reference the STAR+PLUS and STAR Kids managed care programs and removes references to the expired Community-Based Alternatives Waiver Program and Integrated Care Management-Home and Community Support Services Program. The adoption also consolidates rate methodologies for LTSS state plan services delivered through STAR+PLUS and STAR Kids into the applicable Texas Administrative Code rule. The adoption revises the rate methodology for out-of-home respite under the STAR Kids Medically Dependent Children Program (MDCP) to mirror waiver changes and the published billing matrix. Finally, the adoption adds language to the rules to distinguish in-home and out-of-home settings for home health care services. These services include nursing, occupational therapy, and physical therapy, ensuring compliance with the 21st Century Cures Act, which requires all states to implement the use of electronic visit verification (EVV).

COMMENTS

The 31-day comment period ended December 2, 2024.

During this period, HHSC did not receive any comments regarding the proposed rules.

STATUTORY AUTHORITY

The amendments are adopted under 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; and Texas Human Resources Code §32.021 and Texas Government Code §532.0051(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501004
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 14, 2025
Proposal publication date: November 1, 2024
For further information, please call: (512) 867-7817

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 33. LICENSING

The Texas Alcoholic Beverage Commission (TABC) adopts amendments to 16 TAC §33.2, relating to Application and Fee Payment Procedures, 16 TAC §33.23, relating to License and Permit Fees, 16 TAC §33.44, relating to Excise Tax Bonds, 16 TAC §33.45, relating to Bonds for Alternating Brewery Proprietorships and Contract Brewing Arrangements, 16 TAC §33.57, relating to Application Withdrawn, 16 TAC §33.75, relating to Penalties and Suspension, 16 TAC §33.93, relating to Notification Requirements, 16 TAC §33.100, relating to General Provisions, 16 TAC §33.103, relating to Notice and Opportunity for Hearing, and 16 TAC §33.104, relating to Contents of Emergency Order.

TABC also adopts the repeal of 16 TAC §33.101, relating to Authority of the Executive Director, and 16 TAC §33.105, relating to Appeals of Emergency Orders.

The amendments and repeals are adopted without changes to the proposed text as published in the November 29, 2024, issue of the *Texas Register* (49 TexReg 9677). The amended rules will not be republished.

REASONED JUSTIFICATION. The adopted amendment to §33.2(a) removes a reference to physical application forms provided by TABC to reflect the fact that applications may now be filled out and submitted in a digital format through the agency's online business portal.

The adopted amendment to §33.23(c) reduces the minimum number of days that a nonprofit temporary event permit may be

issued from two days to one day. The agency's goal is to reduce the regulatory burden on applicants.

The adopted amendments to §§33.44(b) and 33.75(c) update internal rule citations to the appropriate, current rules to conform with previous changes to rule numbering.

The adopted amendments to §33.45 remove references to statutes and terms that correspond with the former brewer's permit that was eliminated by House Bill 1545 (2019).

The adopted amendment to §33.57(b) alters the method for calculating the minimum number of days that must elapse before the agency may withdraw an application. Currently, §33.57(b) provides that TABC may consider an application withdrawn if an applicant fails to respond to requests from the agency for additional information or for remittance of a fee within ten business days. The adopted amendment changes that timeline to ten calendar days to account for the fact that the agency's online business portal is generally accessible 24 hours a day, seven days a week. However, the agency still retains discretion to withdraw the application after that time period.

The adopted amendment to §33.93(b) removes a reference to reporting changes to the contact information for seller-server schools. The requirements for seller server school certificates are found in Chapter 50 and the agency is relocating that language to §50.24 in a separate and simultaneous rulemaking.

The adopted amendments to §33.100: (1) clarify that emergency orders suspending licenses or permits are initially issued without a hearing, as provided by Alcoholic Beverage Code §11.614; (2) better align the rule language with the statutory language in §11.614(a); and (3) remove obsolete and redundant language regarding the applicability of the Open Meetings Act and Administrative Procedure Act. TABC also adopts the repeal of §33.101 because it is redundant due to the adopted amendments to §33.100. The adopted amendments to §33.103 better align the rule language with the statutory language in §11.614(c) and clarify that the administrative law judge's decision to affirm, modify, or set aside the order is final. The adopted changes to §33.103 render §33.105 obsolete, therefore TABC is repealing §33.105. Finally, the adopted amendment to §33.104 simply adds language clarifying that the term of the suspension must be in the agency's emergency order.

SUMMARY OF COMMENTS. TABC did not receive any comments on the proposed amendments or repeals.

SUBCHAPTER A. APPLICATIONS

16 TAC §33.2

STATUTORY AUTHORITY. TABC adopts the amendments pursuant to TABC's rulemaking authority under Texas Alcoholic Beverage Code §§5.31, 11.614(d), 30.08(2), 62.14(d), 63.05(d). Section 5.31 authorizes TABC to prescribe and publish rules necessary to carry out the provisions of the Alcoholic Beverage Code. Section 11.614(d) authorizes TABC to "prescribe procedures for the determination and appeal of an emergency order issued under {section 11.614}." Section 30.08(2) directs TABC to "adopt rules which it determines to be necessary to implement and administer the provisions of {Chapter 30}, including…the duration for a permit issued under {Chapter 30}." Sections 62.14(d) and 63.05(d) both authorize TABC "by rule {to} require an entity that is a party to an alternating brewery proprietorship or contract brewing arrangement to post with the commission a bond in an amount determined by the commission…"

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501023
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER B. FEES AND PAYMENTS

16 TAC §33.23

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31 and 30.08(2) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 30.08(2) directs TABC to "adopt rules which it determines to be necessary to implement and administer the provisions of {Chapter 30}, including...the duration for a permit issued under {Chapter 30}."

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501024
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER C. BONDS

16 TAC §33.44, §33.45

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31, 62.14(d) and 63.05(d) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 62.14(d) and 63.05(d) both authorize TABC "by rule {to} require an entity that is a party to an alternating brewery proprietorship or contract brewing arrangement to post with the commission a bond in an amount determined by the commission…"

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501025

Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER D. APPLICATION REVIEW AND PROTESTS

16 TAC §33.57

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §5.31 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501027
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER E. EVENTS AT A TEMPORARY LOCATION

16 TAC §33.75

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §5.31 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501028
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER F. LICENSE AND PERMIT ACTION

16 TAC §33.93

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §5.31 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501029
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER G. EMERGENCY ORDERS

16 TAC §§33.100, 33.103, 33.104

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31 and 11.614 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 11.614 authorizes TABC to prescribe procedures for the determination and appeal of emergency orders temporarily suspending a license.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501026
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

16 TAC §33.101, §33.105

STATUTORY AUTHORITY. The repeals are adopted pursuant to TABC's rulemaking authority under §§5.31 and 11.614 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 11.614 authorizes TABC to prescribe procedures for the determination and appeal of emergency orders temporarily suspending a license.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501030

Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

CHAPTER 45. MARKETING PRACTICES

The Texas Alcoholic Beverage Commission (TABC) adopts amendments to 16 TAC §45.9, relating to Withdrawal of Application, 16 TAC §45.11, relating to When Reapplication is Required, 16 TAC §45.12, relating to Application Procedures During Interruption of Federal Agency Operations, 16 TAC §45.20, relating to Exhibiting Certificates to Representatives of the Commission, 16 TAC §45.23, relating to Alteration of Labels, 16 TAC §45.30, relating to Certificates of Registration for a Distilled Spirit Product, 16 TAC §45.40, related to Certificate of Registration for a Malt Beverage Product, 16 TAC §45.50, relating to Certificate of Registration for Wine, and 16 TAC §45.105, relating to Advertising. The amendments are adopted without changes to the proposed text as published in the November 29, 2024, issue of the *Texas Register* (49 TexReg 9681). The amended rules will not be republished.

REASONED JUSTIFICATION. The adopted amendment to §45.9 adds language to mirror the process for license and permit application withdrawals found in §33.57. This change is intended to provide clarity for applicants and consistency for the agency. The adopted amendments to §§45.11, 45.12, and 45.20 remove redundant language in references to a Certificate of Label Approval (COLA) and change references to the product registration certificate for consistency. The adopted amendment to §45.23 allows the executive director to name a designee to approve relabeling of bottled alcoholic beverages to ensure agency efficiency and removes redundant language. The adopted amendments to §§45.30, 45.40, and 45.50 make corresponding changes in each section to update the product registration process for distilled spirits, malt beverages, and wine, to mirror existing agency practices.

The adopted amendments to §45.105 provide clarity on the permissible forms of outdoor advertising at retail establishments. Pursuant to Alcoholic Beverage Code §108.52, "no outdoor advertising is permitted in this state except that which is authorized by this section or under rules of the commission..." Currently, §45.105(a) references a restriction on certain types of outdoor advertising and creates an inference that the rule also authorizes other forms of outdoor advertising. Adopted subsection (a)(2) is intended to clarify that, unless otherwise prohibited under the rule, outdoor advertising is permissible. For additional clarity, the subsection also incorporates the Alcoholic Beverage Code's definitions for outdoor advertising, billboards, and electric signs. Adopted subsection (a)(5) reiterates the inducement prohibitions in §45.110 and Alcoholic Beverage Code §§102.04, 102.07, 102.15, and 108.06. Adopted subsection (a)(6) acknowledges the permissible avenues for upper-tier members to sell or provide signage to retailers under §§45.113(d) and 45.117(d), which may meet the definition of outdoor advertising, so that the prohibition in subsection (a)(5) does not conflict with those authorizations. Lastly, adopted subsection (a)(6) also allows the signage provided to a retailer by an upper-tier member under §§45.113 and 45.117 to be placed on the exterior walls of the building or enclosure on the retailer's premises. This change is intended to reduce the regulatory burden on retailers.

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

SUBCHAPTER A. GENERAL PROVISIONS

16 TAC §§45.9, 45.11, 45.12

STATUTORY AUTHORITY. TABC adopts the amendments pursuant to TABC's rulemaking authority under §§5.31, 101.67, 101.671, and 108.52(c) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 101.67 and 101.671 direct TABC to prescribe rules for the registration of alcoholic beverage products with the state. Section 108.52(c) directs the agency to adopt reasonable rules relating to the type of outdoor advertising retail licensees and permittees may erect or maintain on the retailer's premises.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501015
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER B. ENFORCEMENT

16 TAC §45.20, §45.23

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31, 101.67, and 101.671 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 101.67 and 101.671 direct TABC to prescribe rules for the registration of alcoholic beverage products with the state.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501016
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER C. SPECIFIC REQUIREMENTS FOR DISTILLED SPIRITS

16 TAC §45.30

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31, 101.67, and 101.671 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 101.67 and 101.671 direct TABC to prescribe rules for the registration of alcoholic beverage products with the state.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501017
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER D. SPECIFIC REQUIREMENTS FOR MALT BEVERAGES

16 TAC §45.40

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31, 101.67, and 101.671 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 101.67 and 101.671 direct TABC to prescribe rules for the registration of alcoholic beverage products with the state.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501018
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER E. SPECIFIC REQUIREMENTS FOR WINE

16 TAC §45.50

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31, 101.67, and 101.671 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Sections 101.67 and 101.671 direct TABC to prescribe rules for the registration of alcoholic beverage products with the state.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501019
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

SUBCHAPTER F. ADVERTISING AND PROMOTION

16 TAC §45.105

STATUTORY AUTHORITY. The amendments are adopted pursuant to TABC's rulemaking authority under §§5.31 and 108.52 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 108.52(c) directs TABC to adopt reasonable rules relating to the type of outdoor advertising retail licensees and permittees may erect or maintain on the retailer's premises.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501020
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

CHAPTER 50. ALCOHOLIC BEVERAGE SELLER SERVER AND DELIVERY DRIVER TRAINING

SUBCHAPTER C. SELLER SERVER SCHOOL CERTIFICATES AND REQUIREMENTS

16 TAC §50.24

The Texas Alcoholic Beverage Commission (TABC) adopts an amendment to 16 TAC §50.24, relating to Seller Server School Certificates and Requirements. The amendment is adopted without changes to the proposed text as published in the November 29, 2024, issue of the *Texas Register* (49 TexReg 9685). The amended rule will not be republished.

REASONED JUSTIFICATION. The adopted amendment adds language clarifying that the holder of a seller server certificate must maintain a current mailing address, telephone number, and email address on file with TABC. The amendment also requires

the holder of such a certificate to update that information within seven business days of any changes. The amendment is intended to ensure the agency has current contact information for all certificate holders. This adoption is made in conjunction with adopted amendments to 16 TAC §33.93, which is being done in a separate and simultaneous rulemaking.

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

STATUTORY AUTHORITY. TABC adopts the amendment pursuant to TABC's rulemaking authority under §§5.31 and 106.14 of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 106.14 directs the commission to adopt rules establishing requirements for approved seller training programs.

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

Filed with the Office of the Secretary of State on March 25, 2025.

TRD-202501007
Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Effective date: April 14, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 206-3491

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

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

The Texas Department of Insurance (TDI) adopts the repeal of 28 TAC §§3.1 - 3.8, and new sections in Division 1, containing §3.1 and §3.2; Division 2, containing §§3.10 - 3.23; Division 3, containing §3.40 and §3.41; Division 4, containing §§3.50 - 3.52; and Division 5, containing §§3.60 - 3.62, concerning filing and submission requirements for life, annuity, accident, health, and health maintenance organization (HMO) products. TDI adopts the amendments to §3.3100 and repeal of §3.3101 and §3.3102 of Subchapter S, concerning readability. TDI also adopts the amendments to §§3.4004, 3.4005, and 3.4009 of Subchapter Z, concerning certain life, accident, health, and annuity forms that are exempt from review, and the repeal of §3.4020, concerning policy form certifications in connection with exempt filings.

The repeals are adopted without changes to the proposal published in the October 4, 2024, issue of the *Texas Register* (49 TexReg 8018). The commissioner adopts §§3.12, 3.15, 3.19, 3.22, 3.50, 3.60, 3.62, 3.3100, and 3.4005, without changes to the proposed text in the same issue. These rules will not be republished. Sections 3.1, 3.2, 3.10, 3.11, 3.13, 3.14, 3.16 - 3.18, 3.20, 3.21, 3.23, 3.40, 3.41, 3.51, 3.52, 3.61, 3.4004, and 3.4009 are adopted with changes in response to public comment and to make nonsubstantive changes to update punctuation and grammar, reflecting current agency drafting style and plain language references. These rules will be republished.

In separate rulemaking, TDI adopts amendments to 28 TAC §7.1301 and repeals §7.1302, concerning the billing system for regulatory fees, to be consistent with new and amended sections in 28 TAC Chapter 3. The adopted amendments and repeal in Chapter 7 are also published in this issue of the *Texas Register*.

REASONED JUSTIFICATION. This adoption streamlines and modernizes the filing processes for life, annuity, accident, health, and HMO products, including form, rate, network, and advertising filings. These rules last underwent significant updates in 2003. The adoption:

- updates standards governing all filings that are submitted to TDI's Life and Health Division through SERFF;

- repeals provisions related to the manual TDI billing system;

- aligns filing procedures across the Life and Health Division by extending filing rules to apply to HMO and network filings;

- limits excessive use of variability in a filing to help TDI ensure compliance and promptly process filings;

- addresses acceptable methods of premium payment and circumstances when third-party payments must be accepted;

- expands the applicability of readability and plain language requirements to all life, annuity, credit, accident, health, and HMO products, other than group annuities and major medical products subject to existing plain language rules;

- strengthens consumer protections related to applications by adding disclosure requirements and clarifying that an applicant cannot be asked to sign an application before receiving a written copy;

- narrows the scope of filings eligible to be filed exempt; and

- reorganizes the rules for clarity and readability.

Descriptions of the new, amended, and repealed sections follow, organized by subchapter and division.

Subchapter A. Submission Requirements for Filings and Departmental Actions Related to Such Filings.

Repeal of §§3.1 - 3.8.

The sections being repealed last underwent significant updates in 2003. TDI repeals these sections in order to modernize and reorganize the filing requirements in the new adopted sections.

Division 1. Applicability, Scope, and Definitions.

In response to a comment, TDI changed the title of Division 1 as proposed to remove the word "severability" because it was erroneously included; the division does not address severability.

Section 3.1. Applicability and Scope. The new section generally tracks provisions contained in former §3.1, which is repealed. It explains that the subchapter applies to all form, rate, advertising, network, group eligibility, and informational filings for products including life, annuity, accident and health, credit life, credit accident and health, and HMO products. The new section differs from former §3.1 in that the former section did not apply to HMO products. The expanded applicability in the new section reflects that these filings are processed using the same submission procedures. While the section is written broadly to capture a wide range of product and filing types, it does not require issuers to

make any filing that is not already required under the rules that are repealed or other existing rules. TDI has changed paragraph (1)(B) as proposed to clarify that a form filing includes any other coverage document attached to or made part of a document described in paragraph (1)(A).

Section 3.2. Definitions. The new section defines 33 terms for use in Subchapter A. Included among these are some terms contained in former §3.2, which is repealed. The definitions for these terms are updated to align with terms used by industry through the filing process. In response to comments, TDI has changed paragraph (2) of new §3.2 as proposed to clarify that in blanket coverage there are neither individual applications, nor individual underwriting. TDI has also changed paragraph (7) as proposed to add a reference to the Insurance Code within the definition of "evidence of coverage," and TDI has changed paragraph (28) as proposed to remove a reference to a subsequent electronic system designated by the department.

Division 2. General Filing Requirements.

Section 3.10. Requested Filing Mode. The new section is similar to subsections (a)(1) - (3) and (b)(1) in former §3.5, which is repealed. The new section outlines four requested filing modes and specifies the types of filings that are eligible to be submitted on a file-and-use or exempt basis, at the option of the insurer, rather than being filed for review or approval. A filing that is not subject to review or approval may be filed in an informational filing mode. To conform with the filing modes listed in SERFF, TDI has changed the catchline of paragraph (1) as proposed to say "and" instead of "or."

Section 3.11. Submission Requirements. The new section outlines submission requirements that apply to all filing types. It aligns closely with the submission requirements found in former §3.3 and §3.4(c) and (m), which are repealed. Subsection (a) requires issuers to submit filings electronically through the System for Electronic Rates & Forms Filing (SERFF), and subsection (b) addresses how the department would handle a system outage. In response to a comment, TDI has removed from subsection (a) as proposed a reference to a subsequent electronic system.

The new section includes language from former §3.3, but updates and simplifies it in regard to transmittal information to align with SERFF submission fields. Since some information previously collected through transmittal checklists can now be collected within SERFF fields, subsection (c) of the new section specifies the information that must be included, either in applicable SERFF fields or in a transmittal checklist. As technology evolves, TDI may modify transmittal checklists to streamline filing processes and avoid duplicative requirements. Most of the information specified in subsection (c) is substantially similar to that in former §3.3 and §3.4(c) and (m). Company information in subsection (c)(1) is broader, to reflect SERFF fields. A confidentiality designation is included in subsection (c)(4) because SERFF allows all filings to be posted for public access, unless a document within the form is designated as containing confidential information. To provide a more complete listing of the types of forms or documents that might be filed, TDI has changed subsection (c)(7)(F) as proposed to add document, evidence of coverage, and amendment to the list. Requirements in subsection (c)(10) expand on requirements from former §3.3(b)(2)(J)(ii) to include a copy of a form approved before January 1, 2012, which is the date TDI's SERFF records begin. TDI has changed subsection (c)(10) as proposed to clarify that the informational elements listed in subparagraphs (A) - (E) are in connection with the forms that the filing will be used with.

Subsection (d) of the new section addresses submission requirements for a substantially similar, exact copy, substitution, or resubmission filing, which are similar to former requirements in §3.6(a)(3), (4), and (6). Many of the certification requirements in former §3.6 are included in new §3.16. To clarify how issuers should illustrate differences, TDI has changed subsection (d)(2) as proposed to use the word "redlined" instead of "underlined."

Subsection (e) of the new section references requirements for advertising filings contained in Chapter 21, Subchapter B.

Subsection (f) of the new section specifies that TDI may ask for any additional information necessary, which aligns with former §3.6(d).

Section 3.12. Contact Person. The new section aligns closely with language in former §3.4(b). Additions include paragraph (2), requiring an issuer to provide the contact person's email address (rather than providing it "if available," as in the repealed section), and paragraph (3)(B), requiring that an issuer clearly authorize their designee to act on behalf of the issuer with respect to the type of filing. Designees might include a consulting firm, qualified actuary, or legal counsel.

Section 3.13. Filing Fees. The new section sets all form and rate filing fee amounts at $100, subject to certain exceptions, which are consistent with the fees in former §3.4(r). The new section does not apply filing fees to any other filing types (e.g., advertising, network, group eligibility, or informational filings). These changes simplify the fee structure formerly addressed in §3.4(r). The new section requires all form and rate filing fees to be paid through SERFF. In response to a comment, TDI has changed subsection (d) as proposed to remove a reference to a subsequent electronic system designated by the department. New §3.13 requires issuers to pay filing fees at the time a filing is accepted for review and provides that TDI may consider a filing withdrawn if the issuer does not pay the fee within five business days following acceptance for review. This ensures that the appropriate fee will be paid before a filing is approved. The new section will eliminate the need for TDI's manual billing system; thus, TDI proposed to repeal 28 TAC §7.1302, which addresses TDI's manual billing system.

Section 3.14. Purpose and Use. The new section includes provisions similar to former §3.2(9) and §3.3(b)(2)(F). These provisions are included in paragraphs (1) - (4), (6), and (7) of the new section. Instead of using the term "form," which was in former §3.2(9), the new section uses the term "filing" to reflect the subchapter's focus on filing requirements. Paragraph (3)(B) provides examples of the types of key or unique provisions in an accident and health filing that must be identified, including exclusive provider benefits and innovative excepted benefit products. Innovative excepted benefit products would include experimental or nonconventional coverage types addressed in 28 TAC §3.3081 and authorized by Insurance Code §1201.103. Paragraph (5) of the new section does not duplicate a provision from former §3.2 or §3.3. It requires a filing to explain any new program or initiative addressed by the filing. Examples of this include a value-added noninsurance benefit authorized by Insurance Code §1701.061, or a steering or tiering program addressed in Insurance Code §1458.101. This provision will streamline TDI's review by helping staff understand how the filing will be used at the beginning of the review and reducing the need to ask additional questions. In response to comment, TDI has changed paragraph (5) as proposed to add examples of a new program or initiative.

Section 3.15. Confidential Information in Filings. The new section codifies TDI's existing process for handling confidential information in filings and aligns with the Property and Casualty Filings Made Easy rules in 28 TAC Chapter 5, Subchapter M. The new subsections address public inspection of filings through SERFF Filing Access; confidentiality and disclosure under the Texas Public Information Act; a prohibition against declaring an entire filing confidential; redaction; and the confidentiality of personally identifiable information. The definition of personally identifiable information under new §3.2 does not include the name of a group policyholder, thus this section does not require an issuer to designate a group policy face page as confidential.

Section 3.16. Certifications. The new section lists requirements for certifications that are similar to those in former §3.4(j) and §3.6(a). Subsection (a) of the new section lists general certifications required for all filings to affirm the company's responsibility to thoroughly review a filing, consistent with former §3.6(a)(1). Paragraphs (1) and (2) state the certification is on behalf of the issuer and the issuer is bound by it. In response to comment, TDI has changed paragraph (3) as proposed to provide that a certification state that the issuer--rather than the individual--is familiar with the laws applicable to the filing and believes the filing is compliant. Paragraph (4) states that the individual making the certification has reviewed the filing and that the information in the filing is true and correct. Paragraph (5) states that the form filed is not deceptive or misleading; under previous rules this certification was required only in exempt filings. Paragraph (6) affirms that, if applicable, the filing accurately reflects the Flesch score of each form.

Subsection (b) lists additional certifications from former §3.6(a)(2) that apply only to certain filings by creating new Figure §3.16(b) to clearly display when these specific certifications should be used. The first two certifications ensure that companies do not knowingly file forms with compliance deficiencies that have been previously flagged by the department. The third certification ensures that companies review and update previously filed forms as needed to comply with new requirements before submitting a substantially similar, exact copy, or substitution filing. The fourth and fifth certifications affirm that all changes to a form are identified and that any exact copy filing meets the definition. The sixth certification affirms that a substitution filing is made only for forms that have not been issued. The seventh certification affirms that a form will be marketed only as supplemental coverage. The eighth certification affirms that products created using matrix or insert page forms will comply with applicable requirements, since TDI does not review such products in their final form. The ninth - 13th certifications affirm that exempt filings will comply with Chapter 3, Subchapter Z, similar to certifications in former §3.6(a)(9).

Subsection (c) outlines the consequences for submitting false certifications by referencing Insurance Code §841.704 and §843.464, which address criminal penalties for knowingly making false statements to TDI.

Section 3.17. Form and Rate Filing Requirements. The new section updates form and rate filing requirements for efficient review. Subsection (a) specifies that, except for general use filings, a single filing may contain rates and forms only for one product.

Subsection (b) requires general use forms to be filed individually, unless the forms are reasonably related and intended to be used with one or more of the same underlying products. These provisions are substantially similar to the former rules that are repealed; for example, former §3.4(r)(1)(A) specified the $100 filing fee applies to "each contract or policy, including . . . its certificate, . . . application, and . . . riders filed as part of the entire policy or contract." These provisions ensure that filings are accurately classified on the basis of the type of product and help TDI staff apply the correct product standards. TDI encourages issuers to identify related filings in the general information provided with the filing so that TDI can assign related filings to the same reviewer, or otherwise coordinate TDI staff to ensure prompt and consistent reviews. Issuers can also identify subsequent filings as "substantially similar" to a previous filing, which allows TDI staff to focus on new language and perform a faster review.

Subsection (c) specifies the minimum requirements for a face page.

Subsection (d) addresses the requirements for unique form numbers, which were previously addressed in former §3.4(c)(2). Form numbers are required on each page or below each matrix provision.

Subsection (e) contains requirements for limited, partial refilings that are consistent with former §3.4(h).

Subsection (f) requires amendments and endorsements to be accompanied by a revised form that incorporates the changes made. An amendment will not be approved unless the revised form incorporating the amendment (if applicable) is also approved. This requirement supports plain language and readability and ensures that when consumers are issued coverage, they receive a clean, updated document. An amendment or endorsement form should be issued only to modify a consumer's existing coverage document and should not accompany newly issued coverage. In response to comments, TDI has changed the requirement as proposed to give issuers 180 days after receiving approval for the revised version of the form before the issuer must begin using the revised form.

Section 3.18. Variable Material. The new section includes updated requirements similar to those in former §3.4(d) and (e). These provisions promote the appropriate use of variability where it adds value and efficiency. The limits on variability are necessary to address challenging reviews and ensure compliance. TDI anticipates that the limits on variable material will significantly increase speed-to-market by reducing the time issuers spend correcting deficient filings.

Subsection (a) describes the general and proper use of variable material.

Subsection (b) requires issuers to submit a statement of variability that demonstrates compliance and provides a clear explanation of how the material will vary.

Subsection (c) describes permissible uses of variability. In response to a comment, TDI has changed subsection (c) as proposed to add new paragraph (5), explaining that it is permissible for variability to be used for options selected by a group policyholder, if those options are clearly specified and their use demonstrates compliance with applicable requirements.

Subsection (d) explains limits on variability. A form number cannot be variable because TDI's approval of a form is tied to the form number. Likewise, an issuer's name cannot be variable because TDI separately approves each issuer's use of a form. Instead, issuers can submit an exact copy filing if they experience a name change or want to use the same form that was approved for another company. Different product types must be filed in separate filings so the filing reflects the appropriate type of in-

surance and the correct review standards can be applied. While variability cannot be used to create different product types, issuers have other tools available that support efficient filing methods, including general use, matrix provisions, insert page filing options, and the option to identify a filing as substantially similar to another filing, which allows for a streamlined review. The ranges of variability specified must be consistent with any applicable rate filing. TDI cannot approve a form unless it can verify that the issued form will comply with applicable requirements.

Subsection (e) addresses fill-in material for life and annuity forms, consistent with former §3.4(d)(2). In response to a comment, TDI has changed subsection (e) as proposed to clarify that it only applies to individual forms.

Subsection (f) prohibits the use of variable material in life forms for text and specifications of nonforfeiture assumptions, similar to former §3.4(e)(2), and it clarifies proper use of zero-range entries.

Subsection (g) clarifies that any change to a statement of variability is considered a change to the form itself and must be filed in conjunction with the form.

Subsection (h) specifies that TDI may request examples of issued forms without variability, if needed to aid staff's understanding of how the variability will function. The limits set on variability in this section provide insurers with clear guidance on the proper and expected use of variable material to ensure efficient reviews. These limits do not restrict general use filings that can capture similar documents used in a variety of contract forms.

Section 3.19. Matrix and Insert Page Forms. The new section sets out submission requirements that apply to a matrix or insert page form filing. The requirements are similar to requirements in former §3.4(f) and (g), but they are combined where requirements for matrix or insert pages are identical. Subsection (a)(1) addresses form number requirements, and subsection (a)(2) clarifies when a matrix provision can be used in multiple products. Subsection (a)(3) requires the issuer to explain how the forms will be used. Subsection (b) explains how an insert page may be used to replace an existing page of a previously approved or exempted form, consistent with former §3.4(g)(3).

Section 3.20. Plain Language and Readability Requirements. The new section extends plain language and readability requirements to life and annuity products (other than group annuity products) and group accident and health excepted benefit products, other than major medical plans. Major medical plans continue to be subject to plain language and readability requirements under similar provisions in 28 TAC Chapter 3, Subchapter G. To promote uniformity, the requirements in this section replace similar readability requirements for individual accident and health products under 28 TAC Chapter 3, Subchapter S, which are repealed.

Subsection (a) describes the purpose of the plain language requirements.

Subsection (b) describes the forms that the plain language requirements apply to.

Subsection (c) requires applicable forms to be written in plain language.

Subsection (d) sets the Flesch Reading Ease score at 40; references the method of calculation in 28 TAC §3.602(b)(1), (c), and (d); requires a statement of the Flesch score; and states that TDI may require additional information to verify compliance. The calculation method allows certain text to be excluded, including language required by any state or federal law.

Subsection (e) provides guidance to issuers by describing plain language best practices. In response to a comment, TDI has changed subsection (e)(7)(D) as proposed to replace the word "unnecessarily" with "unreasonably."

Subsection (f) addresses how a definitions section may be used.

Subsection (g) addresses font size and formatting.

Subsection (h) specifies when a table of contents or index is required.

These provisions are in line with industry standards and provide additional guidance to aid companies in submitting compliant form filings. Most issuers are already using plain language best practices.

Section 3.21. Group Filings. The new section includes updated requirements similar to those in former §3.4(o) and §3.6(c). Group filing requirements are streamlined by not including the requirement from former §3.6(c)(2) for issuers to submit separate form filings for each group type.

Subsection (a) uses updated language to identify the Insurance Code provisions that address eligible policyholders for group and blanket coverage, applies the criteria for accident and health policyholders to apply to groups purchasing HMO coverage, specifies when an issuer must submit a group eligibility filing, and explains how group eligibility information and forms may be submitted. TDI has changed subsection (a)(1) as proposed to use "including," instead of "as follows," to ensure the rule does not constrain issuers from citing additional group eligibility statutes. Under the new section, issuers will not be required to submit the group eligibility information for review for each product being issued. Instead, if TDI has verified the group's eligibility in the past five years, the issuer will submit only an informational filing. For consistency with subsection (a)(2)(B), TDI has changed subsection (a)(2)(C) as proposed to clarify that the associated form numbers are those that are "to be issued to the group."

Subsection (b) specifies the group eligibility filing requirements for coverage to be issued to an association, which are similar to requirements in former §3.6(c)(3)(B) - (D). Those filings must identify the types of coverage the issuer will offer the association; demonstrate that the association is an eligible group policyholder; and include an alternate face page and a copy of the association's constitution, bylaws, and articles of incorporation. In recognition that subsection (b) applies to various types of organizations with different governance structures, TDI has changed subsection (b)(1) as proposed to refer to "other formative or organizational documents regulating the conduct of the association's internal affairs."

Subsection (c) specifies the group eligibility filing requirements for coverage to be issued to a trust, which are similar to requirements in former §3.6(c)(3)(D) and (F). Trust filings must include a copy of the trust agreement and an alternate face page form for each related industry group. Association trust filings also must include a list of all participating associations and a reference to the group eligibility filing for each association.

Subsection (d) requires issuers to notify TDI of additional associations within a multiple association trust by making an informational filing and is similar to requirements in former §3.6(c)(3)(E). Issuers must notify TDI of any additions to the trust upon enrollment and include additional documentation.

Subsection (e) requires issuers to submit a group eligibility filing for any type of group or blanket policyholder that is not identified in statute as an eligible policyholder, including actuarial information similar to requirements in former §3.4(q)(6). These filings are needed to determine whether it is in consumers' best interest to allow a particular "discretionary group" to offer insurance coverage.

Subsection (f) specifies information that issuers must provide when issuing a major medical health benefit plan to an association, which is similar to requirements in former §3.6(c)(3)(A) and relevant for determining the applicable requirements. For example, different requirements apply to member-only bona fide associations, bona fide employer associations, and associations issuing coverage to small employers versus large employers.

Subsection (g) clarifies that products issued to educational institutions on a group basis must be filed under Insurance Code §1131.064 or §1251.056, and that products issued to educational institutions on a blanket basis must be filed under Insurance Code §1251.353. While educational institutions are specifically identified as eligible blanket policyholders under Insurance Code §1251.353, the statute does not specifically identify them as eligible group policyholders.

Subsection (h) is consistent with former §3.4(o), which required issuers to ensure that insurance certificates or HMO evidences of coverage being delivered to Texas residents comply with all the applicable laws of this state and include copies of out-of-state documentation.

Section 3.22. Braile and Non-English Filings. The new section provides guidance regarding braille and non-English filings. Subsection (a) aligns with former §3.4004(h) and requires a certification that the form meets the definition of an exact copy. Subsection (b) allows a filing that includes only a braille or non-English language version of a previously approved form to be filed in an informational mode or an exempt mode.

Section 3.23. Acceptance, Rejection, and Disposition of Filings. The new section includes reorganized versions of provisions in former §3.7 to clarify procedures for accepting and processing filings and to avoid restating statutory provisions. New subsection (a) addresses acceptance of filings and includes provisions similar to former §3.7(a) and (b). Subsection (a)(1) explains that filings that are subject to approval and not rejected will be considered filed as of the submission date. It also references the statutory provisions that address deemer periods. Subsection (a)(2) explains that an exempt filing that is not rejected will be considered exempt as of the disposition date. Subsection (a)(3) explains that an informational filing that is not rejected will be considered filed as of the submission date and will be closed with an informational disposition.

Subsection (b) addresses rejection of filings that are incomplete or otherwise do not meet submission requirements, similar to former §3.7(a)(2). TDI may reject a filing if an issuer does not make corrections within two business days of TDI's request for corrections. This limited timeframe reflects the straightforward nature of submission deficiencies, in contrast to the more complex and substantive nature of the compliance standards for which corrections may be requested under subsection (c). TDI will not reopen a filing that has been rejected.

Subsection (c) is similar to former §3.7(c) in addressing requests for correction and extensions and waivers of deemer dates. These provisions are necessary to ensure that a form is not deemed approved when compliance issues have been identified. Submission requirements for corrections consist of a summary and certification of identified changes similar to those in former §3.6(a)(5)(E) and (F). TDI has changed the proposed text of subsection (c)(1)(B) to use a higher-level cross-reference to HMO rules, to avoid a conflict if those rules are reorganized. In the interest of processing filings promptly, subsection (c)(3) requires issuers to submit corrections within 10 business days. This replaces the 30-day period provided in former §3.7(c)(4) and is necessary to allow TDI to review filings within the statutory deemer dates. In response to comments, TDI has changed subsection (c)(3) as proposed to clarify that upon request from an issuer, TDI may agree to extend the time the issuer has to submit corrections.

Subsection (d) addresses how TDI will notify issuers of a filing disposition.

Subsection (e) explains that TDI may withdraw approval only after notice and opportunity for hearing, consistent with former §3.7(e).

Subsection (f) addresses issuer responsibilities to retain records related to form filings.

Division 3. Requirements Relating to Application Form Filings.

Section 3.40. Applications Generally. The new section explains TDI's expectations for application form filings. Subsection (a) requires application form filings to address the type of contracts and products the application will be used with and whether the application will be used in paper, electronic, or telephonic form.

Subsection (b) requires issuers to submit entire applications for review and to make clear what an applicant is required to complete. This section does not require issuers to file screenshots or websites for review, but rather to include in the form filing all text that may be used in an application, however it is delivered.

Subsection (c) explains the requirements for applications to be used by multiple issuers. Subsections (a), (b), and (c) are consistent with TDI's current review standards.

Subsection (d) specifies fairness standards for questions asked on an application form. Questions must be consistent with underwriting standards, limited to information necessary to issue or administer the policy, and may not require the applicant to self-diagnose.

Subsection (e) specifies disclosure requirements for application forms, explaining that the application will become part of the contract and helping applicants understand underwriting standards. In response to comments, TDI has changed subsection (e)(1) as proposed to add "if applicable" and to clarify that the application will become part of the contract. This change clarifies that the new language will be required only for an application form that will become part of the contract. It also requires applications to include a method for applicants to opt out of electronic communications if the issuer does not seek affirmative consent. This provision helps issuers ensure that their forms and procedures comply with Insurance Code Chapter 35, as amended by House Bill 1040, 88th Legislature, 2023. Finally, it requires issuers to disclose how applicants' personal information may be obtained from third parties.

Section 3.41. Standards for Electronic and Telephonic Applications. The new section adds provisions to aid issuers in complying with appropriate delivery of applications, consistent with TDI's current review standards. Subsection (a) references an issuer's obligation to comply with Insurance Code Chapter 35.

Subsection (b) requires issuers to provide applicants with a written copy of the completed application before signing. This provision is needed to ensure that a consumer is not asked to verbally sign an application without being able to verify that it was completed accurately. It does not prevent an issuer from delivering a written copy of the application electronically.

Subsection (c) requires issuers to deliver the completed application in a manner that allows the consumer to keep it for their records in compliance with Business and Commerce Code §322.008(a) and Insurance Code §35.004(c).

In response to a comment, TDI has changed §3.41 to remove proposed subsection (d), which would have required issuers to include a description of security procedures that will be used to verify the authenticity of an electronic transaction.

Division 4. Requirements Specific to Accident, Health, and HMO Filings.

Section 3.50. Filing Requirements for Health Plan Disclosures. The new section is similar to the requirements in former §3.4(i) and identifies each product for which an outline of coverage or similar plan disclosure is required to be filed. Applicable product filings must either include the required disclosure document or reference the filing ID that the document was filed separately under.

Section 3.51. Payment of Premiums or Cost Sharing. The new section implements Insurance Code Chapter 541 and addresses consumer protections related to restrictions on the form or manner of premium or cost-sharing payments for major medical and Medicare Supplement coverage. In response to comments, TDI has changed subsections (a) and (b) as proposed. As adopted, subsection (a) specifies that any restriction on the form or manner of payment of premiums or cost sharing must be specified in the contract, and subsection (b) requires issuers to provide consumers with reasonable options for paying premiums and cost-sharing and prohibits issuers from requiring payment by personal check.

Subsection (c) clarifies that the section does not modify the requirements or applicability of Insurance Code §1369.0542.

Section 3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage. The new section adds clarity to the filing requirements for issuers terminating or nonrenewing all guaranteed renewable major medical coverage in a given market or service area. This is needed to provide clarity on how to file required notices. These filings give TDI the opportunity to help issuers comply. They also allow TDI to help consumers affected by terminations.

Subsection (a) references the rules that require issuers to provide notice regarding termination of guaranteed renewable major medical coverage. In response to comments, TDI has changed subsection (a) as proposed to clarify that issuers must submit an informational filing to TDI through SERFF for each applicable line of business and removed the reference to the 180-day timeframe, since that is already addressed in other rules.

Subsection (b) identifies the information that issuers must include in filings related to termination of guaranteed renewable major medical coverage. In response to comments, TDI has changed subsection (b) as proposed to clarify that it only applies to a filing made under subsection (a) when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area.

Subsection (c) clarifies that the filing requirements are in addition to withdrawal plan rules in 28 TAC Chapter 7, Subchapter R, if the termination of coverage constitutes a withdrawal under Insurance Code Chapter 827.

Division 5. Actuarial Filing Requirements.

Section 3.60. General Actuarial Filing Requirements. The new section requires issuers to submit either rate filings or other actuarial information as required by law and specifies the existing applicable statutes and rules. This section replaces provisions in former §3.1(8) and (10) and §3.4(p), which are repealed.

Section 3.61. Actuarial Information for Certain Accident and Health Filings. The new section specifies the actuarial information that must be included for certain accident and health products. This section includes updated versions of filing requirements contained in former §3.4(q)(5) and (6). Subsection (a) specifies that the section applies to individual accident and health products and group accident and health products issued to alternative types of group policyholders.

Subsection (b) clarifies that the section does not apply to rate filings for non-grandfathered individual major medical, small group major medical, Medicare supplement, or long-term care products. Rate filing standards for these are addressed in separate rules.

Subsection (c) clarifies that a premium rate schedule must be filed before being used.

Subsection (d) requires a premium rate schedule to be accompanied by an actuarial memorandum signed by a qualified actuary.

Subsection (e) specifies actuarial filing submission requirements for new products, which were not specified in the repealed sections, beyond a brief reference in former §3.4(q)(6). This information is necessary to implement Insurance Code §1251.056 and §1701.057, which require TDI to assess whether benefits are reasonable in relation to the premiums charged. In response to a comment, TDI has changed the text of §3.61(e)(2) as proposed to clarify that issuers may file either new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer.

Subsection (f) specifies requirements for rate adjustment filings for existing products, and replaces provisions addressed in former §3.4(q)(5).

Section 3.62. Actuarial Information for Life and Annuity Filings. The new section replaces former §3.4(q)(1) and (2) to update the actuarial information required for life and annuity filings, consistent with current agency standards. Subsection (a)(1) references requirements in Insurance Code Chapter 1105. Subsection (a)(2) addresses actuarial information required for universal life filings. Subsection (a)(3) references the actuarial information required for variable life forms. Subsection (a)(4) requires a certification similar to former §3.4(q)(1)(C).

Subsection (b) addresses actuarial information required for annuity filings, which is substantially similar to former §3.4(q)(2).

Subsection (c) addresses multiple guaranteed interest charge periods.

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

Section 3.3100. Policy Readability Generally. Amendments to the section revise duplicative readability references in Chapter 3, Subchapter S, to align with standards listed in new §3.20. Sub-

section (a) is amended to add the title for Insurance Code Chapter 1201, Subchapter E, and strike unnecessary references to Chapter 1201. Subsection (b) is amended to reference plain language and readability standards in new Chapter 3, Subchapter A.

Repeal of §3.3101 and §3.3102. The sections are repealed to avoid duplication of provisions related to plain language and readability standards in new §3.20.

Subchapter Z. Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review.

Section 3.4004. Exempt Forms. Amendments to the section update the types of forms that are eligible to be filed in an exempt filing mode and the types of forms that must be filed for review. Exempt filings are not permitted for products with a history of compliance issues or consumer protection concerns.

Amendments in subsection (a) broadly exempt group and individual term life insurance forms. Exempt privileges are removed for product types that are subject to actuarial review, including whole life, endowment life, and certain limited refilings. This change will have minimal impact on issuers because the volume of exempt filings is low; an estimated four whole life filings may be impacted per year based on filing patterns in 2022 and 2023. Issuers can elect "file and use" if they do not want to wait for TDI to complete its review. The subsection is simplified to remove reference to different types of groups, forms, and products previously addressed in paragraphs (1) - (3). Individual variable life with a separate account only, which was previously specified as exempt in paragraph (3)(Q) is renumbered as paragraph (2). Subsequent paragraphs are renumbered. Nonsubstantive amendments are made to paragraphs (3) and (4) as renumbered to clarify abbreviated terms. Paragraph (5) as renumbered is amended to remove exempt privileges for limited refilings that change the mortality table or interest rates for new issues under the policy form because these filings require actuarial review.

Amendments to subsection (b) clarify that it addresses the types of life insurance forms that are not permitted to be filed as exempt. Paragraph (1) is amended to clarify that universal life includes flexible premium adjustable life. Paragraph (2) is amended to remove universal-related life, which duplicates the reference to universal life in paragraph (1), and add whole life, consistent with the removal of ordinary life from subsection (a)(3)(A) because it is subject to actuarial review. Paragraph (3) is amended to remove adjustable life, which is now referenced in paragraph (1) and add endowment life, consistent with its removal from subsection (a)(3)(M) - (O), because it is subject to actuarial review. Nonsubstantive amendments are made to paragraphs (8) and (10) - (12) to conform to agency style, add titles to statutory citations, and replace "equity indexed" with the more commonly used term "index-linked crediting." TDI has changed paragraph (12) as proposed by substituting the word "forms" for a list of form types, consistent with other amendments to the section. New paragraph (13) is added for limited refilings for life insurance that change the mortality table or interest rates for new issues under the policy form, consistent with the amendment made in subsection (a)(4).

Nonsubstantive amendments are made in subsection (c) to conform to agency style by replacing "which" with "that," and removing the words, "including applications," because applications are already captured by the term "forms."

Amendments to subsection (d) clarify that it addresses the types of annuity forms that are not permitted to be filed as exempt. The term "index-linked crediting" replaces "equity indexed" to be consistent with the terminology more commonly used by issuers. New paragraph (6) is added to list contingent deferred annuities. TDI has changed subsection (d)(5) as proposed to conform to similar amendments to the section by substituting the word "forms" for a list of various form types that had been included in the subsection as proposed.

Amendments in subsection (e) update the types of accident and health forms that can be filed as exempt. Nonsubstantive amendments in paragraph (1)(A) and (C) simplify the exemption of certain group accident and health forms by removing reference to different types of forms. Paragraph (1) is amended to remove exempt privileges for blanket forms in subparagraph (B) because of a pattern of compliance issues. Subsequent subparagraphs are redesignated. Nonsubstantive amendments are made to paragraph (1)(B) as redesignated to clarify the exemption for employer plans that supplement Medicare. Nonsubstantive amendments in paragraph (2) simplify the exemption of certain types of group and individual accident and health forms by removing reference to different types of forms. Paragraph (2)(C) is amended to remove exempt privileges for dental forms because of a pattern of compliance issues and clarify that hospital indemnity forms are eligible to be filed exempt. Paragraph (2)(D) is amended to remove exempt privileges for in-patient confinement and basic hospital expense coverages because, unless they are structured as hospital indemnity coverage, they are reviewed as major medical products. Subsequent subparagraphs are redesignated. A nonsubstantive amendment in paragraph (2)(H) removes the reference to Champus supplements because those policies are rarely filed, so the example is not useful. Paragraph (2)(K) is amended to remove exempt privileges for prescription drug policies because major medical review standards apply. Paragraph (3) is amended to remove exempt filing privileges for certain alternate face pages because group eligibility filing requirements are addressed in Chapter 3, Subchapter A. Under new §3.13, group eligibility filings are not charged a filing fee.

Amendments to subsection (f) remove repetitive language and clarify that it addresses the types of forms and rates that are not permitted to be filed as exempt. Paragraph (1) is amended to modernize the language related to comprehensive or major medical policies by adding a reference to "guaranteed renewable or short-term limited duration" and removing the reference to limited benefit policies, which are no longer permitted under federal law. Nonsubstantive amendments are made to paragraphs (2) - (6), including adding titles to statutory citations, replacing a reference to preferred provider rules with a reference to statute, and removing unnecessary phrases like "but not limited to" and "the authority of." New paragraph (7) is added to list fixed indemnity coverage for more than hospital confinement because such forms often provide innovative benefits and contain compliance issues. In response to a comment, TDI has changed paragraph (7) as proposed to simplify the wording. New paragraph (8) is added to clarify that the exempt status for forms does not extend to rates that are required to be filed. TDI has identified that rates related to individual health products that have been filed as exempt are often unreasonable in relation to the benefits provided. New paragraph (9) is added to list dental policies because TDI has consistently found compliance issues related to unique requirements in Texas law.

Amendments to subsection (g) remove unnecessary language related to certifications and remove a reference to §3.4020, which is repealed. While exact copies can almost always be filed exempt, an exception is added to disallow an exact copy filing to be filed exempt for preferred provider benefit plans, so that staff can verify that these plans have satisfied examination requirements added to Insurance Code §1301.056.

An amendment to subsection (h) removes the reference to the outdated certification form. Certifications are addressed in new §3.16. For clarity and consistency with new §3.22, the term "foreign language" is replaced with references to the terms "braille" and "non-English."

Section 3.4005. General Information. Amendments to subsection (c) remove unnecessary language related to certifications and a reference to former §3.4020, which is repealed. Language is added to reference the certifications required for exempt filings in §3.16. Also, a nonsubstantive amendment is made to subsection (b) to improve readability.

Section 3.4009. Sanctions and Cancellation of Exempt Filing Privileges. The amendments to subsection (a) explain that an insurer's exempt filing privileges may be cancelled if the insurer makes an exempt filing that fails to comply, which results in TDI determining that the filing has failed audit. If TDI cancels exempt filing privileges, this will be communicated in the failed audit notice. As proposed, subsection (a) incorrectly specified that notice of failed audit will be issued consistent with §3.23; this section does not address failed audit notices. TDI has changed subsection (a) as proposed to reference §3.4008 instead of §3.23. Amendments to the section remove the requirement that TDI hold a hearing before canceling an insurer's exempt filing privilege. However, the amendments do not remove an insurer's right to request a hearing to challenge the failed audit determination, which is consistent with Insurance Code Chapter 36. In response to a comment, TDI has changed §3.4009(a) as proposed to add a sentence stating that an issuer can request a hearing if it disagrees with TDI's determination. TDI anticipates that the need to take action under this section will be rare. However, to protect consumers and maintain a fair and competitive market, it is important to ensure TDI can take prompt action when needed. Nonsubstantive amendments are made in subsections (b) and (c) to improve readability.

Section 3.4020. Section 3.4020, which contains a figure with outdated certifications, is repealed. Certifications are now contained in new §3.16. Conforming changes are made in §3.4004 and §3.4005 to remove references to former §3.4020.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on November 4, 2024. In advance of the proposal, TDI also solicited comments on an informal draft of the rule text posted to the TDI website January 19, 2024.

Commenters: TDI received comments from three commenters. Two commenters spoke at a public hearing on the proposal held on November 7, 2024. Commenters in support of the proposal with changes were the American Council of Life Insurers, Texas Association of Health Plans, and Texas Association of Life and Health Insurers.

General Comments

Comment. One commenter states that the new rules will apply only prospectively and that previously filed documents should be audited based on rules in effect at the time of filing. The commenter recommends clarifying the applicability in the adoption order and adding rule text that specifies that forms received before the effective date will be governed by the laws and rules in effect on the submission date. The commenter also recommends clarifying that the proposed plain language and readability standards under §3.20 apply only to forms filed after the rule's effective date and do not require issuers to refile previously approved forms.

Agency Response. TDI declines to make a change. TDI agrees that the new rules will apply only prospectively but disagrees that additional rule text is needed. Staff conducting audits will be aware of the rule's effective date.

Comment. One commenter expresses appreciation for the opportunity to comment on the rule and looks forward to future collaborations.

Agency Response. TDI values the comments received and appreciates the contributions from stakeholders.

Comment. One commenter recommends reposting these rules for all stakeholders to review new language.

Agency Response. TDI declines to repropose the rules. Changes to the rules from proposal are in response to comments or to address nonsubstantive issues. No new subject matter is addressed and no new persons are affected, so reproposal is not necessary and would delay implementation of the rules.

Comments on §3.1. Applicability and Scope.

Comment. One commenter asks for clarification on whether Division 1 contains a severability provision, because the word "severability" is listed in the proposed Division title.

Agency Response. The reference to "severability" in the title of Division 1 was in error. Because case law dictates that severability is implied, TDI no longer includes severability provisions in rules. The title of Division 1 as proposed is changed in this adoption to remove this word.

Comment. One commenter notes that §3.1 does not reference the applicability of the rules to filings made under the Interstate Insurance Compact under Insurance Code Chapter 5001. The commenter also asks for clarification on how the standards in §3.41 would interact with the Compact. The commenter recommends modifying §3.1 to state that the rule does not change the uniform standards adopted by the Compact.

Agency Response. TDI agrees that filings made through the Compact are authorized under Insurance Code Chapter 5001 but believes it is unnecessary to make the requested change. Texas has joined with other states in the Interstate Insurance Product Regulation Compact. *See* Tex. Ins. Code Ch. 5001. The Interstate Insurance Product Regulation Commission states that "companies have the choice of filing products through the Insurance Compact or filing products directly with a state. If a company chooses the latter course, then the regulator will apply the existing product standard laws and procedures of the state. If a company files with the Insurance Compact, then the Insurance Compact's Uniform Standards and review process will apply. Many companies find it more efficient and expeditious to make one filing through the Insurance Compact for all Compacting States than to make individual filings in each state."

Comments on §3.2. Definitions.

Comment. One commenter states that the definition of "blanket policy or contract" in §3.2 is inconsistent with the provisions in

Subchapters H and I in Insurance Code Chapter 1251 that address blanket accident and health insurance. The commenter asks why the proposed definition specifies that a blanket policy will not have individual application or underwriting.

Agency Response. The proposed definition aligns closely with Insurance Code §1251.401, which states, "An individual application from an insured under a blanket accident and health insurance policy is not required." This definition is needed because the requirements for group and blanket coverage are different, and TDI cannot accurately review filings that are improperly classified. The definition adopts the common understanding of the term. For example, the Utah Insurance Code defines it as "covering a defined class of persons . . . without individual underwriting or application {and} that is determined by definition without designating each person covered." TDI modifies the wording of the definition to clarify neither individual applications nor individual underwriting are included in blanket coverage.

Comment. Two commenters request changes to the definition of "insert page" in §3.2 and offer alternative language describing an insert page as providing a "comprehensive description" of a topic. One commenter states that the language being repealed in §3.4(g) is clearer. The commenter states that the proposed definition better describes a "replacement page," and that many insurers refer to insert pages as only forms that may be included or excluded from a contract based on a particular plan.

Agency Response. TDI declines to modify the definition of insert page in §3.2. It aligns closely with the requirements that were in former in §3.4(g) and is defined broadly enough to encompass both a "replacement page" and an "insert page" as described by the commenters. The proposed definition allows insert pages to be used as a modular approach to constructing contract forms, which also allows those individual forms to be replaced when necessary.

Comment. One commenter suggests modifying the definition of "rider" to read "A form that adds, expands or changes benefits or provisions."

Agency Response. TDI disagrees with the suggestion because contract changes should be filed as an amendment or endorsement. Riders are typically used to provide optional coverage, often for additional cost. They should not conflict with or modify the terms of a contract or reduce benefits.

Comment on §3.11. Submission Requirements.

Comment. One commenter expresses concern with language in §3.11 and other sections that requires issuers to use SERFF "or a subsequent electronic system." The commenter states that changes to the designated system should only be done by rule to comply with Government Code Chapter 2001. The commenter also states that SERFF is an NAIC system and suggests adding a reference to the specific SERFF Filing Manual in effect and drafting the rule to comply with Insurance Code §36.004(c).

Agency Response. TDI understands the commenter's concern about a subsequent electronic system and has changed §§3.2(28), 3.11(a), and 3.13(d) as proposed to remove that language. TDI disagrees that SERFF is a "rule, regulation, directive, or standard adopted by" the NAIC and subject to Insurance Code §36.004. SERFF is an electronic system. Since TDI is not adopting the SERFF Filing Manual, the version number is not relevant to the rule.

Comment on §3.13. Filing Fees.

Comment. One commenter asks for clarification on the structure of fees for matrix filings under §3.13(a)(3) if a filing has more than 10 matrix provisions. The commenter also asks if the matrix fee structure also applies to insert forms.

Agency Response. The fee structure under §3.13(a)(3) for matrix filings charges $50 per form (matrix provision) up to $500. Any filing with more than 10 matrix forms will be charged only the $500 maximum fee. The fee structure for matrix filings does not apply to insert pages.

Comment on §3.14. Purpose and Use.

Comment. One commenter asks for clarification on the meaning of "a new program or initiative" under §3.14(5) and whether it includes value-added services.

Agency Response. To provide additional clarification as requested by the commenter, TDI has changed §3.14(5) as proposed to include examples of a new program or initiative, including a value-added noninsurance benefit, or a steering or tiering program.

Comments on §3.15. Confidential Information on Filings.

Comment. One commenter recommends amending §3.15 to require TDI to notify an insurer before releasing information in response to an open records request, to allow the insurer to explain why the information is or should remain confidential. The commenter suggests that this could reduce the need to request a decision from the Office of the Attorney General.

Agency Response. TDI declines to make a change because the procedure for open records is outside the scope of the rule. The language in this subsection provides clarity on how documents with confidential information should be marked in accordance with SERFF functionality. Documents that are not marked as confidential become open to the public upon filing through the SERFF public access system. Documents marked as confidential and responsive to an open records request will be referred to the Office of the Attorney General in accordance with the Public Information Act.

Comment. One commenter supports the language in subsection §3.15(f) because it clarifies how individual names can be protected in group filings.

Agency Response. TDI appreciates the support.

Comment on §3.16. Certifications.

Comment. One commenter expresses concern with the requirement under §3.16(a)(3) for individuals to certify that they are familiar with all applicable statutes and regulations, in contrast to former §3.6(a)(1)(A)(iii), which applied this certification to the company. The commenter notes that because forms are often compiled by multiple operational areas of the issuer and each area contributes specialized knowledge, it may be difficult to find one individual who is able to certify to this across the entire filing, particularly given the risk of criminal liability specified under §3.16(c). The commenter suggests modifying the certification to be at the issuer level, and striking subsection (c). A second commenter recommends TDI provide a draft certification for issuers to follow.

Agency Response. TDI understands the commenter's concerns and in response to the comment has changed §3.16(a)(3) as proposed to reference the issuer rather than the individual. TDI declines to delete subsection (c), because it is important that issuers understand the potential consequences for making

false certifications. With respect to the second commenter, TDI agrees and will continue to make the text of certifications available within the transmittal checklists posted on the TDI website.

Comments on §3.17. Form and Rate Filing Requirements.

Comment. Two commenters recommend modifying §3.17(a) to specifically state that term life and accidental death and dismemberment (AD&D) benefits may be contained in an integrated document. The commenters also recommend that multiproduct group policies and applications be permitted, noting that the group policy might simply address the roles and responsibilities of the group policyholder and insurer, while the certificate addresses the coverage provisions. One commenter recommends modifying the definition of "product" in §3.2(24) to include a sentence that states, "Forms which provide both term life and AD&D in an integrated fashion will be considered as one product."

Agency Response. TDI agrees that issuers are permitted to include term life and AD&D benefits in an integrated contract but disagrees that a change to the rule text is needed. Section 3.17(a) already specifies that the rule "does not prevent an issuer from filing a product that contains multiple types of benefits that will be issued in combination in a single contract if that combination otherwise complies with applicable requirements." Section 3.17(b) permits a form (such as a multiproduct application or policy shell) to be filed on a general use basis. The definition of "product" in §3.2(24) also does not limit an issuer's ability to offer multiproduct group policies or applications. TDI recognizes that issuers sometimes combine multiple benefits in a single policy, and other times file stand-alone riders or certificates that can be used in combination. This rule continues to permit both approaches.

Comment. Three commenters suggest changes to §3.17(f) as proposed. One commenter states that it would be administratively burdensome to immediately incorporate newly approved amendments into all forms, particularly since forms are issued to members throughout the calendar year. The commenter suggests that the rule designate a set amount of time, such as six months after approval, before issuers must begin issuing the new forms with the amendments incorporated, so that issuers have sufficient time to load and test the new forms before they are issued to members. Two other commenters suggest that issuers should be permitted to inform TDI that the text will be incorporated with the revised text for new issues and bear the original form number with an additional statement indicating the forms are amended with the form number of the endorsement or amendment. One of the commenters notes that for "issue system efficiency, insurers need the ability to issue the new benefit within a rider, even to an existing certificate." The commenter also asks for clarification on the meaning of "amendment" in this section, and states that if it refers to a legal amendment to the contract, it would be cumbersome for issuers to use a new form number when a previously approved form will be used with an amendment.

Agency Response. The term "amendment" is defined in §3.2(1), and that meaning applies to its use in §3.17(f). The requirements in §3.17(f) apply only to amendments and do not apply to riders. TDI appreciates the commenters' concerns and in response to the comments has changed §3.17(f) as proposed in the way recommended by the first commenter to provide up to 180 days for the issuer to begin issuing the revised version of the form. TDI believes this approach will mitigate the concerns from the other commenters. TDI declines to permit issuers to incorporate amendments without filing a revised version of the form, because this would conflict with the statutory requirements for issuers to file forms with TDI. However, this does not prevent issuers from using form numbering conventions that include a version number or date to reflect the relationship between newer and older versions of a form.

Comments on §3.18. Variable Material.

Comment. Two commenters recommend changing §3.18(d)(2) to allow company names to be bracketed as variable. One commenter states that the prohibition on bracketing the company names diminishes the benefit of the Uniform Certificate of Authority Application (UCAA) process that issuers follow when undergoing a name change. If the company name cannot be variable, then the company must refile all forms after completing the UCAA name change process. A second commenter offers alternatives to subsection (d)(2) as proposed, such as allowing variability contingent on approval of a name change in a certificate of authority, a name-change endorsement, or an informational filing. The commenter also suggests clarifying that the variability of the company name permits the issuing company to change its name but does not permit a distinctly different company to use the form.

Agency Response. TDI declines to modify §3.18(d)(2) because the entity that is accepting the risk for a form is a fundamental element of a form. Under §3.4004(g), an issuer may submit filings that are identical, other than the issuer's name, as an exact copy filing that is eligible to be filed on an exempt basis. This reduces the administrative time and expense of making filings following a name change.

Comment. One commenter asks for clarification on whether the requirement in §3.18(d)(4) applies in the context of AD&D coverage issued in combination with life insurance, where the AD&D amount is a function of the life insurance amount. The commenter assumes it does not apply in this context.

Agency Response. The limitation on using a range of variability that exceeds the range supported in the issuer's filed rates would apply only to variability within a form for which a rate filing is required. With respect to AD&D policies, a rate filing is required only for AD&D coverage issued to individuals. This provision does not prevent an issuer from issuing life and AD&D coverage under a single policy. Any required rate filing must be consistent with the form as filed, including the range of variability the issuer chooses to specify.

Comment. One commenter asks for clarification concerning the requirements in §3.18. First, the commenter asks for guidance on how to comply with the requirement in subsection (a) that requires the variable material in the form to include specimen language or fill-in material that reflects the most restrictive option. Next, the commenter asks TDI to clarify in subsection (c) that illustrative items like eligibility provisions will be permitted, because the group market needs broad variability in the eligibility provisions. The commenter also asks whether variability is permitted within insert pages and matrix forms.

Agency Response. The requirement for specimen language and fill-in material to reflect the most restrictive option available under variability is a requirement of the former rules being repealed, under §3.4(d)(1). The bracketed language in the filed form should reflect the most restrictive option, if applicable. For example, a bracketed benefit amount should be the minimum benefit amount in the filed range; a bracketed deductible should be the maximum deductible amount in the filed range.

The statement of variability should explain the full range and increments by which the amounts might vary. TDI agrees that variability in eligibility provisions is appropriate, as long as the filing demonstrates compliance with applicable requirements, and has changed the proposed rule text of §3.18 to add new subsection (c)(5) to clarify that options selected by a group policyholder may vary according to clearly specified options. The rule does not prohibit the use of variability in an insert page or matrix form.

Comment. Two commenters raise concerns that the provisions in §3.18(d)(5) and (h) could (1) be applied inconsistently based on individual reviewers' judgment and understanding of the product, (2) require carriers to submit every possible plan design, and (3) result in carriers offering fewer plan options. One commenter states that TDI lacks statutory authority for subsection (h). The commenters note that some filings have broad variability encompassing thousands of permutations for plan designs to give group policyholders the ability to customize their products and that it would be overly burdensome for carriers to file and for TDI to review these individually. Both commenters suggest removing §3.18(d)(5), and one commenter suggests removing §3.18(h). The other commenter asked for clarification on whether under §3.18(h) TDI would expect a carrier to provide exhaustive examples of every possibility, or just a select sampling.

Agency Response. TDI disagrees that these provisions will negatively impact issuers or consumers and declines to make a change. Issuers are obligated to provide a clear explanation of how the material will vary, and TDI is obligated to ensure forms comply with applicable requirements. Section 3.18(d)(5) makes clear that TDI cannot approve a form without a full understanding of how the product will appear when issued. Most uses of variability are straightforward, and most issuers already provide sufficient explanations of variable material; therefore most issuers will not be affected by these provisions. However, when the approach to variability is unusual or particularly complex (such as when there are brackets within brackets that cause an interaction between variable text), subsection (h) gives reviewers another tool to aid in understanding how the product will function by requesting one or more examples of how the form will look when issued to the consumer. This provision does not require issuers to provide exhaustive examples of every permutation contained in the form or reduce the range of variability included.

TDI also disagrees with the commenter's statement that limits on variability are not authorized by statute. The Insurance Code requires issuers to file forms subject to TDI review and approval and does not contemplate the use of variability. Variability is a privilege that is created by rule subject to TDI discretion. Like exempt filings, proper use of variability creates efficiency for both issuers and TDI while creating minimal compliance risk. The requirements in §3.18 seek to balance the dual aims of efficiency and thorough compliance reviews.

Comment. One commenter recommends changes to §3.18(e) and (f) to apply the requirements only to individual life insurance products.

Agency Response. TDI agrees in part, and has changed §3.18(e) as proposed to apply only to individual life and annuity products. TDI declines to change §3.18(f), which applies to both group and individual life and annuity products.

Comment on §3.20. Plain Language and Readability Requirements.

Comment. One commenter suggests changing §3.20(e)(7)(D) to use the term "unreasonably" in place of "unnecessarily" in the provision that states that it is a plain language best practice to avoid referring an insured between sections of a form.

Agency Response. TDI agrees to make the change.

Comments on §3.21. Group Filings.

Comment. One commenter supports changes to group filings, especially removing the requirement to submit separate form filings for each group type. The commenter states that this change will dramatically improve speed-to-market for applicable product types in the Texas market. The commenter also asks for clarification about §3.21(a)(3), which the commenter believes is inconsistent with the proposal's statement that separate forms will not be needed for each group type.

Agency Response. TDI appreciates the support for this change. TDI disagrees that §3.21(a)(3) is inconsistent with the removal of the "one group, one filing" provision. Subsection (a)(3) requires issuers to submit form filings separately from group eligibility filings; it does not require separate forms for different group types. For example, a single group form filing could be made for a product that will be issued to an employer under §1251.051 and a trust under §1251.053. The group eligibility filing required under §3.21(c) for the trust should be submitted separately from the form filing.

Comment. One commenter asks whether §3.21(c) requires issuers to include copies of previously approved forms if the filing IDs and form numbers are provided. The commenter also states that §3.21(d) requires additional filings for a multiple association trust if any new association is added. The commenter states it would be overly complicated to require a complete new filing and recommends that previously approved documents be filed as informational rather than for approval.

Agency Response. Under §3.21(a)(3) and (c), a group eligibility filing is made separate from a form filing, and the only forms required within a group eligibility filing for a trust are alternate face page forms referenced in §3.21(c)(2). The forms that have been previously approved should be referenced as described in §3.21(c)(3)(B).

Comment. One commenter notes that §3.21(g) refers to statutes that mention "other groups," asks why it is necessary to mention these statutes in rule, and asks TDI to clarify that the rule does not require group eligibility filings for educational institutions.

Agency Response. TDI has observed that some issuers are uncertain about how to classify group filings for educational institutions, since educational institutions are not specifically identified by statute as eligible group policyholders. Because of this confusion, TDI includes §3.21(g) to explain that such filings are permitted under the "other groups" statutes and should be classified accordingly. Insurance Code §1131.064 and §1251.056 permit other types of group policyholders subject to a commissioner determination. Group eligibility filings are required for "other groups"--including educational institutions--under §3.21(e) so that TDI can determine whether the "other group" satisfies the statutory criteria. This is consistent with statute and current practice. TDI declines to exempt educational institutions from group eligibility filings because doing so is not supported by statute.

Comment. Two commenters oppose §3.21(h) and TDI's longstanding application of extraterritorial application of Texas law. The commenters outline legal arguments for why they believe it

is inappropriate and unconstitutional for TDI to apply Texas requirements to coverage issued to Texas residents under policies issued to out-of-state group policyholders. The commenters ask why it is necessary for issuers to file out-of-state group documents in addition to the certificate that will be issued in Texas.

Agency Response. TDI declines to make a change. Insurance Code Article 21.42 provides that "any contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance, and governed thereby, notwithstanding such policy or contract of insurance may provide that the contract was executed and the premiums and policy (in case it becomes a demand) should be payable without this State, or at the home office of the company or corporation issuing the same." *See Howell v. Am. Live Stock Ins. Co.*, 483 F.2d 1354, 1360 n.4 (5th Cir. 1973) (stating in the context of group policies, "the fact that the insurer does any business in Texas is sufficient to require that Texas law apply to any contract between it and a Texas resident, regardless of the intention or expectation of the parties"); *General Am. Life Ins. Co. v. Rodriguez*, 641 S.W.2d 264, 266-67 (Tex. App.--Houston [14th Dist.] 1982, no writ) (holding Insurance Code Article 21.42 applies where group life policy issued to out-of-state employer covered employee residing in Texas).

Comments on §3.23. Acceptance, Rejection, and Disposition of Filings.

Comment. Three commenters submitted comments concerning the timeframe for requests for corrections. One commenter asks TDI to confirm that the intent of §3.23(b)(1) is to allow two business days to correct minor issues found during the intake process, and §3.21(c)(3) is to provide 10 business days to respond to reviewer objections on filed forms. The commenter also asks whether, under §3.23(c)(1)(A), TDI expects carriers to proactively request a 45-day extension or waiver of the deemer date, and whether TDI will advise of these options in their requests for correction. Two commenters recommend adding a provision to allow an issuer to waive the deemer period when the issuer needs more time to respond. The commenters note that for complex issues, companies sometimes need more than 10 days to submit corrections after a notice of deficiency to be too short of a timeframe and request additional rule text to ensure that issuers can request more time under §3.23(c). One of the commenters asks TDI to add language allowing the issuer and to extend the timeframes under §3.23(c) on agreement by both parties, noting that this would give some flexibility while ensuring TDI can still hold issuers accountable when appropriate. One commenter states that the deadline of two business days for making corrections to an incomplete filing under §3.23(b) is too short--noting that sometimes submitters may be out of the office on planned or unplanned leave. The commenter suggests changing the deadline to five or 10 business days.

Agency Response. TDI confirms that §3.23(b) gives issuers two business days to make technical corrections to avoid rejection of an incomplete filing, and §3.23(c)(3) gives issuers 10 business days to correct substantive compliance deficiencies. TDI declines to increase the timeframe for submitting corrections under §3.23(b) because the issues are usually easily corrected, and issuers are already meeting these timeframes under existing processes. TDI expects issuers to ensure their filing packages are complete upon submission and have backup staff available to promptly handle any issues. If there are more substantive issues that require more time to correct, the issuer should withdraw the filing and resubmit it when it is complete and ready for review. For substantive corrections during review requested in §3.23(c), paragraph (1) already permits issuers to request an extension or waive the deemer period, so no change is needed. TDI will maintain its current practice of advising issuers of the need to extend or waive a deemer date. TDI agrees to modify paragraph (3) to clarify that TDI may agree to extend the 10-day period for the issuer to submit corrections. This aligns with TDI's current process of granting reasonable extensions on request.

Comment. Two commenters ask for clarification on the meaning and timing of status changes during the filing review process. One commenter notes the prohibition under §3.23(a) on adding new forms after a filing has been accepted and asks how the carrier will know when the filing is in an "accepted" status. Another commenter notes that §3.23 does not address reopening a filing that has been rejected or disapproved and assumes that the issuer can resubmit such filings.

Agency Response. A filing is accepted after TDI confirms that it meets the filing requirements in this subchapter. TDI will review its procedures for using status codes in SERFF to help issuers understand when a filing has been accepted. TDI does not allow a filing to be reopened after it has been rejected or disapproved. An issuer can resubmit the filing after the previous deficiencies have been corrected.

Comment. One commenter opposes the wording in §3.23(e), which states, "Before withdrawing approval, the department will provide notice and opportunity for hearing." The commenter believes the rule is inconsistent with Insurance Code Chapter 1701, which references that the "commissioner" may withdraw approval "after notice and hearing." The commenter expresses concern that using the word "department" reflects broad delegation not authorized by statute, and that the word "opportunity" does not appear in the express statutory requirements.

Agency Response. TDI declines to make a change to §3.23(e) because it is substantially similar to the wording in former §3.7(e)(2) and consistent with the use of the word "department" throughout the rule. Delegation of authority for specific functions, as addressed in Insurance Code Chapter 36, is outside the scope of this rule. TDI believes it is appropriate to give the issuer the opportunity to request a hearing, rather than to obligate issuers to attend a hearing that they may prefer to forego.

Comments on §3.40. Applications Generally.

Comment. One commenter asks whether §3.40 is intended to apply to enrollment forms in the group insurance market. The commenter also asks TDI to change §3.40(b) to clarify that it does not require issuers to file screenshots of electronic applications.

Agency Response. With respect to forms in the group insurance market, TDI does not broadly exempt "enrollment forms" because that term is not used consistently; in some cases, an enrollment form could be purely administrative, while in others the form has a substantive contractual purpose and would be subject to the rule as specified in §3.1(1). TDI declines to change §3.40(b) but confirms the rule does not require the filing of screenshots--just the "text contained on the application."

Comment. Two commenters request removing §3.40(e)(1), which requires an application form to state that the application form will be attached to and become a part of the contract. One

commenter finds this requirement to be excessive because that language is typically already included in the contract or policy the application is attached to. The commenter notes that this requirement would necessitate refiling of forms, which would be burdensome. Another commenter adds that there are cases where the entire contract does not become part of the policy.

Agency Response. TDI declines to remove §3.40(e)(1), because it is important for consumers to understand when filling out an application form that it will become a part of the contract upon completion. This requirement would apply only to applications filed after the rule's effective date, so it would not require refilings of previously approved applications. TDI agrees that applications are occasionally not attached to the contract and clarifies that the provision in §3.40(e)(1) applies only "if applicable."

Comment. One commenter notes that under §3.40(e)(3), an application form is required to include a method for an applicant to opt out of electronic communications. The commenter appreciates the rule referencing the statute that the ability of issuers to use an opt-out, rather than an affirmative consent for conducting business electronically.

Agency Response. TDI appreciates the support for this provision.

Comments on §3.41. Standards for Electronic and Telephonic Applications.

Comment. Two commenters note that §3.41(b) requires issuers to give an applicant a written copy of the completed application before the applicant is asked to sign and submit the application. The commenters believe that this provision could be read to require a paper copy of applications completed telephonically or electronically. The commenters note that requiring a paper copy could conflict with Texas' enactment of the Uniform Electronic Transactions Act and the federal Electronic Signatures in Global and National Commerce Act, which give full legal recognition to electronic records. The commenters also note that the statutes referenced in §3.41(c) support an interpretation that the word "written" means an electronic record, and that issuers can comply with §3.41(b) by electronically providing a written copy of the completed application. The commenters ask TDI to clarify that the rule does not require delivery of a paper copy.

Agency Response. TDI confirms that an issuer can comply with §3.41(b) by electronically providing a written copy of the completed application.

Comment. One commenter states that §3.41(d), which requires disclosure of security procedures, is ambiguous and confusing. The commenter states that some states require submission of the application in the manner in which it is used and asks if this requires screen shots of electronic application platforms. The commenter notes that for applications accessed and submitted through an internet portal, this could require issuers to construct the portal and application before the application is approved, which would severely impair speed-to-market.

Agency Response. As stated in response to another comment, §3.40(b) does not require the filing of screenshots, just the "text contained on the application." TDI agrees to change the rule text as proposed to remove the requirement in §3.41(d) to include a description of security procedures with every filing of an application that will be used with electronic or telephonic transactions.

Comment on §3.50. Filing Requirements for Health Plan Disclosures.

Comment. One commentor states that it is unclear what is meant by the term "similar disclosure" or why it is needed in §3.50.

Agency Response. Similar disclosures would include other notices that are required to be filed in connection with health coverage. For example, if TDI had enforcement responsibilities for the federal Affordable Care Act, then the summary of benefits and coverage would also be filed under these provisions.

Comment on §3.51. Payment of Premiums or Cost Sharing.

Comment. Two commenters oppose §3.51 because it required major medical plans and Medicare Supplement policies to accept third-party payments. One commenter states that they are extremely concerned about this proposed requirement because of a history of bad actors abusing third-party payment schemes. The commenters state that the proposed language is broader than federal requirements and assert that TDI does not have statutory authority to adopt the provision, citing a frequently asked question posting (FAQ) on TDI's website that states that the issue is not addressed by statute. The commenters suggest that if the section is not removed, it should be modified to align with TDI's FAQ and simply require that issuers disclose in the contract any limitations that the issuer imposes on third-party payments.

Agency Response. To avoid any unintended consequences, TDI agrees with the commenters' suggestion to align the section with current practice. TDI has changed §3.51(a) as proposed to specify that any restriction on the form or manner of payment of premiums or cost-sharing must be specified in the contract. TDI has also changed subsection (b) as proposed to require issuers to provide consumers with reasonable options for paying premium and cost-sharing and not require payment by personal check. While the Insurance Code does not specifically address this issue, it is within TDI's authority to adopt rules implementing Insurance Code Chapter 541. Also, Insurance Code §543.002 prohibits insurers from making an insurance contract or agreement relating to an insurance contract other than as expressed in the policy.

Comments on §3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage.

Comment. Two commenters request changes to §3.52 because the section requires issuers to submit a filing to TDI 180 days in advance, but it also addresses both a discontinuation that is subject to a 90-day notice and a refusal to renew that is subject to a 180-day notice. The commenters suggest bifurcating the requirements or clarifying that the 180-day notice applies only when an issuer is withdrawing from the market by refusing to renew all plans. One commenter states that it is inappropriate to apply this section to the discontinuance of Medicare Supplement plans under 28 TAC §3.3308.

Agency Response. TDI agrees with the commenters that a 180-day notice applies only to a refusal to renew all plans and has changed §3.52(a) as proposed to clarify that issuers must submit an informational filing to TDI through SERFF for each applicable line of business, without specifying the timeframe, since that is already addressed in other rules. TDI also changed §3.52(b) as proposed to clarify that it applies only to a filing when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area. No change is needed with respect to Medicare Supplement because those products are outside the scope of this section. Subsection (a) references 28 TAC §3.3038, which applies to individual major medical plans--not 28 TAC §3.3308, which applies to Medicare Supplement.

Comment on §3.61. Actuarial Information for Certain Accident and Health Filings.

Comment. One commenter suggests changing §3.61(e)(2) as proposed to "a new rate manual that includes base rates and rating factors used by the issuer."

Agency Response. TDI agrees with the commenter that a rating manual is acceptable but believes issuers should also have the option to provide rate sheets for each plan. To reflect both options, TDI has changed §3.61(e)(2) as proposed to clarify that issuers may file either new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer.

Comments on §3.4004. Exempt Forms.

Comment. One commenter believes that the proposed changes to §3.4004 do not impact existing policies that have previously been filed as exempt, and notes that it would be extremely disruptive to need to refile forms that have already been issued. The commenter asks TDI to add a provision to clarify that the rules apply only to filings made on or after the new effective date.

Agency Response. TDI agrees that the new rules will apply only prospectively but disagrees that additional rule text is needed.

Comment. Two commenters state that they do not understand why §3.4004(e)(1) is amended to no longer allow blanket forms to be filed exempt, and they ask whether there are particular concerns with certain products. For example, one of the commenters asks why an AD&D policy issued on a group basis would be exempt from review, while a similar AD&D policy issued on a blanket basis would need to be filed for review. The commenters also oppose §3.4004(f)(9), which disallows filing dental plans on an exempt basis. The commenters suggest that limits on filing dental products as exempt should apply only to preferred provider dental plans and that stand-alone dental plans that do not include any kind of PPO or EPO should continue to be exempt.

Agency Response. TDI has identified blanket filings and dental filings as categories that frequently fail audit. TDI believes it will be more efficient for issuers for TDI to review these filings up-front, rather than to make subsequent filings to resolve compliance deficiencies. With respect to "preferred provider" dental plans, TDI notes that such structures are impermissible in Texas under Insurance Code §§1301.002, 1301.0042, and 1451.206. Despite the long-standing prohibition on these plan structures and the prohibition of filing products with preferred provider plan provisions as exempt, companies have continued to submit noncompliant exempt dental filings.

Comment. One commenter asks for clarification on what constitutes other fixed indemnity coverage that is more extensive than hospital indemnity, with reference to §3.4004(f)(7).

Agency Response. Hospital indemnity and other fixed indemnity products are recognized as distinct types of insurance. According to the product coding conventions used in SERFF, indemnity other than hospital is described as "an insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition." In contrast, hospital indemnity is described as "an insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition." To clarify, TDI has changed subsection (f)(7) as proposed to simplify the provision's wording.

Comment. One commenter notes that single premium immediate annuities are eligible to be filed exempt under §3.4004(c)(1), and asks whether single premium deferred group annuities are also eligible to be filed exempt if they meet the criteria under subsection (c)(4). The commenter also asks for clarification with respect to contingent deferred annuities under subsection (d)(6), and asks whether TDI intends to require all forms to be filed for review and approval if they include deferred (as opposed to immediate) business.

Agency Response. Under §3.4004(c)(4), a single premium deferred group annuity may be filed exempt if it does not include persistency bonuses or additional interest credits of any time, waiver of surrender charges (with noted exceptions), two tier values, or market value adjustments. While some types of deferred annuities may be filed exempt, as specified in §3.4004(c), contingent deferred annuities must be filed for review and approval. A contingent deferred annuity is a special type of annuity product that is recognized as a distinct subtype of insurance. According to the product coding conventions used in SERFF, a contingent deferred annuity is "an annuity contract that establishes a life insurer's obligation to make periodic payments for the annuitant's lifetime at the time designated investments, which are not owned or held by the insurer, are depleted to a contractually defined amount due to contractually permitted withdrawals, market performance, fees and/or other charges."

Comment. One commenter noted that limited refilings for annuities are not specified in the exceptions listed in §3.4004(d), and asks for clarification on whether limited refilings that indicate a change in the mortality table or interest rates for new issues under the policy form are permitted to be filed exempt.

Agency Response. Limited refilings for annuity products are eligible to be filed exempt if they meet the criteria specified in §3.4004(c)(5).

Comment on §3.4009. Sanctions and Cancellation of Exempt Filing Privileges.

Comment. One commenter states that the removal in §3.4009 of an insurer's right to file exempt forms without any type of notice and right to a hearing is a violation of due process and Texas law in the Administrative Procedure Act. The commenter is concerned that the proposed amendments to §3.4009 give TDI broad authority to take actions that may be arbitrary and capricious and could result in cancellation for errors that may be inconsequential or inadvertent. The commenter suggests that §3.4009 should reference an insurer's due process right to notice and hearing before the exempt filing privilege is revoked.

Agency Response. TDI disagrees that §3.4009 would allow an issuer's exempt filing privilege to be canceled without notice and an opportunity for a hearing. Notice of a cancellation of exempt filing privilege would be contained in the failed audit notice. TDI has changed §3.4009 as proposed to note that if an issuer disagrees with TDI's determination it may request a hearing and to clarify that the failed audit notice is addressed in §3.4008 instead of §3.23.

SUBCHAPTER A. SUBMISSION REQUIREMENTS FOR FILINGS AND DEPARTMENTAL ACTIONS RELATED TO SUCH FILINGS

28 TAC §§3.1 - 3.8

STATUTORY AUTHORITY. The commissioner adopts the repeal of §§3.1 - 3.8 under Insurance Code §§1111A.015, 1153.005, 1701.060, and 36.001.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

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

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501050
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

DIVISION 1. APPLICABILITY, SCOPE, SEVERABILITY, AND DEFINITIONS

28 TAC §3.1, §3.2

STATUTORY AUTHORITY. The commissioner adopts new §3.1 and §3.2 under Insurance Code §§35.0045, 541.401, 843.151, 1111A.015, 1153.005, 1201.006, 1251.008, 1271.004, 1271.253, 1501.010, 1651.004, 1651.051, 1652.005, 1652.051, 1652.052, 1652.103, 1698.051, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §35.0045 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 35.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Insurance Code Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plans provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.103 provides that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

§3.1. Applicability and Scope.

This subchapter applies to all filings related to a life insurance, annuity, life settlement, credit insurance, accident and health insurance, HMO, or point-of-service product that are filed with the department, including the following filing types:

(1) a form filing submitted under Insurance Code §1111A.005, concerning Requirements for Contract Forms, Disclosure Forms, and Advertisements; Insurance Code §1153.051, concerning Filing of Form; Insurance Code §1271.101, concerning Approval of Form of Evidence of Coverage or Group Contract; or Insurance Code Chapter 1701, concerning Policy Forms, including:

(A) a policy, contract, group agreement, certificate, evidence of coverage, application, enrollment form, rider, amendment or endorsement, insert page, matrix filing, or limited partial refiling; or

(B) any other coverage document attached to or made part of a document described in subparagraph (A) of this paragraph;

(2) a rate filing submitted in connection with a form filing under this subsection or otherwise required to be filed under Division 5 of this subchapter (relating to Actuarial Filing Requirements), including a schedule of charges, actuarial memorandum, or change to rating methodology;

(3) an advertising filing submitted in connection with a product filed under this subchapter, including filings identified under §21.120 of this title (relating to Filing for Review);

(4) a network filing submitted in connection with an HMO plan under Chapter 11 of this title (relating to Health Maintenance Organizations), a preferred or exclusive provider benefit plan under Subchapter X of this chapter (relating to Preferred and Exclusive Provider Plans), or a Medicare Select plan under §3.3325 of this title (relating to Medicare Select Policies, Certificates and Plans of Operation), including:

(A) provider contract forms (including a template, executed contract, amendment, termination, or attestation of compliance), delegated entity contract forms (including a template, executed contract, amendment, or termination), and related filings;

(B) provider directories;

(C) network configuration filings, including:

(i) new applications;

(ii) limited provider networks;

(iii) annual network adequacy report filings;

(iv) access plans;

(v) service area expansions or reductions; and

(vi) material modification to a network configuration;

(D) notices, including a notice of a network termination or an annual application period for physicians and providers to contract; and

(E) quality assurance program filings;

(5) a group eligibility filing, as specified in §3.21 of this title (related to Group Filings), including articles of incorporation, bylaws, constitution, or a trust agreement, policy face page, and any other documentation needed to demonstrate that a prospective group or blanket policyholder is eligible under Insurance Code Chapter 1131, Subchapter B, concerning Group and Wholesale, Franchise, or Employee Life Insurance: Eligible Policyholders; Insurance Code Chapter 1251, Subchapter B, concerning Group Accident and Health Insurance: Eligible Policyholders; or Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders;

(6) an informational filing, other than a form filing, rate filing, advertising filing, network filing, or group eligibility filing, that is required for compliance with Texas law but is not subject to approval, including:

(A) a disclosure, outline of coverage, or a similar plan summary;

(B) notices, including those relating to a discontinuance, withdrawal, uniform benefit modification, and modification of drug coverage;

(C) reports, including reports required for Medicare Supplement in Subchapter T of this title (relating to Minimum Standards for Medicare Supplement Policies) and Long-Term Care in Subchapter Y of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy);

(D) certifications related to form filings, readability scores, actuarial memoranda, statements of variability, and small and large employer health benefit plans;

(E) Medicare SELECT plans of operation and amendments; and

(F) other documents and information necessary to make a filing complete or for a comprehensive review of the filing that are filed in an informational mode.

§3.2. Definitions.

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

(1) Amendment or endorsement--A form that is not a rider that changes or modifies the provisions of an issued policy, certificate, contract, or evidence of coverage.

(2) Blanket policy or contract--A policy or contract authorized by Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders, and issued to a master group policyholder or contract holder that covers all or nearly all individuals within a described group or class of individuals without individual application and without individual underwriting.

(3) Commissioner--The commissioner of insurance.

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

(5) Disposition--The final status of a filing, which is issued in writing by the department and communicated to the issuer upon closing the filing. A disposition status may include approved, disapproved, exempt, failed audit, informational, noncompliant, rejected, reviewed, substitution approval, or withdrawn.

(6) Disposition date--The date the department issues a disposition on a filing.

(7) Evidence of coverage--Any certificate, agreement, or contract, including a blended contract, that is issued by an HMO to an enrollee and states the coverage to which the enrollee is entitled, consistent with Insurance Code §1271.051, concerning Evidence of Coverage: Contract and Certificate Requirements.

(8) Exact copy--A filing that, except for the issuer's name, address, telephone number, or other similar identification information, is identical to a form that was previously approved by the department and is still compliant with current statutes and regulations. A braille or non-English-language copy of a form that is a direct translation from the English version of the form is also an exact copy.

(9) Failed audit--A finding made by the department, consistent with §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms) that a form filed in an exempt filing mode includes one or more compliance deficiencies.

(10) Filing--A document filed with the department under this subchapter, including a form filing, rate filing, advertising filing, group eligibility filing, network filing, or informational filing.

(11) Filing ID--A unique identifier assigned to a filing by SERFF (for example, SERFF ID).

(12) Filing types--A designation used to describe the purpose and contents of a filing, which includes form filings, rate filings, advertising filings, network filings, group eligibility filings, and informational filings and the associated categories identified in §3.1 of this title (relating to Applicability and Scope).

(13) Form--A document required to be filed under Insurance Code §1111A.005, concerning Requirements for Contract Forms, Disclosure Forms, and Advertisements; Insurance Code §1153.051, concerning Filing of Form; Insurance Code §1271.101, concerning Approval of Form of Evidence of Coverage or Group Contract; or Insurance Code §1701.051, concerning Filing Required;

(14) Form number--A unique identifier printed at the lower left-hand corner composed of numbers or letters that is assigned to a unique form.

(15) General use--A filing classification that indicates that the filed forms will be used with other forms submitted in the filing or with previously approved or exempted forms for a certain product or products or a subset of a product or type (for example, an application that will be used with all life products, an application that will be used with all universal life products, an application that will be used with group life and accident and health products, or an application that will be used with major medical and dental products).

(16) HMO--A health maintenance organization as defined in Insurance Code §843.002, concerning Definitions.

(17) Insert page--A form consisting of a page or section of a contract that has a unique identifiable form number and is used in combination with other forms to create a complete contract.

(18) Issuer--An insurance company or HMO that makes a filing under this subchapter.

(19) Limited, partial refiling--A change to a previously approved or exempted life or annuity form that meets one or more of the criteria set forth in subparagraphs (A) - (D) of this paragraph:

(A) a change in the text, interest rate, guaranteed charges, or mortality table used to compute nonforfeiture for life insurance or annuities;

(B) a change in the current interest rate, where such rates are guaranteed and shown in the policy or contract;

(C) a change in the reserves (if the change in reserves affects the text of the policy); or

(D) a change to the separate account for variable products when the separate account is bracketed as variable text on the initial filing.

(20) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, allowing the flexibility to create multiple policies, evidences of coverage, certificates, contracts, or applications by using numerous combinations of the individual provisions.

(21) NAIC--National Association of Insurance Commissioners.

(22) New submission--A filing submission type that is applicable to all filings other than a resubmission subject to Insurance Code §1701.058, concerning Reconsideration of Form.

(23) Personally identifiable information--Facts or details about an individual that can be used either alone or in combination to distinguish the individual's identity, such as:

(A) any individual policyholder's, certificate holder's, or insured's identification, including name, address, phone number, or email;

(B) social security numbers;

(C) insurance policy, contract, or plan numbers;

(D) identification cards;

(E) debit, credit card, bank account, or routing numbers; or

(F) health information about an individual.

(24) Product--A package of benefits with a discrete set of rating and pricing methodologies that will be offered to a consumer within a single policy, group agreement, evidence of coverage, certificate, or contract. In the case of health coverage, a product also includes a particular network type (such as HMO, point of service, preferred provider, exclusive provider, or indemnity).

(25) Qualified actuary--An actuary who is certified by the American Academy of Actuaries to meet the U.S. Qualification Standards.

(26) Resubmission--A filing submission type that contains corrections made to a form that was previously disapproved or for which approval has been withdrawn.

(27) Rider--A form that adds or expands benefits and becomes a part of the policy, group agreement, evidence of coverage, certificate, or contract.

(28) SERFF--The System for Electronic Rates & Forms Filing established by the NAIC.

(29) Submission guide--Documentation provided by the department that includes technical guidance concerning how to submit and classify filings. The submission guide is available on SERFF and on the department's website: www.tdi.texas.gov.

(30) Substantially similar--A form that, except for minor changes that are clearly identified and described in an accompanying document, is identical to a form that the department previously approved and is still compliant with current statutes and regulations.

(31) Substitution--A new submission that includes a form that replaces a previously approved or exempted form that has not been and will not be issued or otherwise used in Texas at any time by the issuer and that has a form number that is the same as the form it is replacing.

(32) Supplemental--A type of product that is specifically designed and issued to supplement other in-force coverage.

(33) Withdrawn filing--A filing that is not pending the department's review and is not considered approved or exempted, including a filing that was submitted and subsequently removed from the department's review for any reason, including at the issuer's request, or by the department because of an issuer's failure to respond to a request for information or request for revision.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501051
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

DIVISION 2. GENERAL FILING REQUIREMENTS

28 TAC §§3.10 - 3.23

STATUTORY AUTHORITY. The commissioner adopts new §§3.10 - 3.23 under Insurance Code §§541.401, 843.151, 843.154, 1111A.015, 1153.005, 1153.006, 1201.006, 1201.101, 1201.206, 1251.008, 1271.004, 1271.253, 1501.010, 1651.004, 1651.051, 1652.005, 1652.051, 1652.052, 1652.103, 1698.051, 1701.053, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 provides that the commissioner, within the limits provided by the section, prescribe the fees to be charged under Insurance Code §843.154.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.006 provides that TDI set a fee not to exceed $200 for a form or schedule filed under Insurance Code Chapter 1153.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing standards for the readability of individual accident and health policies.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement the chapter and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Insurance Code Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and

for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plan provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.103 provides that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1701.053 provides that TDI collect a fee in an amount determined by the commissioner for the filing of the form of a document under Insurance Code Chapter 1701.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

§3.10. Requested Filing Mode.

Requested filing mode. All filings must identify a requested filing mode as described in this section.

(1) Review and approval. The following types of filings must be submitted for review or approval:

(A) a form or rate filing that is required to be filed for review or approval under §3.1(1) or (2) of this title (relating to Applicability and Scope), other than a filing made under paragraphs (2) or (3) of this section;

(B) an advertising filing that is required to be filed for review under §21.120 of this title (relating to Filing for Review);

(C) a group eligibility filing for review; and

(D) a network configuration filing under §3.1(4)(C) of this title.

(2) File and use. A form or rate filing may be submitted in a file-and-use mode only as permitted under Insurance Code §1701.052, concerning File and Use.

(3) Exempt. A form filing may be submitted in an exempt mode only as permitted under Insurance Code §1701.005, concerning Exemptions, and Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review).

(4) Informational. A filing may be submitted in an informational filing mode as specified in §3.1(6) of this title or if paragraphs (1) - (3) of this section do not apply.

§3.11. Submission Requirements.

(a) All filings and supporting documentation within the scope of this subchapter must be submitted through SERFF.

(b) If the electronic system designated by the department experiences a system-wide outage for any reason, any applicable deemer date or due date for a company response is tolled until the outage is resolved. The department may designate an alternative submission method for filings and supporting documents during such an outage.

(c) Filings submitted to the department must provide complete and accurate information about the filing, include responsive information in all applicable SERFF fields, and include applicable responsive information that is not duplicative of SERFF fields in a transmittal checklist uploaded into SERFF as provided in the department's submission guide. Material information required to be submitted in an initial filing through SERFF fields and transmittal checklists will not exceed the following:

(1) the issuer's name, address, and identifying information, including the NAIC number, NAIC group number, federal employer identification number (FEIN), and the issuer's license type and state of domicile;

(2) the contact person information as required by §3.12 of this title (relating to Contact Person);

(3) an explanation of the purpose and use of the filing as required in §3.14 of this title (relating to Purpose and Use);

(4) a clear designation if the issuer would like to make confidential a specific form, rate, or document in the filing, consistent with §3.15 of this title (relating to Confidential Information in Filings);

(5) the information and certifications required in §3.16 of this title (relating to Certifications);

(6) identification of the unique form number of each form submitted;

(7) a classification of the attributes of the filing and forms included in the filing, consistent with the department's submission guide, including the:

(A) type of filing, consistent with the categories identified in §3.1 of this title (relating to Applicability and Scope);

(B) type of submission, including new or resubmission;

(C) requested filing mode, including review and approval, file and use, informational, or exempt, as described in §3.10 of this title (relating to Requested Filing Mode);

(D) requested effective date for the filing;

(E) type of product and subtype of product, consistent with the product classification guidance provided in the department's submission guide;

(F) type of form or document, including policy, evidence of coverage, certificate, application or enrollment, schedule of benefits, rider, amendment, endorsement, outline of coverage, advertising, network access plan, provider contract, provider addendum, provider leasing agreement, and provider directory;

(G) type of rate, including a new or revised rate; and

(H) type of market, including individual, franchise, or group, and if applicable:

(i) size of group, including small, large, or small and large;

(ii) type of group, including employer, association, trust, discretionary, blanket, or other; and

(iii) name of group policyholder, in connection with a group eligibility filing;

(8) rate filing information for any product a rate filing is required for;

(9) a statement that the submission will be used on a general-use basis, only with the product being filed, or with previously approved or exempted forms;

(10) in the case of a filing that will be used with previously approved or exempted forms, or other pending filings, a list of the following information in connection with the forms the filing will be used with:

(A) the form numbers and filing IDs of the pending or previously approved or exempted forms;

(B) the disposition dates of the previously approved or exempted forms;

(C) for a form approved before January 1, 2012, a copy of the approved or exempted form;

(D) if applicable, the updated list of form numbers the previously approved or exempted form is to be used with; and

(E) a brief description of when or how each submitted form or rate will be used with the previously approved or exempted forms or other pending forms;

(11) an explanation of any variable material as required by §3.18 of this title (relating to Variable Material); and

(12) the Flesch score for each submitted form, consistent with §3.20 of this title (relating to Plain Language and Readability Requirements).

(d) For a substantially similar, exact copy, substitution, or resubmission filing, the issuer must include the following information concerning how the forms in the filing relate to the forms that were previously approved, exempted, disapproved, or withdrawn from approval, as applicable:

(1) the form number, filing ID, and disposition date of the previously filed form; and

(2) a summary of the differences between the previously approved form and the new form, including a description of any deleted text and a clear identification of all changes with new or modified text redlined.

(e) An advertising filing must include the information and certifications required under Chapter 21, Subchapter B of this title (relating to Advertising, Certain Trade Practices, and Solicitation).

(f) The department may request any additional information necessary for a comprehensive review of any filing.

§3.13. Filing Fees.

(a) For a form filing identified under §3.1(1) of this of this title (relating to Applicability and Scope), a fee of $100 is required, subject to the following exceptions:

(1) a fee of $50 is required for an exempt form filing that is made under Insurance Code Chapter 1701, concerning Policy Forms, and Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review);

(2) a fee of $50 is required for a resubmission of a previously disapproved form, or a form for which approval has been withdrawn;

(3) for a matrix filing, due to the ability to create multiple contracts or policies from matrix provisions, a fee of $50 per form is required, subject to a maximum fee of $500 per filing; and

(4) no fee shall be required for a substitution filing.

(b) For a rate filing made under §3.1(2) of this title that is separate from a form filing:

(1) a fee of $100 is required for a filing under Insurance Code Chapters 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance; 1651, concerning Long-Term Care Benefit Plans; and 1652, concerning Medicare Supplement Benefit Plans; and

(2) a fee of $50 is required for all other rate filings.

(c) No fee is required for advertising, network, group eligibility, or informational filings under §3.1(3) - (6) of this title.

(d) Filing fees required under this section must be paid to the department using the electronic funds transfer system provided on SERFF.

(e) Fees are due and must be paid at the time a filing is accepted for review. If the issuer does not pay the fee within five business days following the date of acceptance for review, the department may consider the filing withdrawn from review by the issuer. The department will not give any withdrawn filing consideration until the issuer resubmits the filing as a new filing.

§3.14. Purpose and Use.

Each filing must include an explanation of the purpose and use of the forms, rates, advertising, networks, or other information contained in the filing within the general information section of the filing that includes:

(1) how the contents of the filing will be used (for example, the application will be used on a general-use basis; or used with specific policies, evidences of coverage, or contract forms previously approved or exempted);

(2) the type of coverage addressed by the filing;

(3) any key or unique provisions contained in the filing, including:

(A) for a life or annuity filing, the inclusion of bonus interest, additional interest credits, two-tier values, bail-out, market value adjustments, and long-term care;

(B) for an accident and health filing, the inclusion of preferred or exclusive provider benefits, innovative excepted benefit products, standalone prescription drugs, or innovative benefits in a Medicare supplement policy;

(4) if applicable, how the product will be marketed (for example, direct, agent, or electronic);

(5) if applicable, whether the filing addresses a new program or initiative (for example, a value-added noninsurance benefit, or a steering or tiering program) and, if so, how the program will affect consumers and whether the program or initiative has been filed, approved, or disapproved in other states;

(6) if applicable, to whom the product is to be marketed, for example, specific group types or sizes, such as an annuity contract marketed to issue ages 25 - 60; or a health benefit plan that will issued on the exchange; and

(7) if applicable, an indication of whether the filing is prompted by a business change such as an assumption, a name change, or a demutualization/conversion.

§3.16. Certifications.

(a) General certification - all filings. All filings must include the following certifications:

(1) the certification is on behalf of the issuer;

(2) the issuer is bound by the certification;

(3) the issuer is familiar with all statutes and regulations of this state and the United States that are applicable to the filing and certifies that to the issuer's best knowledge, information, and belief, the filing complies with those statutes and regulations;

(4) the individual making the certification has reviewed the filing and the information in the filing is true and correct;

(5) the form filed is not deceptive or misleading; and

(6) if applicable, the Flesch score of each form is accurately reflected and meets the requirements of §3.20 of this title (relating to Plain Language and Readability Requirements).

(b) Additional certifications. An issuer must include additional certifications as applicable and specified in Figure §3.16(b). An individual making a certification referenced in Figure §3.16(b) must also make the certifications required by subsection (a) of this section. Figure: 28 TAC §3.16(b)

(c) Certification requirements. A false certification made under this section is an offense under Insurance Code §841.704, concerning False Statement, Report, or Other Document; Criminal Penalty, and §843.464, concerning Criminal Penalty.

§3.17. Form and Rate Filing Requirements.

(a) Except as provided by subsection (b) of this section, for a form or rate filing, only one product (including all forms that will constitute the entire contract and their associated rates) may be submitted in a single filing. This does not prevent an issuer from filing a product that contains multiple types of benefits that will be issued in combination in a single contract if that combination otherwise complies with applicable requirements.

(b) A form may be submitted for general use with multiple policies, evidences of coverage, or certificates. A form submitted for general use must be filed individually, except that multiple forms that are clearly related and intended to be used with one or more of the same underlying products may be filed together.

(c) Each form must prominently display on the cover page or the first page a face page that includes:

(1) the full name of the issuer assuming the risk of the product; and

(2) the complete mailing address of the issuer.

(d) Each form submitted must be designated by a unique form number that:

(1) is sufficient to distinguish it from all other forms used by the issuer;

(2) is shown in the lower left-hand corner of each page of the form, or in the case of a matrix provision, is shown below each matrix provision; and

(3) has the additional identifying form number requirements set forth in §3.5201 of this title (relating to Submission of Form and Rate Filings) if the form is submitted under Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance.

(e) A limited, partial refiling must contain the change and any additional actuarial information necessary for a comprehensive review of the refiling, if applicable.

(f) An amendment that is submitted to modify an existing form must be accompanied by a revised version of that form (with a new unique form number) that incorporates the contents of the amendment, unless the amendment does not apply to newly issued forms. After the 180th day following the date the revised version of the form is approved, for newly issued coverage, the issuer must use the revised version of the form, rather than the amendment.

§3.18. Variable Material.

(a) Variable material generally. As specified in this section, an issuer may file forms, advertising, or provider contracts using variable material to illustrate the ways an issued document may vary from the filed material. Any variable material must be identified using brackets and include specimen language or fill-in material that reflects the most restrictive option, if applicable, within the range of variability. Variable material may not be used in an issued form. The issued form must clearly state the actual benefits and contract terms.

(b) Statement of variability. When variable material is included in a filing, the issuer must submit a statement of variability to accompany the filing that:

(1) provides a clear explanation of how the material will vary for each variable option or range that appears in the brackets on the form; and

(2) demonstrates compliance with applicable requirements.

(c) Permitted uses of variable material. It is acceptable for an issuer to use variable material to illustrate:

(1) how a document may vary due solely to the age, sex, or classification of the insured or enrollee;

(2) the range of benefit levels or options that will be offered to consumers;

(3) nonsubstantive administrative items in the document, such as phone numbers, addresses, or third-party administrators;

(4) the type of group the policy will be issued to if different review standards do not apply based on the group type; and

(5) how a form may vary based on clearly specified options selected by a group policyholder.

(d) Prohibited uses of variable material. It is not acceptable for:

(1) a unique form number on a form to be bracketed as variable;

(2) the issuer name to be bracketed as variable;

(3) a form to use variability to create different types of products using a single form number, rather than making separate product filings;

(4) a form to specify a range of variability that exceeds the range supported in the issuer's filed rates or schedule of charges and actuarial memorandum, if applicable; or

(5) an issuer to use variability to an extent that the department is unable to fully understand how the product will appear when issued.

(e) Fill-in material for individual life and annuity forms. Individual life and annuity forms must contain fill-in material for a 35-year-old insured. If the form is not issued at age 35, the fill-in material must contain the youngest issue age. If any form includes reduced death benefits, the fill-in material must include the age with the greatest reduction in benefits at issue. The fill-in material must be for the longest premium-paying period available.

(f) Life and annuity standards.

(1) For life forms, the text and specifications of nonforfeiture assumptions cannot include variable material;

(2) For life and annuity forms, a zero entry in a range of values on the specifications page:

(A) is acceptable for tiering levels, expense charges, or other fees applicable under the contract; and

(B) is not acceptable for any benefit or credit provided for in the language of the contract.

(g) Changes to variability. Any change to a statement of variability is considered a change to the form itself and must be filed in conjunction with the form.

(h) Examples upon request. The department reserves the right to request that the issuer supplement its filing with examples of forms without variability, including examples of forms actually issued to consumers (with confidential information redacted).

§3.20. Plain Language and Readability Requirements.

(a) Purpose. This section establishes plain language requirements and procedures to make contracts easier to read by the public and to remove language that may be unjust, deceptive, misleading, or unreasonably confusing.

(b) Applicability. This section applies to all forms that are filed under this subchapter and issued to consumers, except for:

(1) forms that are subject to Subchapter G of this chapter (relating to Plain Language Requirements for Health Benefit Policies); and

(2) group annuity products.

(c) Plain language. Forms must be written in plain language and organized in a manner to make it easy for consumers to understand.

(d) Flesch Reading Ease requirements.

(1) The text of the form must achieve a minimum Flesch Reading Ease score of 40, calculated using the method described in §3.602(b)(1), (c), and (d) of this title (relating to Plain Language Requirements).

(2) An issuer must include a statement of the Flesch score of the document when the form is submitted to the department. The department may require the submission of further information to verify compliance.

(e) Best practices. In determining whether forms are written in plain language and organized in a manner to aid consumer understanding, the department will consider plain language best practices, including:

(1) the use of short, familiar words or words that are used in common speech, rather than the use of jargon or technical terms, and defining technical terms used when necessary;

(2) whether the form is written in a clear and coherent manner;

(3) the unnecessary use of technical or abstract words;

(4) whether short sentences are used in paragraphs limited to a single topic, when possible, rather than the use of complex and compound sentences;

(5) the unnecessary use of prefixes and suffixes;

(6) whether the style, arrangement, and overall appearance of the form gives undue prominence to any portion of the text; and

(7) the organization of the form, including as modified by any rider, endorsement, or amendment, such as:

(A) whether the form is organized in a logical order, with clear sections and headings;

(B) whether the form's coverage provisions are self-contained and independent;

(C) whether the form is appropriately divided and captioned in meaningful sequence, where each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section;

(D) whether the form unreasonably refers the reader from section to section;

(E) whether general policy provisions, such as defined words and terms or limitations and exclusions, are located in a common area and appropriately captioned; and

(F) whether the use of a separate form, such as an amendment or endorsement used to modify a contract, policy, certificate, or evidence of coverage, will result in confusion about the coverage, particularly if this will occur at the time coverage is first issued.

(f) Definitions. Companies may use a separate definitions section for words used throughout the policy or evidence of coverage. If a separate definitions section is used, it must appear early in the form.

(g) Formatting. The form must:

(1) except for specification pages, schedules, and tables, be printed in not less than 10-point type;

(2) use a font style and size that is easy to read, considering the audience; and

(3) use a format that aids readability, with sufficient white space and the use of bulleted or numbered lists when appropriate.

(h) Table of contents. A form must contain a table of contents or an index of the principal sections if it has more than 3,000 words on three or fewer pages of text or if it has more than three pages, regardless of the number of words.

§3.21. Group Filings.

(a) An issuer submitting a filing for a group policy, agreement, evidence of coverage, or contract must comply with the requirements in this section.

(1) An issuer must identify the specific group type the form is being filed under by indicating the applicable Insurance Code section, including:

(A) for life insurance, Insurance Code Chapter 1131, Subchapter B, concerning Group and Wholesale, Franchise, or Employee Life Insurance: Eligible Policyholders;

(B) for accident and health insurance and HMO coverage, Insurance Code Chapter 1251, Subchapter B, concerning Group Accident and Health Insurance: Eligible Policyholders; or

(C) for accident and health insurance, Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders.

(2) If Texas resident members of a group will be eligible to obtain coverage under a product issued to a group type specified in subsections (b) - (f) of this section, then an issuer must submit a group eligibility filing, as specified in those subsections, indicating:

(A) the name of the group;

(B) the products to be issued to the group;

(C) the associated form numbers to be issued to the group and filing IDs the forms were approved under; and

(D) either:

(i) information that demonstrates that the group is eligible; or

(ii) a reference to a previous filing ID submitted by the issuer that the group's eligibility was verified under if the filing was made within the past five years and there has not been a material change to the information submitted or the group's continued eligibility.

(3) Forms to be used with multiple groups must be submitted separately from the group eligibility filing. Forms to be used with a single group may be submitted separately or in conjunction with the group eligibility filing.

(b) For a product to be issued to an association under Insurance Code §1131.060, concerning Nonprofit Organizations or Associations; §1251.052, concerning Associations; §1251.053, concerning Funds Established by Employers, Labor Unions, or Associations; or §1251.358, concerning Association, the issuer must submit a group eligibility filing that includes:

(1) a copy of the association's constitution, bylaws, and articles of incorporation, or other formative or organizational documents regulating the conduct of the association's internal affairs;

(2) an alternate face page form that identifies the association, unless the forms are filed to be used with a specific association, in which case the association must be identified on the case-specific face page;

(3) identification of the types of coverage the issuer intends to offer the association; and

(4) information demonstrating that the association is an eligible group policyholder.

(c) For a product to be issued to a trust under Insurance Code §1251.053, the issuer must submit a group eligibility filing that includes:

(1) a copy of the trust agreement;

(2) an alternate face page form for each related industry group, with a unique form number; and

(3) for a product to be issued to associations participating in a multiple association trust:

(A) a listing of all the associations participating in the multiple association trust; and

(B) a reference to the unique filing ID or IDs in which the department previously confirmed that each participating association is an eligible group, consistent with subsection (b) of this section.

(d) An issuer that has received a determination for a filing to be issued to associations participating in a multiple association trust must make a group eligibility filing for information to notify the department of any subsequent additions of participating associations upon enrollment. The filing must include the documentation required in subsection (c) of this section for each association that joins the trust after the initial filing.

(e) An issuer that intends to offer a product to a type of group or blanket policyholder that is not identified in statute as an eligible policyholder must submit a group eligibility filing that demonstrates the group's eligibility, consistent with Insurance Code §1131.064, concerning Other Groups, §1251.056, concerning Other Groups, and §1251.359, concerning Coverage for Other Risks. The issuer must also submit actuarial information as required in §3.61 of this title (relating to Actuarial Information for Certain Accident and Health Filings), as applicable.

(f) For a major medical health benefit plan issued to an association under Insurance Code §1251.052, the issuer must:

(1) for a member-only association, identify whether the plan is issued to a member-only bona fide association as defined under §21.2702 of this title (relating to Definitions); or

(2) for an employer association filing:

(A) comply with all filing requirements set forth in Chapter 26 of this title (relating to Employer-Related Health Benefit Plan Regulations);

(B) specify whether the plan will cover small or large employer members; and

(C) specify whether the group is considered a bona fide employer association under §26.301 of this title (relating to Applicability, Definitions, and Scope).

(g) A product to be issued to an educational institution, if it is issued on a group basis, must be filed under Insurance Code §1131.064 or §1251.056, or, if it is issued on a blanket basis, must be filed under §1251.353, concerning Educational Institutions.

(h) An issuer licensed in this state that issues a certificate of insurance or evidence of coverage covering a Texas resident is responsi-

ble for ensuring that the form complies with applicable Texas insurance laws and rules, regardless of whether the group policy, agreement, or contract underlying the certificate or evidence of coverage was issued outside the state. A copy of the master policy, group agreement, or contract issued outside of Texas must accompany any life, annuity, credit, or accident and health certificate, or HMO evidence of coverage filed for review or filed as exempt, along with certification and evidence that the master policy, group agreement, or contract was lawfully issued and delivered in a state the issuer was authorized to do business in.

§3.23. Acceptance, Rejection, and Disposition of Filings.

(a) Acceptance, approval, and exemption of filings. Upon submission, a filing will be accepted for preliminary review of compliance with the filing requirements in this subchapter. If the filing requirements in this subchapter have not been satisfied, the department will consider the filing incomplete and may reject the filing or request that the issuer make corrections. After a filing has been accepted by the department, an issuer is not permitted to expand the scope of a filing, such as by submitting additional forms for review, unless the department has instructed the issuer to do so.

(1) Review period for filings subject to approval. Filings subject to approval, whether filed in a review-and-approval mode or a file-and-use mode, will be reviewed for compliance with the Insurance Code, this title, and any other applicable law of this state or the United States. Filings are considered filed as of the date the filing is submitted, unless the filing is rejected as provided in subsection (b) of this section. The filings, after review, will be affirmatively approved or disapproved within the statutory deemer period if applicable, under Insurance Code §1271.102, concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval; §1701.054, concerning Approval of Form; or §1701.058, concerning Reconsideration of Form, unless the department initiates a request for correction as set forth in subsection (c) of this section.

(2) Date for exempt filings. As permitted under Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review), an issuer may submit a filing in an exempt mode. A filing closed with an exempt disposition is considered exempt as of the disposition date, unless the filing is rejected as provided in subsection (b) of this section. Exempt filings are subject to audit as specified in §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms).

(3) Date for informational filings. A filing submitted in an informational mode will be closed with an informational disposition, unless the department determines that the filing is subject to review. Informational filings are considered filed as of the date the filing is submitted, unless the filing is rejected as provided in subsection (b) of this section.

(b) Rejection of filings.

(1) If the department determines that a filing does not meet the requirements of this subchapter, the department will reject the filing as incomplete and notify the issuer of the reason for rejection or request that the issuer make corrections to the filing. If the issuer does not make corrections within two business days of the department's request for corrections, the department may reject the filing. A filing that is closed with a rejected disposition will not be considered to have been filed or accepted with the department for purposes of Insurance Code §§1153.106, concerning Rate Outside Certain Percentages of Presumptive Rate; 1271.102; or 1701.054, or this subchapter.

(2) The department may reject a filing for failure to comply with any requirement in this subchapter, for example if a filing:

(A) is marked confidential in its entirety;

(B) contains an individual consumer's personally identifiable information in violation of §3.15 of this title (relating to Confidential Information in Filings);

(C) contains changes from the previous form that are not clearly identified; or

(D) contains a certification that is materially inaccurate.

(3) The department will not reopen a rejected filing to allow the issuer to make corrections. The issuer must submit a new filing for the department to consider any corrections.

(c) Request for correction.

(1) Rather than disapproving a filing, the department may request that the issuer make corrections to a form that contains compliance deficiencies if:

(A) for an insurance filing, the issuer, as necessary and at least seven days before the date the filing is deemed approved (unless otherwise permitted by the department):

(i) requests a 45-day extension of the review period; or

(ii) provides a waiver of the issuer's right to deem the filing approved, if applicable; or

(B) for an HMO filing, consistent with §11.301 of this title (relating to Filing Requirements):

(i) the department notifies the issuer that the review period has been postponed; or

(ii) the issuer, as necessary and no less than seven days before the date the filing is deemed approved (unless otherwise permitted by the department), provides a waiver of the issuer's right to deem the filing approved.

(2) An issuer submitting a form as a correction to a pending form must provide:

(A) a summary of the differences between the previously reviewed form and the corrected form, including a description of any deleted text, and a clear identification of all changes, with new or modified text redlined; and

(B) a statement that no changes were made to the form other than those identified.

(3) If an issuer fails to submit corrections to the department within 10 business days after the department provides a notice of any deficiencies and request for corrections, the department may consider the filing withdrawn from review by the issuer. The department will not give any withdrawn filing consideration unless the issuer resubmits it as a new filing. Upon request from an issuer, TDI may agree to extend the 10-day period under this paragraph.

(d) Disposition. The department will send written or electronic notice of any actions taken by the department when it has completed the processing of the filing. The notice will state the disposition and its effective date.

(e) Withdrawal of approval. Before withdrawing approval, the department will provide notice and opportunity for hearing. The notice will specify each applicable form number and the compliance deficiencies.

(f) Retention of filings and dispositions. Companies must retain the written notification or a copy of the electronic notification as documentation of the department's action on a form and maintain

copies of approved, reviewed, and exempted forms. This requirement no longer applies if there are no lives insured under the form and the issuer has submitted a written or electronic request that the department withdraw approval of the form.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501052
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

DIVISION 3. REQUIREMENTS RELATING TO APPLICATION FORM FILINGS

28 TAC §3.40, §3.41

STATUTORY AUTHORITY. The commissioner adopts new §3.40 and §3.41 under Insurance Code §§35.0045, 541.401, 843.151, 1153.005, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §35.0045 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 35.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement the Insurance Code Chapter 1153.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

§3.40. Applications Generally.

(a) Application form filings must include an explanation of the purpose and use of the application that specifies:

(1) the purpose of the application, including the type of contracts and products the application will be used for; and

(2) whether the application will be in paper, electronic, or telephonic form.

(b) Application form filings must:

(1) include a form of the application that shows all text contained on the application, including all sections and questions that the applicant must complete, and any additional drop-downs, scripts, questions, questionnaires, or supplements that may be conditionally required on the basis of the applicant's responses; and

(2) clearly indicate which statements an applicant must agree to in order to be considered eligible for coverage.

(c) Applications for use by multiple companies or for use in offering products from multiple companies must be submitted to the department by each issuer that will use the form and must prominently display:

(1) the full name of each issuer assuming the risk of the products, and the products offered by each issuer;

(2) the complete mailing address of each issuer; and

(3) a means of designating the appropriate issuer (such as checkboxes) that coverage is being sought through.

(d) Questions that applicants must complete on an application:

(1) must be limited to questions necessary to issue or administer the policy or contract;

(2) may not be structured in a manner that requires the applicant to self-diagnose; and

(3) if limited by time or scope, must be consistent with the underwriting standards.

(e) Application forms must:

(1) if applicable, clearly state that the application will become part of the contract;

(2) state that coverage may not be denied on the basis of information not requested in the application except as described in the application;

(3) include a method for an applicant to opt out of electronic communications if the issuer does not seek affirmative consent for conducting business electronically under Insurance Code §35.004, concerning Minimum Standards for Regulated Entities Conducting Business with Consumers; and

(4) if the issuer will obtain personal information on applicants from third parties, disclose the types of information that might be

obtained, the circumstances when it might be obtained, and how it will be used.

§3.41. Standards for Electronic and Telephonic Applications.

(a) When conducting business electronically, an issuer must comply with Insurance Code Chapter 35, concerning Electronic Transactions.

(b) For all applications, including applications that involve electronic or telephonic transactions, the issuer must provide the applicant with a written copy of the completed application, including any responses given verbally, before the applicant is asked to sign and submit the application.

(c) The issuer must deliver the completed written application in a manner that allows the consumer to retain the information, consistent with Texas Business and Commerce Code §322.008(a), concerning Provision of Information in Writing; Presentation of Records, and Insurance Code §35.004(c), concerning Minimum Standards for Regulated Entities Electronically Conducting Business with Consumers.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501053
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

DIVISION 4. REQUIREMENTS SPECIFIC TO ACCIDENT, HEALTH, AND HMO FILINGS

28 TAC §§3.50 - 3.52

STATUTORY AUTHORITY. The commissioner adopts new §§3.50 - 3.52 under Insurance Code §§541.401, 843.151, 1201.006, 1202.051, 1271.004, 1301.007, 1501.010, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1202.051 provides that the commissioner adopt rules necessary to implement the section and meet the minimum requirements of federal law.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1301.007 provides that the commissioner may adopt rules necessary to implement Insurance Code Chapter 1301.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement Insurance Code Chapter 1701.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section.

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

§3.51. Payment of Premiums or Cost Sharing.

(a) An issuer may not impose any restriction on the form or manner of the payment of premiums or cost-sharing for accident, health, or HMO coverage, unless the restriction is clearly disclosed in the application and the policy, certificate, or contract.

(b) A policy, certificate, or contract of accident, health, or HMO coverage must provide consumers with reasonable options for paying premiums and cost-sharing, and cannot require payment by personal check.

(c) Nothing in this section modifies the requirements or applicability of Insurance Code §1369.0542, concerning Effects of Reductions in Out-of-Pocket Expenses on Cost Sharing.

§3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage.

(a) Any issuer required to provide notice to the department related to a termination by discontinuance or refusal to renew all guaranteed renewable major medical coverage in a given market or service area under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions), §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association), §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market), or §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) must submit an informational filing to TDI through SERFF for each applicable line of business.

(b) A filing that is made under subsection (a) of this section when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area must include:

(1) whether a withdrawal plan has been submitted under Chapter 7, Subchapter R of this title (relating to Withdrawal Plan Requirements and Procedures) and Insurance Code Chapter 827, concerning Withdrawal and Restriction Plans;

(2) as applicable, the service areas affected by the withdrawal and a reference to the filing ID that the issuer filed the service area reduction under;

(3) the number of covered lives affected in each Texas county;

(4) the effective date or dates the coverage will terminate on;

(5) a copy of the notices to be provided to policyholders, group contract holders, and enrollees; and

(6) a list of products that will be terminated that includes the form numbers and filing IDs.

(c) Filing requirements in this section are in addition to requirements in Chapter 7, Subchapter R of this title that may apply if the failure to renew coverage constitutes a withdrawal under Insurance Code Chapter 827.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501054
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

DIVISION 5. ACTUARIAL FILING REQUIREMENTS

28 TAC §§3.60 - 3.62

STATUTORY AUTHORITY. The commissioner adopts new §§3.60 - 3.62 under Insurance Code §§843.151, 1107.108, 1111A.015, 1153.005, 1153.103, 1201.006, 1201.206, 1251.008, 1271.004, 1501.010, 1651.004, 1651.051, 1651.053, 1651.055, 1652.005, 1652.051, 1652.052, 1652.101 - 1652.103, 1698.051, 1698.052, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1107.108 provides that the commissioner may adopt rules to implement the provisions of Insurance Code Chapter 1107.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.103 provides that the commissioner, after notice and a hearing, by rule may adopt a presumptive premium rate for various classes of business and terms of coverage regarding credit life insurance and credit accident and health insurance.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1651.053 provides that the commissioner adopt rules to establish standards for loss ratios of long-term care benefit plans.

Insurance Code §1651.055 provides that the commissioner adopt rules to stabilize long-term care premium rates.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plans provisions that are not otherwise specifically authorized by statute and

that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.101 provides that the commissioner adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans.

Insurance Code §1652.102 provides that the commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

Insurance Code §1652.103 provides that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1698.052 provides that the commissioner adopt rules and provide guidance related to individual health plans, including qualified health plans, to address several factors, including covered benefits or health benefit plan design.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

§3.61. Actuarial Information for Certain Accident and Health Filings.

(a) This section applies to:

(1) individual accident and health products under Insurance Code §1701.057, concerning Withdrawal of Individual Accident and Health Insurance Policy Form Approval; and

(2) group accident and health coverage issued to alternative types of group policyholders under Insurance Code §1251.056, concerning Other Groups, and §1251.359, concerning Coverage for Other Risks.

(b) This section does not apply to rate filings specified in §3.60(9) - (11) of this title (relating to General Actuarial Filing Requirements).

(c) No premium rate schedule may be used until a copy of the schedule has been filed with the department.

(d) Each premium rate schedule must be accompanied by an actuarial memorandum, signed by a qualified actuary.

(e) A new product filing must include the following actuarial information:

(1) the form numbers the rates apply to and the filing IDs that the forms were filed, approved, or exempted under;

(2) new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer;

(3) an actuarial memorandum that contains:

(A) a brief description of the policy benefits, renewability provision, and general marketing method;

(B) a brief description of how rates were determined, including a general description and source of each assumption used;

(C) a list of retention components, including, expenses, taxes, fees, and profit expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

(D) the target loss ratio, including a brief description of how it was calculated, and all components used in its calculation;

(E) a description of the experience used in developing the issuer's rates, including the level of credibility and appropriateness of experience data or justification for the use of the proposed manual rates if the issuer's own experience is not credible;

(F) assumptions and support used in developing rates, including adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits; and

(G) any other data used to support the proposed rate.

(f) A rate adjustment filing for an existing product must include:

(1) the form numbers that the rate adjustments apply to and the filing IDs that the forms were filed, approved, or exempted under;

(2) a new rate sheet that includes rates for each plan and each combination of rating factors used by the issuer; and

(3) an actuarial memorandum that contains:

(A) a brief description of the benefits, renewability provision, and the general marketing method;

(B) scope and reason for the rate revision;

(C) a description of the experience used in developing the issuer's rates, including past experience, loss ratios for all applicable prior experience periods, and the level of credibility and appropriateness of experience data;

(D) a brief description of how revised rates were determined, including a general description and source of each assumption used;

(E) a list of expenses, taxes, fees, and profit, expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

(F) the target loss ratio and description of how it was calculated;

(G) assumptions and support used in developing rates, including adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits; and

(H) any other data used to support the proposed rate increase.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501055
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

SUBCHAPTER S. MINIMUM STANDARDS AND BENEFITS AND READABILITY FOR INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES

28 TAC §3.3100

STATUTORY AUTHORITY. The commissioner adopts amendments to §3.3100 under Insurance Code §§1201.006, 1201.101, 1201.206, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing specific standards for the content and manner of sale of an individual accident and health insurance policy.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501056
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

28 TAC §3.3101, §3.3102

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.3101 and §3.3102 under Insurance Code §§1201.006, 1201.101, 1201.206, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing specific standards for the content and manner of sale of an individual accident and health insurance policy.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501062
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

SUBCHAPTER Z. EXEMPTION FROM REVIEW AND APPROVAL OF CERTAIN LIFE, ACCIDENT, HEALTH AND ANNUITY FORMS AND EXPEDITION OF REVIEW

28 TAC §§3.4004, 3.4005, 3.4009

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.4004, 3.4005, and 3.4009 under Insurance Code §§1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

§3.4004. Exempt Forms.

(a) Group and individual life forms. The group and individual life insurance forms specified in this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, concerning Policy Forms, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (b) of this section:

(1) group and individual term life insurance forms;

(2) individual variable life policies with a separate account only;

(3) rider forms listed in subparagraphs (A) - (K) of this paragraph:

(A) accidental death benefit riders;

(B) waiver of premium riders;

(C) guaranteed insurability riders;

(D) individual retirement account (IRA) riders (to include Roth and Simple IRAs);

(E) preliminary term riders;

(F) conversion riders;

(G) exchange riders;

(H) waiver of cost riders, including waiver of cost and monthly expense charge, and waiver of cost and premium payment;

(I) dividend option riders;

(J) additional insured riders; and

(K) additional insurance on base insured riders;

(4) endorsement forms listed in subparagraphs (A) - (K) of this paragraph:

(A) optional retirement program (ORP) endorsements;

(B) nontransferability endorsements;

(C) H.R. 10 (Keogh plan) endorsements;

(D) tax sheltered annuity endorsements;

(E) nonassignability endorsements;

(F) settlement option endorsements;

(G) individual retirement account endorsements (to include Roth and Simple IRAs);

(H) unisex endorsements;

(I) loan endorsements;

(J) waiver of surrender charges on disability or confinement in a hospital or nursing home endorsements; and

(K) step-up or roll-up death benefit endorsements; and

(5) limited refilings for changes to the separate account for variable products.

(b) Exceptions. A filing identified in subsection (a)(1) of this section is not permitted to be filed as exempt for any group or individual life insurance forms providing the types of coverages set out in paragraphs (1) - (13) of this subsection:

(1) universal life, including flexible premium adjustable life;

(2) whole life;

(3) endowment life;

(4) variable life with a fixed account;

(5) business value;

(6) any forms containing a market value adjustment;

(7) deposit term;

(8) forms subject to Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance;

(9) any life insurance product used to fund prepaid funeral contracts;

(10) any form containing a persistency bonus provision, no-lapse premium provision, or other additional interest credit to the policy value provision (guaranteed or non-guaranteed), index-linked crediting provision, residual death benefit provision, accelerated death

benefit provision, long-term care or other accident- and health-related benefit provision;

(11) applications for use with variable life or index-linked life, or forms that contain a market value adjustment provision, a long-term care or other accident- and health-related benefit provision;

(12) forms issued under the authority of Insurance Code §1131.064, concerning Other Groups, that are related to discretionary groups; or

(13) limited refilings for life insurance that indicate a change in the mortality table or interest rates for new issues under the policy form.

(c) Group and individual annuity forms. The group and individual annuity forms specified in paragraphs (1) - (7) of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms are required by the laws of Texas, another state, or of the United States to be specifically approved or are otherwise excepted in subsection (d) of this section:

(1) single premium immediate annuities (including variable immediate annuities);

(2) deferred annuities used as structured settlement options;

(3) individual deferred annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability, or confinement in a hospital or nursing home); two-tier values; or a market value adjustment:

(A) for purposes of this paragraph, and paragraph (4) of this subsection, "waiver of surrender charges" means a waiver of surrender charges that is applied to any amount greater than 10% of the surrender value;

(B) for purposes of this paragraph, and paragraph (4) of this subsection, "two-tier values" means values on an annuity available at the maturity date of the contract that are different, depending on whether the value is taken from the contract in a lump sum or left with the issuer for periodic payments, regardless of whether the different values are available at issue or later;

(4) group annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability, or confinement in a hospital or nursing home), two-tier values, or a market value adjustment; group annuities that are guaranteed investment contracts (GICs), synthetic GICs, funding agreements, and unallocated group annuities funding pension plans;

(5) limited refilings for annuity products that indicate only a change in the mortality table or interest rates for new issues under the policy form, or changes to the separate account for variable products;

(6) variable annuities with a separate account only, which do not include a provision for guaranteed living benefits; and

(7) reversionary annuities.

(d) Exceptions. A filing identified in subsection (c) of this section may not be filed as exempt for any of the following annuity forms:

(1) annuities used to fund prepaid funeral contracts;

(2) variable annuities that contain guaranteed living benefit provisions;

(3) annuities that contain an index-linked crediting, long-term care, or other accident- and health-related benefit provision;

(4) applications for use with variable annuities, index-linked crediting annuities, annuities that contain a market-value-adjustment, or that contain a long-term care or other accident- and health-related provision;

(5) group annuity forms issued under the authority of Insurance Code §1131.064, relating to discretionary groups; or

(6) contingent deferred annuities.

(e) Group and individual accident and health forms. The group and individual accident and health insurance forms specified in paragraphs (1) and (2) of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (f) of this section:

(1) the group accident and health forms set out in subparagraphs (A) - (C) of this paragraph:

(A) a group accident and health form issued to employers under Insurance Code §1251.051, concerning Employers, or to a labor union or association of labor unions under Insurance Code §1251.052, concerning Associations;

(B) group forms issued under Insurance Code §§1251.051; 1251.052; or 1251.053, concerning Funds Established by Employers, Labor Unions, or Associations, respectively, that provide Medicare Supplement coverage to an employer, multiple employer arrangement, or a labor union and that are exempt from regulation under Insurance Code §1652.002(b)(1), concerning Medicare Supplement Benefit Plan;

(C) group forms issued under Insurance Code §1251.051 and §1251.052 that provide long-term care coverage to a single employer, a labor union, or an association of labor unions through a policy that is delivered or issued for delivery outside of Texas;

(2) group and individual accident and health forms that provide the following coverages:

(A) accident only (including occupational accident and other specified accident);

(B) accidental death and dismemberment;

(C) hospital indemnity;

(D) vision;

(E) specified disease (including cancer, heart attack, stroke, and other specifically named diseases);

(F) disability coverages (including income replacement, key-man, buy/sell, and overhead expense);

(G) policies designed to provide conversion coverages;

(H) other permitted coverages that are designed to supplement other in-force health insurance; and

(I) group stop loss/excess loss policies containing an attachment point of $5,000 or more.

(f) Exceptions. A filing identified in subsection (e) of this section is not permitted to be filed as exempt for any of the following insurance forms or rates:

(1) a group or individual health insurance policy that provides, on a comprehensive basis for illness and injury, a combination of hospital, medical, and surgical coverages, including any guaranteed renewable or short-term limited-duration major medical policies;

(2) a Medicare supplement policy as defined in Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, except as specifically provided in subsection (e)(1)(C) of this section;

(3) a long-term care policy as defined in Insurance Code Chapter 1651, concerning Long-Term Care Benefit Plans, (including any policies providing nursing home or home health care coverages), except as specifically provided in subsection (e)(1)(D) of this section;

(4) a form containing preferred provider or exclusive provider benefit plan provisions as defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans;

(5) a group form that is issued under Insurance Code §1251.056, concerning Other Groups;

(6) a conversion policy subject to the provisions of Chapter 21, Subchapter SS of this title, (relating to Continuation and Conversion Provisions), except for policies providing conversion from a policy included as an exempt form in this section;

(7) a policy that provides fixed indemnity coverage for more than hospital confinement, including a policy that provides limited long-term care coverage for a period of less than 12 months;

(8) rate or actuarial information that is required to be filed, even if the form is filed exempt as permitted by this section; and

(9) a dental policy.

(g) Copies of previously approved forms. Except for filings not eligible to be filed exempt under subsection (f)(4) of this section, a form not otherwise exempted under this subchapter that is an exact copy of a form is exempt from the review and approval requirements of Insurance Code Chapter 1701. These forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(h) Copies of previously approved forms subsequently submitted in braille or a non-English language. Any form not otherwise exempted under this subchapter that is submitted in braille as an exact copy of a previously approved form, or any form that has been translated into a non-English language from its previously approved English version, is exempt from the review and approval requirements of Insurance Code Chapter 1701. These forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter.

§3.4009. Sanctions and Cancellation of Exempt Filing Privileges.

(a) The privileges under this subchapter that permit an insurer to make exempt filings may be canceled if the insurer makes an exempt filing that fails to comply with one or more provisions of this title or the Insurance Code that results in the department determining that the filing has failed audit. If the issuer disagrees with TDI's determination under this section, it may request a hearing. The department will issue a notice of failed audit consistent with §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms) that explains:

(1) the compliance deficiencies identified during the audit process;

(2) the corrective action required;

(3) the cancellation of the insurer's exempt filing privileges; and

(4) how those privileges may be reinstated.

(b) If an insurer's privileges to make exempt filings under this subchapter are cancelled, the insurer is required to file for review and approval any and all forms intended for use in Texas, until the privileges under these sections are reinstated.

(c) Reinstatement of any privilege canceled under these sections will occur after a period of not more than one year, as provided in the notice of failed audit under subsection (a) of this section. An insurer may make application for reinstatement prior to the passage of the period specified in the notice of failed audit under subsection (a) of this section.

(d) Nothing in these sections limits the commissioner from imposing any other sanction authorized by the Insurance Code or other applicable law.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501057
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

28 TAC §3.4020

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.4020 under Insurance Code §§1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

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

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501058

Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

CHAPTER 7. CORPORATE AND FINANCIAL REGULATION

SUBCHAPTER M. REGULATORY FEES

The commissioner of insurance adopts amendments to 28 TAC §7.1301, concerning regulatory fees and the repeal of §7.1302. The amendments and repeal are adopted without changes to the proposed text published in the October 4, 2024, issue of the *Texas Register* (49 TexReg 8049). The sections will not be republished.

REASONED JUSTIFICATION. Amending §7.1301 and repealing §7.1302 are necessary to conform to the proposed repeal, amendment, and addition of new sections in 28 TAC Chapter 3, Subchapter A, which are also adopted in this edition of the *Texas Register.* Rules in 28 TAC Chapter 3, Subchapter A, are expanded to include filings by health maintenance organizations (HMOs). The fee amounts for HMO filings addressed in §7.1301 are replaced with fee amounts specified in new 28 TAC §3.13. Former 28 TAC §3.7, which referenced the billing system in §7.1302, is repealed. New 28 TAC §3.13 requires filing fees to be paid through the electronic funds transfer (EFT) system provided within the System for Electronic Rates & Forms Filing (SERFF). This change eliminates the need for the electronic billing system; thus, §7.1302 is repealed.

Descriptions of the adopted amendments follow.

Section 7.1301. Regulatory Fees. Amendments to subsection (g) revise paragraph (4) and delete paragraph (5) to remove the existing provisions that specify a fee of $100 for an evidence of coverage that requires approval, and a fee of $50 for a filing that is required by rule but that does not require approval. Subsection (g)(4) is amended to reference filing fees specified in 28 TAC §3.13 for a filing governed by 28 TAC Chapter 3, Subchapter A. Subchapter A of 28 TAC Chapter 3 applies to form, rate advertising, network, group eligibility, and informational filings for life and health products, and also applies to HMO products. As adopted separately in this edition of the *Texas Register,* 28 TAC §3.13 requires a fee of $100 for form and rate filings (including HMO evidence of coverage forms and their associated schedules of charges), subject to certain exceptions, and no fee for other types of filings (such as network filings). In addition, the Texas Department of Insurance (TDI) adopts nonsubstantive changes throughout §7.1301 to conform to agency style and usage guidelines, and to add titles to Insurance Code references.

Repeal of §7.1302. TDI adopts the repeal of §7.1302, which established TDI's internal billing system. This change aligns with the repeal of former 28 TAC §3.7, and the adoption of new 28 TAC §3.13, which requires issuers to pay filing fees previously governed by §7.1302 through the SERFF EFT system. This change will increase efficiency for TDI and issuers by reducing the administrative work involved in creating, processing, and paying invoices.

SUMMARY OF COMMENTS. TDI provided a 30-day public comment period that ended on November 4, 2024. TDI did not receive any comments on the proposed amendments or repeal.

28 TAC §7.1301

STATUTORY AUTHORITY. The commissioner adopts amendments to §7.1301 under Insurance Code §§843.154, 1153.005, 1153.006, 1701.053, and 36.001.

Insurance Code §843.154 provides that the commissioner, within the limits provided by the section, prescribe the fees to be charged under the section.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.006 provides that TDI set a fee not to exceed $200 for a form or schedule filed under Insurance Code Chapter 1153.

Insurance Code §1701.053 provides that TDI collect a fee in an amount determined by the commissioner for the filing of the form of a document under Insurance Code Chapter 1701.

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

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501060
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

28 TAC §7.1302

STATUTORY AUTHORITY. The commissioner adopts the repeal of §7.1302 under Insurance Code §§843.154, 1153.005, 1153.006, 1701.053, and 36.001.

Insurance Code §843.154 provides that the commissioner, within the limits provided by the section, prescribe the fees to be charged under the section.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.006 provides that TDI set a fee not to exceed $200 for a form or schedule filed under Insurance Code Chapter 1153.

Insurance Code §1701.053 provides that TDI collect a fee in an amount determined by the commissioner for the filing of the form of a document under Insurance Code Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's

powers and duties under the Insurance Code and other laws of this state.

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

Filed with the Office of the Secretary of State on March 28, 2025.

TRD-202501059
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: April 17, 2025
Proposal publication date: October 4, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

The Texas Parks and Wildlife Commission in a duly noticed meeting on January 23, 2025, adopted the repeal of 31 TAC §§65.81 - 61.85, new §65.81, and amendments to §§65.80, 65.88, 65.90, 65.92, 65.94, 65.95, and 65.99, concerning Disease Detection and Response, and amendments to §§65.602 - 65.605, 65.610, and 65.611, concerning Deer Breeders Permits. Section 65.88, concerning Carcass Movement Restrictions, §65.99, concerning Breeding Facilities Epidemiologically Connected to Deer Infected with CWD; Positive Deer Breeding Facilities, and §65.605, concerning Facility Standards and Care of Deer, are adopted with changes to the proposed text as published in the December 20, 2024, issue of the *Texas Register* (49 TexReg 10303) and will be republished. The repeals, new §65.81, and amendments to §§65.80, 65.90, 65.92, 65.94, 65.95, 65.602 - 65.604, 65.610, and 65.611 are adopted without change and will not be republished.

The change to §65.88 replaces the word "as" with the word "a" in subsections (a)(2) and (d)(2) to preserve grammatical sense and alters the title of the subsection to reflect the fact that the section now prescribes carcass disposal requirements and no longer addresses carcass movement.

The change to §65.95 renumbers paragraphs (1)- (5) in subsection (g) to correct a numbering error in the current rule. The change is nonsubstantive.

The change to §65.605 alters subsections (g) and (h) to clarify the circumstances under which infrastructure within deer breeder facilities may be used to handle species other than deer, including other susceptible species and livestock.

The repeals, amendments, and new rule eliminate the current zone-based disease response strategy for chronic wasting disease (CWD) detections in free-range and captive deer populations, implement a new risk-mitigation strategy based on confirmed cases of CWD in free-range populations of native and exotic species, and implement additional testing and fencing requirements for deer breeding facilities. The intent of the rules is to reduce the probability of CWD being spread from locations and facilities where it does or might exist and to minimize regulatory inconvenience for hunters, landowners, and land managers.

CWD is a fatal neurodegenerative disorder that affects cervid species such as white-tailed deer, mule deer, elk, red deer, sika, and others (susceptible species). CWD is classified as a TSE (transmissible spongiform encephalopathy), a family of diseases that includes scrapie (found in sheep) and bovine spongiform encephalopathy (BSE, found in cattle and commonly known as "Mad Cow Disease"), and variant Creutzfeldt-Jakob Disease (vCJD) in humans. CWD is transmitted both directly (through deer-to-deer contact) and indirectly (through environmental contamination).

The department and the Texas Animal Health Commission (TAHC) have been engaged in combatting CWD in Texas since 2002, including in response to repeated detections within deer breeding facilities. Since 2002, more than 150,000 "not detected" post-mortem CWD test results have been obtained from free-ranging (i.e., not breeder) deer in Texas, and deer breeders have submitted approximately 76,000 "not detected" post-mortem test results in addition to 112,000 ante-mortem test results as well.

Much remains unknown about CWD. The peculiarities of its transmission (how it is passed from animal to animal), infection rate (the frequency of occurrence through time or other comparative standard), incubation period (the time from exposure to clinical manifestation), and potential for transmission to other species are still being investigated and are not thoroughly understood. There is currently no scientific evidence to indicate that CWD is transmissible to humans; however, both the CDC and the World Health Organization strongly recommend avoiding consumption of meat from CWD-infected deer. What is known is that CWD is invariably fatal to cervids. Moreover, a high prevalence of the disease correlates with deer population decline in at least one free-ranging population in the United States, and there is evidence that hunters tend to avoid areas of high CWD prevalence. Additionally, the apparent persistence of CWD in contaminated environments represents a significant obstacle to eradication of CWD from either captive or free-ranging cervid populations. The potential implications of CWD for Texas and its multi-billion-dollar ranching, hunting, real estate, tourism, and wildlife management-related economies could be significant, unless it is managed and measures are in place to aid in containment where possible.

The department has engaged in frequent rulemaking over the years to address both the general threat posed by CWD and the repeated detection of CWD in deer breeding facilities. In 2005, the department adopted rules (30 TexReg 3595) that closed the Texas border to the entry of out-of-state captive white-tailed and mule deer and increased regulatory requirements regarding disease monitoring and recordkeeping. In 2012, based on recommendations from the department's CWD Task Force (an ad hoc group of deer management professionals, landowners, veterinarians, scientists, and deer breeders), the department adopted rules (37 TexReg 10231) to implement a CWD containment strategy in response to the detection of CWD in free-ranging mule deer located in the Hueco Mountains, the first detection of CWD in Texas. In 2015, the department discovered CWD in a deer breeding facility in Medina County and adopted emergency rules (40 TexReg 5566) to respond immediately to the threat, followed by rules (41 TexReg 815) intended to function through the 2015-2016 hunting season. Working closely with TAHC and with the assistance of the Center for Public Policy Dispute Resolution of

the University of Texas School of Law, the department intensively utilized input from stakeholders and interested parties to develop and adopt comprehensive CWD management rules in 2016 (41 TexReg 5726). Since 2002, the department has made a continuous, concerted effort to involve the regulated community and stakeholders in the process of developing appropriate CWD response, management, and containment strategies, including input from the Breeder User Group (an ad hoc group of deer breeders), the CWD Task Force, the Private Lands Advisory Committee (an advisory group of private landowners from various ecological regions of the state), and the White-tailed Deer and Mule Deer Advisory Committees (advisory groups of landowners, hunters, wildlife managers, and other stakeholders), resulting in a series of rulemakings necessitated by or in response to the continued detections of CWD in both free-range and captive populations.

Until now, the department's strategy for containing CWD on the landscape was to respond to CWD detections in both captive and free-ranging populations by designating CWD management zones by rule. Within those zones, the movement of live deer under department-issued permits was restricted, testing of all hunter-harvested deer was required, and special provisions governing the processing and movement of deer carcasses were placed in effect. One unforeseen consequence of that approach is that the constant stream of CWD discoveries in breeding facilities has resulted in continuous rulemaking, because each time CWD is discovered, the commission must promulgate a zone by rule in response. Staff has been directed by the commission to replace the current zone-based system with some other method of mitigating the risk of the spread of CWD that does not involve the necessity of rulemaking every time CWD is discovered in a breeding facility or free-range populations. The commission's directive is accomplished by this rulemaking.

The rules contained in Division 2 of Chapter 65, Subchapter B, govern the department's disease management protocols with respect to the detection of CWD within deer breeding facilities. Those rules can generally be described as functioning together to implement testing standards necessary to provide statistically representative sampling within deer breeding facilities for purposes of minimally effective surveillance for CWD. One of the most effective approaches to managing infectious diseases and arresting the spread of a disease is to segregate exposed populations (individuals or populations with unknown contact with an infectious agent) from unexposed populations. As a matter of epidemiological probability, when animals from a population at higher risk of harboring an infectious disease are introduced to a population of animals at a lower risk of harboring an infectious disease, the confidence that the receiving population will remain disease-free is reduced.

Department records indicate that within the last five years (since January 1, 2020), 30 deer breeding facilities where CWD has been confirmed transferred a total of 8,799 deer to 249 additional deer breeding facilities and 487 release sites located in a total of 144 counties in Texas.

The current comprehensive rules address disease response with respect to directly connected facilities (facilities where CWD has been detected) and indirectly connected facilities (facilities that receive deer that were in the same facility with a CWD-positive deer prior to being transferred to another facility), implementing requirements for disease testing and movement of breeder deer to and from indirectly connected facilities, and requiring ante-mortem testing of all age-eligible deer prior to transfer to another breeding facility or release site. Those rules are predicated on a "tracing" model that is a universally accepted epidemiological methodology for disease tracking and control. The department, TAHC, and the United States Department of Agriculture (USDA) utilize a five-year "trace window" to develop information to characterize the particulars concerning the potential spread of CWD. The five-year window is important because (based on the literature and the USDA cervid disease program standards) it encompasses the time period from possible exposure to CWD, through the incubation period, to the time at which the disease can be transmitted to another animal or the environment.

The current rules also address disease transmission risk associated with the movement of deer carcasses by implementing statewide disposal requirements. These disposal requirements ensure that unused carcass parts are either left at the site of harvest, disposed of in a landfill, or buried under at least three feet of earth. Proper carcass disposal mitigates risk associated with environmental contamination and potential spread of infected carcass parts by scavengers, providing an effective management strategy.

The rules as adopted are necessary to protect the state's white-tailed and mule deer populations, as well as the long-term viability of associated hunting, wildlife management, and deer breeding industries. To minimize the severity of biological and economic impacts resulting from CWD, the rules implement more rigorous protocols within deer breeding facilities located in a specified proximity to a free-range CWD detection than was previously required in CWD Containment Zones. The rules provide a pathway for any deer breeders within a specified proximity to a free-range CWD detection to continue to move and release breeder deer.

The repeals eliminate rules imposing CWD management zones, conditions for live-animal movement under department-issued permits within those zones, special provisions for breeding facilities within zones, powers of the executive director, and check station requirements, none of which are necessary any longer.

The amendment to §65.80, concerning Definitions, removes the current definitions, which are either unnecessary or redundant, and allows the definitions of §65.90, concerning Definitions, to be applicable to the entirety of the subchapter.

New §65.81, concerning Risk Mitigation Provisions, implements a new approach for isolating, reducing, and if possible, preventing the spread of CWD from locations where it is confirmed to exist, without the need for rulemaking each time a detection occurs, and without utilizing check stations or mandatory testing of hunter-harvested deer. The new approach is based on additional safeguards with respect to the movement of live deer under department-issued permits in proximity to locations where CWD is detected in free-range deer.

New subsection (a) provides for the applicability of the new rule to the human-assisted movement of live deer under department-issued permits within five linear miles of a location where CWD has been detected in a free-range white-tailed deer or susceptible species or within 25 miles of a location where CWD has been detected in a free-range mule deer (hereinafter, "proximity to a free-range positive," "proximity values"), provide for resolution of conflict with other regulatory provisions, and allow for the cessation of the rule's applicability when the department has determined, using the best available science, that CWD is not likely present in such areas. The new subsection is necessary to clearly articulate when and where the provisions of the new rule

apply, and under what conditions the applicability of the rules ceases. The five-mile and 25-mile values were selected because they represent the average natural dispersal ranges for free-range buck white-tailed and mule deer, respectively. The five-mile proximity factor is also applied to susceptible species as a general index of movement and takes into consideration that such animals are not indigenous.

New subsection (b) specifically addresses the movement of live deer under a deer breeder's permit in proximity to a free-range positive. New subsection (b)(1) specifies that the department will notify the holder of a deer breeder's permit in the event that the permittee's facility has become subject to the applicability of the rule, which is necessary to establish the point in time the department will use to calculate compliance with various time-based provisions of the rules.

New subsection (b)(2) provides that a deer breeder in proximity to a free-range positive could, provided the facility is designated movement qualified (MQ) by the department (authorized by the department to transfer deer), continue to transfer deer, but only to other breeders or release sites that are also within proximity to the free-range positive. The department's primary concern is to prevent the spread of CWD from where it is known to exist by limiting the movement of live deer via department-issued permits from such areas to new areas beyond the natural dispersal range of deer, which is the case under rules currently in effect.

New subsection (b)(3) and (4) provides the conditions under which the department would allow the transfer of breeder deer from a breeding facility in proximity to a free-range positive to locations beyond the proximity distances. The department has determined that if a breeding facility in proximity to a free-range positive has been "double fenced" for at least one year prior to the detection and a round of ante-mortem testing of all eligible-age deer within the facility is completed (with results of "not detected") following the free-range detection, the risk of spreading CWD is probably low. Alternatively, the department has determined that if a breeding facility in proximity to a free-range positive has been "double fenced" for less than one year prior to detection (or not at all) and then completes a round of ante-mortem testing of all eligible-age deer within the facility (with results of "not detected") not sooner than one year following the completion of the "double fence," and one year has passed following the whole-herd test, the risk of spreading CWD is probably low. A "double fence" is believed to be an effective (but not absolute) barrier to CWD transmission because it prevents physical contact between free-range animals (both native deer and susceptible species) and breeder deer. In order to gain some assurance that CWD has not been passed from free-range animals to deer within a facility, a whole-herd ante-mortem test functions as an efficacious screening tool in conjunction with current rules requiring individual breeder deer to be ante-mortem tested prior to transfer; thus, the combination of physical barrier, whole-herd testing, sufficient time, and individual testing prior to transfer is believed to present an acceptable assurance that the likelihood of CWD being present (yet undetected) is low, especially when combined with mandatory retention of visible identification on all breeder deer at release sites, which will greatly assist in the recovery and testing of exposed animals should CWD be detected in the originating facility.

New paragraph (4) acknowledges the efficacy of surveillance achieved during the effectiveness of the current rules being proposed for repeal in this rulemaking and the associated epidemiological value of that surveillance to breeding facilities prospectively affected by the new rules. Under those rules, all hunter-harvested deer in CWD management zones were subject to mandatory or voluntary CWD testing. In order to accommodate the situations in which a breeding facility was prohibited under the CWD management zone rules from transferring deer to any location authorized to receive breeder deer, the proposed new rule would allow such facilities to transfer deer to any location in the state authorized to receive deer, provided the facility meets the new fencing requirements in the proposed amendment to §65.905, concerning Facility Requirements and Care of Deer, and is otherwise authorized to transfer deer (i.e., not a breeding facility where CWD has been confirmed or a breeding facility epidemiologically linked to a breeding facility where CWD has been confirmed or otherwise not in compliance with rules regarding movement qualification).

New subsection (b)(5) provides for situations in which a new permit is sought for a facility at a location that is already within proximity values from a free-range positive. As discussed previously in this preamble, the proximity values of the rules are predicated on the natural range of indigenous species of deer and reflect the premise that where CWD is known to exist the likelihood of its detection, if it is spreading, can be expected to be higher at closer distances to the free-range positive ("index case" or "index positive"); therefore, the new paragraph implements a number of measures intended to minimize the elevated risk of spreading CWD via the movement of breeder deer from facilities in proximity to an index case. First, the new paragraph would require a prospective permittee to conduct an environmental assessment (using department-approved methodologies) of possible exposure of the site to CWD prions, which is necessary to provide assurance that a site is not already infected (in which case the department will not authorize the facility to receive deer; it is axiomatic that places where CWD is known to exist should not be the location of deer breeding activities that could cause the transmission of CWD to additional animals). The provision also stipulates that if the site was ever previously the site of a deer breeder facility, the environmental assessment would be required for the entirety of that site. Second, the new paragraph would require, for an initial period of three years following the first introduction of deer to a new facility, that all deer introduced into or born in the facility remain in the facility for a minimum of 20 months (i.e., "residency,"), which is necessary to provide another layer of assurance that CWD is not present. The 20-month value represents an acceptable length of time, post-exposure to CWD prions (if present), that CWD could be expected to have progressed to the point of being detectable using current ante-mortem testing methodologies. New paragraph (6) provides that during the three-year period required by paragraph (5), the department would authorize the transfer of deer meeting the 20-month residency requirement to any facility authorized to receive deer (anywhere in the state), but deer that do not meet the 20-month residency requirement can be transferred only to release sites that are entirely within proximity distance of the free-range positive. The transfer of deer to release sites within the proximity distance does not represent as high a comparative risk for epidemiological assessment as the transfer of deer to facilities beyond the proximity distance, because CWD is known to exist within the area already. On the other hand, deer transferred beyond the proximity distance have the potential to expose new areas not previously known to have CWD; therefore, the department believes it is prudent to restrict the transfer of deer beyond the proximity distance only to breeder deer that have a "not detected" antemortem test result for a tissue sample collected after the 20-month residency has been established.

The provision also allows the department to waive the 20-month residency requirement after the initial three-year period if the department determines there is reason to believe CWD prions are not present in the facility.

New subsection (b)(7) provides that the department will issue a new breeder permit to any qualified individual, but will not authorize the possession of breeder deer at any location where a susceptible species has tested positive for CWD or where CWD prions are determined to exist. The department does not believe it is prudent to allow deer to be concentrated within a captive breeding facility at a location where CWD is already known to be present.

New subsection (b)(8) prohibits the recapture of deer that escape from a deer breeding facility located in proximity to a free-range positive except as authorized by the department or in a herd plan. A deer that escapes from a facility in proximity to a free-range positive could become exposed to CWD; therefore, the return of an escaped deer to a deer breeding facility could introduce CWD to that facility, which is undesirable. Therefore, the provision prohibits the return of escaped breeder deer to breeding facilities in proximity to a free-range positive while making exceptions for situations in which the department believes recapture is necessary and the risk is low or non-existent, or it is otherwise allowed under a herd plan.

New subsection (b)(9) addresses the expansion of an existing deer breeding facility in proximity to an index positive by requiring the site to be subject to the assessment and residency measures required by paragraphs (5) and (6) and treating the expanded facility as a new facility. The enlargement of a facility in an area where CWD has been discovered means that environmental contamination could have occurred and CWD could now be present within the perimeter of the enlarged facility. Therefore, the amendment prescribes the same requirements to assess and screen for the presence of prions that are prescribed by rule for new facilities.

New subsection (c) provides for the authorization of activities pursuant to a Deer Management Permit (DMP) at a property in proximity to a free-range positive. A DMP authorizes the capture and temporary captivity of free-range deer for natural breeding purposes (which may include breeder deer introduced to the temporary breeding enclosure) within a high-fence property, after which the deer must be released to the wild. The department reasons that CWD prevalence (if CWD exists) in the population of deer on that property could be exacerbated because deer are concentrated in a DMP pen; therefore, the new subsection requires DMP recipients in proximity to a free-range positive to test either 100 percent of hunter-harvested deer or 15 hunter-harvested deer (whichever value is lower) during the hunting season for which the DMP was issued, which would give the department some idea of disease status on the property. The provision also requires permittees to maintain a daily harvest log, provide it upon request of any department employee acting within the scope of official duties, submit it to the department electronically by the April 1 following the hunting season for which it was issued, and retain it for a period of one year. The harvest log is a useful tool for the department to assess compliance with the rule and ensure testing requirements are achieved. The subsection also conditions the further issuance of DMPs on compliance with the test requirements of the proposed new subsection and specifies methodology for permittees to attain compliance in the event that a permittee is unable to provide a sufficient number of test results for the year of permit issuance. Finally, the subsection provides that the department will not issue a DMP for any property where CWD has been confirmed or that is epidemiologically linked to a positive facility. It is axiomatic that places where CWD is known to exist or that have received deer from a breeding facility where CWD exists should not be used as locations for DMP activities that could cause an increase in prevalence rates beyond what would normally occur in the free-ranging population.

The amendment to §65.88, concerning Deer Carcass Disposal Requirements, standardizes carcass disposal methods to eliminate separate requirements applicable to susceptible species harvested outside of Texas and clarifies existing rules governing disposal of carcasses. The amendment eliminates current subsection (a), modifies current subsection (b) to accommodate applicability to susceptible species harvested outside of Texas, adds new subsection (b) to expressly prohibit rendering as an acceptable method of disposal, and alters current subsection (c) to allow for the deboning of carcasses at a location other than the property of harvest. The amendment also clarifies that persons opting to bury unused carcass parts are expected to immediately cover those parts as provided in the current rule, and that during the time period, if any, between the processing of a carcass and eventual disposal, the unused carcass parts must be protected from being scattered, consumed, or removed. The amendment is intended to remove ambiguity regarding the timeliness of compliance with the current rule and clarify what is and what is not an acceptable method of carcass disposal. Similar changes are made to subsection (d). The amendment eliminates current subsections (e) and (f) because they are no longer necessary.

The amendment to §65.90, concerning Definitions, adds definitions for "CWD-positive," "free-range deer," "location of detection," "not available/unavailable for testing," "positive breeding facility," "susceptible species," and "whole-herd test." All white-tailed and mule deer in this state are the property of the people of this state; however, various provisions of Parks and Wildlife Code authorize the temporary or (conditionally) permanent possession of white-tailed and mule deer under certain permits. The provisions of this subchapter distinguish between deer held in captivity under a deer breeding permit from all other deer, and it is helpful to have a useful term to refer to all deer other than deer held in captivity; therefore, the amendment defines "free-range deer" as "a deer that is not a breeder deer." Similarly, the provisions of the subchapter are frequently conditioned on the confirmed presence or assumed absence of CWD in various scenarios; therefore, "CWD-positive," is defined as "an animal that has received a "detected" or "positive" CWD test result confirmed by the National Veterinary Services Laboratory," and "positive breeding facility" is defined as "a deer breeding facility where CWD has been confirmed to exist." "Not available/unavailable for testing" is defined as "for a Category B trace-out deer breeding facility, a deer that is no longer present in a facility and cannot be found or the whereabouts of which are otherwise unknown." The provisions of the rules address different compliance scenarios affecting facilities that have been epidemiologically linked to a positive facility. Those scenarios depend on the presence or absence of deer that could have been exposed to CWD (and thus infected) and the availability of those deer for testing. In some cases, a deer might already have been released and cannot be found, or perhaps died without being tested; therefore, a definition of the term is necessary to clearly indicate when the provisions of various elements of the rulemaking are to be employed. The amendment defines "susceptible species" as "any cervid species or part of a cervid species that is susceptible to CWD,"

which is necessary because white-tailed and mule deer can contract CWD from certain species of exotic livestock and non-native wildlife; thus, the rules must account for the discovery of CWD in animals in general, not just in native wildlife. "Whole-herd test" is defined as "the administration of an ante-mortem test to the entirety of test-eligible deer in the inventory of a breeding facility," which is necessary to create a useful shorthand reference. In §65.81, concerning CWD Risk Mitigation Provisions, the applicability of that section to breeding facilities is predicated on the distance any given deer breeding facility is from a location where CWD has been confirmed in a free-range white-tailed, mule deer, or other susceptible species. The department intends for that standard to be as close as possible to the actual distance between the deer breeding facility and the exact spot where the deer was killed, but acknowledges that this will not always be possible; therefore, the amendment defines "location of detection" as "the exact location, to the extent that it can be determined, at which a deer confirmed to be positive for CWD died." Finally, the amendment alters the definition of "liberated deer" to remove redundancy and includes the presence of other identifiers that could testify to the fact that a deer was at one time a breeder deer.

The amendment to §65.92, concerning CWD Testing, alters internal references to conform with changes made elsewhere in the rulemaking that would allow retropharyngeal lymph nodes (RLN) by themselves to be sufficient for testing purposes with respect to DMP activities in proximity to a free-range positive. RLNs have greater sensitivity than the obex for detecting CWD in deer; further, because DMP activities are unidirectional (the deer remain on the property and cannot be moved) and much reduced in potential for epidemiological complexity, the epidemiological information gained by submission of both tissues is of less importance; thus, a single type of tissue can be used for testing, as opposed to the lymph node/obex pair required for testing in deer breeding facilities, where epidemiological complexity can be significant.

The amendment to §65.94, concerning Breeding Facility Minimum Movement Qualification, alters an internal citation to reflect changes made to the title of §65.605, concerning Facility Standards and Care of Deer, elsewhere in this rulemaking.

The amendment to §65.95, concerning Movement of Breeder Deer, requires the owner of a prospective release site for breeder deer to provide independent verification that the entirety of the release site is surrounded by a fence meeting the requirements of current subsection (c)(3). There have been instances in which unscrupulous persons have been untruthful with respect to the fence requirements or even the actual location of a release site. Although it is a violation of current rule and Parks and Wildlife Code to fail to have and maintain a lawful fence, the sheer number of release sites makes it impossible for the department to verify that every release site is in compliance with the rules; therefore, because the department firmly believes it is imperative that released breeder deer be to some reasonable extent segregated from other free-range populations because of the threat of CWD, it is prudent to require an independent confirmation that the required fencing exists as a condition of authorizing such releases.

The amendment also prohibits the release of breeder deer that are not permanently marked in accordance with the requirements of Parks and Wildlife Code, §43.3561, which stipulates that not later than March 31 of the year following the year in which a breeder deer is born, the breeder deer must be identified by placing a tag in one ear. Section 43.3561 also requires deer breeders to immediately replace an identification tag that has been dislodged, damaged, or removed by means other than human agency and allows the removal of a tag only for the purpose of immediately replacing the tag with a tag that meets the requirements of Parks and Wildlife Code, §43.3561. Faithfulness to the statute, especially in light of the rules as adopted, will increase the ability of the department and landowners to quickly identify and remove specific deer from release sites for testing in the event a release site becomes epidemiologically linked to a deer breeding facility where CWD has been confirmed, greatly assisting in disease management and response.

The amendment to §65.99, concerning Breeding Facilities Epidemiologically Connected to Deer Infected with CWD; Positive Deer Breeding Facilities, eliminates references to provisions in Division 1 of this subchapter that are no longer meaningful. The amendment also corrects an inaccurate internal reference in subsection (e)(3).

The amendment adds new subsection (f) to provide additional avenues to restore MQ status for breeding facilities that have been designated NMQ because they are epidemiologically linked to a positive facility (index facility) under subsection (e) of the current rules (i.e., Category B Trace-out Facilities). The amendment provides two alternatives to the current five-year trace window, both based on the elapsed time since any given facility has been epidemiologically connected to the index facility. The first addresses the riskiest facilities, those in which deer implicated in an epidemiological investigation were received by the facility 36 months or less following detection of CWD in the index facility. New subsection (f)(1) provides that for such facilities, MQ status could be restored, provided the facility is fenced in accordance with the requirements of §65.605, concerning Facility Standards and Care of Deer; all trace deer available for testing (whether in the facility or in another facility as a result of transfer) are tested as required under current rule; a minimum of 25 percent of the total number of test-eligible deer in the facility are tested (ante-mortem and/or post-mortem, with "not detected" results) in each of the two reporting years preceding notification of Category B status; all trace deer that cannot be located for testing were in the facility for at least 20 months before being ante-mortem tested (with "not detected" results); and the facility has been in compliance for the previous two reporting years with all provisions of statute and rule that govern the possession of breeder deer. The provision implements a combination of enhanced physical barriers, elevated testing effort, and residency requirements, in the context of continuous regulatory compliance, to provide a realistic, though minimal, assurance that if CWD has been introduced to a Category B facility, it will a) not be spread via physical contact through a single fence from animals in the facility to animals outside the facility, and b) be detected in the facility before deer are transferred elsewhere. The department notes that although the measures provide a few scientifically defensible protections, they do not provide absolute or even high confidence that CWD will not be spread from facilities where they are employed.

The second pathway addresses facilities in which deer implicated in an epidemiological investigation were received by the facility more than 36 months following detection of CWD in the index facility. Empirical evidence suggests that the incubation period of CWD is typically around 18 to 24 months, depending on the individual animal, and becomes progressively easier to detect, if present, from that point on. Thus, for facilities in which trace deer were received at a point in time earlier than 36 months

from the date a facility becomes a Category B facility, there is a correspondingly increased assurance that if it is present it will be detected, provided a double fence segregates breeder deer from other susceptible species, all trace deer available for testing are post-mortem tested, all trace deer unavailable for testing were ante-mortem tested (with results of "not detected") at least once in the 60 months from the time CWD was detected in the positive facility (or at any time after the detection occurred), and the facility is in compliance with all statutory or regulatory provisions applicable to the possession of breeder deer. Having noted that the provisions as adopted are approaching minimally acceptable standards with respect to disease detection and management, the department strongly encourages the regulated community to recognize the value of due diligence with respect to the provenance of deer acquired from other breeders and the magnitude of potential disease transmission, which will greatly aid the department in disease management efforts as well as precluding the imposition of measures that can be avoided with greater caution. Furthermore, the department seeks to emphasize the importance of regulatory compliance by the regulated community, as circumvention of rules reduces the effectiveness of efforts to mitigate disease transmission and poses avoidable risks to other members of the regulated community, landowners, and hunters. Finally, the provision stipulates that compliance with the rules does not relieve a permittee of any obligations otherwise imposed by a herd plan, which is necessary to make clear that terms and conditions of herd plans, because they are jointly administered and enforced by the department and TAHC, are independent from and in addition to the regulatory requirements of the subchapter.

The amendment alters current subsection (h) to implement additional measures to facilitate and expedite the department's epidemiological investigations in the event that CWD is detected in a breeding facility. The amendment requires a permittee, within 14 days of being notified of a suspect detection, to conduct and provide to the department a pen-by-pen inventory (to include the pen where the positive deer was at the time of the detection) and immediately cease the internal movement of deer between pens in the facility unless otherwise authorized by the department. Upon confirmation of CWD, a permittee must euthanize all trace deer within seven days (unless authorized by the department or in a herd plan), and either enter into a herd plan or agree to depopulate the facility. The prompt isolation of deer, cessation of deer movement, removal of trace deer, and initiation of mitigation actions greatly aids department efforts to contain and slow the spread of CWD. Finally, the amendment makes conforming changes to internal cross-references.

The amendment to §65.602, concerning Permit Requirement and Permit Privileges; General Provisions, adds a reference to Subchapter B of the chapter to subsection (b)(4) and eliminates the time-based provision in subsection (d). The amendment to subsection (b) is necessary because another element of this rulemaking affects attempts to recapture escaped breeder deer and the two provisions should be harmonized to prevent confusion. The alteration to subsection (d) is necessary because the provision is no longer applicable or necessary. The amendment eliminates current subsection (e) and relocates its contents to §65.605, concerning Facility Standards and Care of Deer, so that all provisions regarding fencing and infrastructure are in a single location.

The amendment to §65.603, concerning Application and Permit Issuance, requires applicants for a new deer breeder's permit to provide evidence that required fencing exists and has been inspected as stipulated by §65.605, concerning Facility Standards and Care of Deer (for reasons addressed earlier in this preamble in the discussion of new §65.81) and clarifies that a facility/fence inspector cannot be an employee of the department or the permittee, which is intended to prevent conflicts of interest. The amendment also updates an internal reference to definitions.

The amendment to §65.604, concerning Disease Monitoring, alters the reference to Subchapter B of Chapter 65 to remove a reference to Division 2, which is no longer necessary.

The amendment to §65.605, concerning Holding Facility Standards and Care of Deer, retitles the section, implements additional fencing requirements, prescribes internal infrastructure requirements, and prohibits the sharing (except for specific temporary instances) of any space within a breeding facility with any animals other than the breeder deer permitted to be in the facility.

Elsewhere in this rulemaking the department prescribes standards to mitigate the risk of the spread of CWD from locations where it has been confirmed in free-range populations of susceptible species. One component of those risk-mitigation measures is the requirement for affected deer breeding facilities to erect additional fencing (i.e., "double fence") as necessary to ensure that deer within the facility (with one exception for temporary movement within a facility) are at all times behind at least two fences capable of retaining deer. For ease of reference, this is referred to as "double fence" or "double fencing." The department believes it is prudent to require all new deer breeding facilities to comply with those fencing standards moving forward, which will provide additional protections with respect to disease transmission and the benefit of enhancing the ability of new facilities to seamlessly maintain movement status in the event that CWD is confirmed in proximity to the facility at some point in the future. The amendment stipulates that the external, perimeter fence component at no point be within five feet of an internal component of the double fence, or within ten feet of the perimeter fence component of another deer breeding facility, both of which are necessary to prevent nose-to-nose or direct contact between deer in one facility and deer in another facility or free-ranging susceptible species.

The amendment to 65.605 also adds new subsection (c) to make explicit that under the rules as proposed, a deer breeding facility consists of the entirety of the area within the perimeter fence required under subsection (b).

The amendment to §65.605 also adds new subsections (d) and (e) to ensure that breeder deer are at all times (with exceptions) contained inside the "double fence" and stipulates that in the interstitial spaces between the perimeter fence of the facility and the fencing of the pens within the facility, no supplemental food or water is permitted and no animals (including breeder deer) are allowed to be present, except what is necessary to facilitate movement of breeder deer between pens within the facility. As noted earlier in this preamble, CWD can be transmitted environmentally (contaminated soil, vegetation, feed, excreta) as well as through direct animal-to-animal contact. The department considers that it is therefore important for the spaces between internal fencing components (e.g. facility pens) and the perimeter fence to function as a buffer to prevent direct animal contact. The amendment contains an exception for the temporary use of such spaces as needed to move or drive deer between fenced components within the facility, provided they are not allowed to linger or to have unsupervised access to such spaces.

The amendment to §65.605 also creates new subsections (f) - (h) to clarify the use of infrastructure within the perimeter fence of a deer breeding facility with respect to animals other than the breeder deer within the facility. The department has become aware that in some cases breeder deer from more than one permitted facility have been allowed shared access to handling barns and working pens, which should not be occurring because it presents an unacceptable risk of CWD being transmitted between breeding facilities via environmental or direct contact. Therefore, the amendment relocates the requirements of current §65.602(e), and explicitly prohibits the shared use of infrastructure by breeder deer within the facility and any other susceptible species, other than the temporary use of such infrastructure for handling and working livestock and non-susceptible species. The amendment also provides clarification that facility infrastructure such as buildings, sheds, etc. need not be completely within and separate from the perimeter fence required by the rules, so long as the external walls of various infrastructure function as a de facto component of the double fencing required by the proposed rules. The amendment to §65.605 also adds new subsection (j) to clarify that no current permittee is required to erect a perimeter fence but all permittees are required to comply with the other provisions of the proposed amendment. Finally, the amendment adds new subsection (i) to require all deer breeding facilities on a single property to be separated by at least 10 feet. In this way, there is no shared fencing that would allow or facilitate direct animal-to-animal contact.

The amendment to §65.610, concerning Transfer of Deer, acknowledges the offense of violating Parks and Wildlife Code, §43.3561, for reasons explained earlier in this rulemaking with respect to the amendment to §65.95.

The amendment to §65.611, concerning Prohibited Acts, makes changes as necessary to conform the applicability of the section to the subchapter.

The department received 1,414 comments opposing adoption of the rules as proposed. Of those comments, 201 provided a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow. The department notes that because some comments in opposition to the rules consisted of multiple points, the department has organized the response to public comment accordingly; therefore, the number of responses is greater than the number of commenters.

Eighteen commenters opposed adoption of the rules as proposed and stated that the rules are onerous, overkill, out of control, excessive, government overreach, intrusive, a witch hunt, or some other similar descriptive language meant to characterize the department's actions as arbitrary, egregious, and unnecessary. The department notes that the comments in most if not all cases seemed to be directed at the agency's rulemaking regarding CWD management generally and did not identify opposition to any specific component or provision of the rules as proposed. The department nevertheless disagrees with the comments and responds that until now, a primary component of the department's response to the emergence of CWD has been the creation by rule of CWD management zones surrounding locations where CWD is detected, within which surveillance sampling in the form of mandatory testing of hunter-harvested deer is conducted to determine the prevalence and distribution of CWD in that area. The zone system was unpopular, particularly in those areas where zones were established, because of perceived stigma. However, the department has a statutory duty to protect and conserve captive and free-ranging populations of indigenous deer and because CWD continues to be detected (primarily in deer breeding facilities and release sites associated with breeding facilities) across the state, the commission directed staff to develop another approach, which is reflected in the rules as adopted, that eliminates CWD management zones and associated rules. The department believes the rules as adopted have a credible probability of retarding community spread in free-ranging populations when and where it is detected. The department believes the rules as adopted are sensible, appropriate, and reasonable, as well as an indication that public comment is taken seriously by the commission and department. No changes were made as a result of the comments.

Thirteen commenters opposed adoption of the rules as proposed and stated that CWD cannot be eradicated and hasn't been eradicated in free range herds. The department agrees with the comments in part and responds that once established, CWD cannot be eradicated; the goal of the agency's rules isn't eradication, it's early detection. There are examples where the rapid detection and intensive management of CWD in free-range herds appears to have prevented further detections. Even within Texas, no further detections have been found in Del Rio (three free-ranging positives) for at least four hunting seasons following the timely, intensive efforts to reduce native deer populations in addition to other mitigation measures. The department does recognize, though, that in areas where CWD has become established (in animals, the environment, or both), efficient eradication of the disease may not be possible; however, it is precisely because it is difficult if not impossible to eradicate CWD once it is established that it is imperative to keep the disease from spreading. No changes were made as a result of the comments.

Twelve commenters opposed adoption of the rules as proposed and stated that the rules are evidence of department antipathy or animosity towards deer breeders and indicative of a department desire to eliminate or destroy deer breeding, describing the rules, variously, as discriminatory, bullying, crippling, a "war on breeders," "trying to put breeders out of business," "punishing" breeders, and other unflattering adjectives and phrases with negative connotations meant to indicate belief in a pre-existing, continuing bias or animus towards deer breeding and deer breeders. The department disagrees with the comments and responds that the rules as adopted are not intended to be punitive or a demonstration of disregard or contempt for the regulated community; rather, they represent the earnest desire of the department to discharge its statutory duty to protect and conserve the wildlife resources of the state from the growing threat of CWD and to do so in a manner that is conscientious and respectful of the interests of the regulated community. As noted in the department response to other comments, many comments seemed to be directed at the agency's historical or previous rulemaking regarding CWD management generally and did not express opposition to any particular component or provision of the proposed rules. The department also notes that adoption of the rules was publicly supported on the record by the Texas Deer Association, historically the primary voice for the regulated community. No changes were made as a result of the comments.

Eleven commenters opposed adoption and stated the rules as proposed would hurt property values. The department disagrees with the comment and responds that the rules prescribe testing requirements for the transfer of breeder deer between deer breeders and enhances surveillance requirements at trace-out release sites, neither which have been demonstrated to affect property values. No changes were made as a result of the comments.

Eleven commenters opposed adoption of the rules as proposed and stated in various ways that the rules are not justified because of the low positivity and prevalence rates for CWD in captive deer populations and because there is no evidence that CWD is more common in breeder pens than in the wild. The department disagrees with the comments and responds that comparing positivity and prevalence rates in captive versus free-ranging populations (especially on a statewide scale) is of little to no value in informing disease management strategies because captive deer, which are artificially concentrated at high densities and frequently translocated over long distances, are a subjectively distinct and different epidemiological context in comparison to free-ranging deer, which are loose on the landscape, far more dispersed, and absolutely limited by natural home ranges. In any case, the data show that the majority of CWD detections and newly affected areas in Texas over the last 10 years can be attributed to breeder deer as well as the transfer of breeder deer from one location to another, which strongly suggests that continued attention to disease monitoring in captive populations is warranted, especially in the absence of robust surveillance efforts (such as mandatory testing of hunter-harvested deer currently required in CWD management zones, which are repealed in this rulemaking) in areas where CWD is detected in either captive or free-ranging populations. The rules as adopted address that fact. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the rules will harm, kill, destroy, or otherwise negatively impact deer hunting, and another seven commenters stated in various ways that the rules will hurt small businesses, businesses associated with the hunting industry, employment, job creation, the state economy, and local economies, and other general assertions of extreme financial hardship or harm at both micro and macro levels. The department disagrees with the comments and responds that the rules as adopted, to the extent that they affect individuals other than deer breeders, liberalize carcass movement and disposal requirements for hunters and landowners, and completely eliminate mandatory testing of hunter-harvested deer and other requirements associated with CWD management zones, which are being eliminated. The remainder of the rules as adopted do not directly regulate any persons other than those who hold a deer breeder permit and those who purchase deer from deer breeders for purposes of release and whose release sites are subsequently linked epidemiologically to a deer breeding facility where CWD has been detected ("positive facility"). The department notes again that there is a common misperception that deer breeders furnish or are responsible for a significant component of the deer population in Texas; in fact, captive-bred deer represent an extremely small percentage (generously estimated at less than four percent) of the total number of deer harvested annually in Texas and in that context, whatever ancillary, indirect economic impact of the rules as adopted is exceedingly minor, if it exists at all. The department also notes that if CWD is allowed to become widespread, the economic impacts and the impacts to the far larger economy associated with the hunting of free-ranging deer, as well as further negative impacts to the regulated community itself will be significant. The department also notes that the rules as adopted were supported by the Texas Deer Association, historically the primary voice for the regulated community. No changes were made as a result of the comments.

Nine commenters opposed adoption of the rules as proposed and cited the department's response to the discovery of CWD at the department's Kerr Wildlife Management Area (WMA) as evidence of a double-standard, incompetence, wasted research opportunity, and department dishonesty, all which make the rules unnecessary. The department disagrees with the comments and responds, first, that the rules, as proposed and adopted, have exactly no relationship with or connection to events at the Kerr WMA; however, when a deer in the research herd at the Kerr WMA was suspected of being positive for CWD (on the basis of a live-animal test), the department promptly responded by depopulating the facility to mitigate the risk that the facility presented to surrounding deer populations, which is consistent with department protocol, best management recommendations for similar situations in general, and sound science. The department disagrees depopulation of the facility was a wasted research opportunity, as the scientific literature is already clear with respect to what occurs in a captive population following confirmation of CWD (additional transmission, infection, and mortality), and allowing the disease if present to incubate and spread would have been irresponsible in the absence of appropriate biosecurity and confinement measures. The department asserts that the prompt execution of protocol to mitigate the transmission of CWD within and outside the Kerr WMA deer breeding facility was clearly the correct decision. The department also notes that it has been completely transparent at all times with respect to this incident, having immediately issued press releases to inform the public, providing notification to adjoining landowners, local officials (including legislators), and media outlets. The department further notes that all records and data regarding the incident are public records available for inspection by request. No changes were made as a result of the comments.

Nine commenters opposed adoption of the rules as proposed and stated in various ways that the department is overreacting, blowing things out of proportion, or otherwise reacting with inappropriate alarm. The department disagrees with the comments and responds that the rules as adopted are necessary in light of the continuing detection of CWD in deer breeding facilities and the commission's direction to eliminate the zone system of CWD surveillance. The department also responds that it is similarly necessary to enhance the department's ability to quickly test deer at release sites that have been epidemiologically linked to a positive deer breeding facility or facilities. No changes were made as a result of the comments.

Nine commenters opposed adoption of the rules as proposed and stated that CWD isn't killing deer, the state is. The department infers that the subject of the comments is depopulation events conducted at deer breeding facilities within which CWD has been confirmed. The department disagrees with the comments and responds, first, that depopulation is not mandatory under the rules as proposed unless the affected permittee refuses to sign a department herd plan designed to mitigate disease propagation risk, and that in any case, CWD is invariably fatal; thus, because current rules prohibit the removal of live deer from positive facilities, it is highly probable that it is simply a matter of time before every deer within a positive facility succumbs to the disease anyway. Depopulation is simply a more expedient, less epidemiologically problematic avenue to disease suppression. No changes were made as a result of the comments.

Eight commenters opposed adoption of the rules as proposed and expressed doubts concerning the threat or indeed the existence of CWD, claiming the disease has been around forever, isn't fatal, has no effect on deer populations, only affects small portions of the deer population, hasn't caused "die-offs," isn't prevalent, has never killed a deer, cannot be acquired by natural means, is a government plot to control private property and food supply, a scam to obtain federal funds, or some other, similar

expression of incredulity or disbelief, and that the department's response to CWD is therefore a waste of time and money because it is not warranted. The department disagrees with the comments and responds that although it is true that much remains to be done before CWD is well understood, there is absolutely no scientific debate at all as to whether it is real, transmissible, transmissible without human agency, without question invariably fatal once acquired, and can have population level effects if allowed to spread. Further, the department notes that the absence of large-scale die-offs isn't an appropriate metric because CWD can take years to reach a high enough prevalence in free-ranging deer populations for such effects to become observable, at which point it becomes impossible to eradicate. The department's management efforts are intended to prevent this outcome from occurring. The department also responds that although the department's CWD management efforts are funded in large part by federal grants under the Pittman-Robertson Act of 1937 (which imposed a federal excise tax on firearms and ammunition sales to provide annual matching funds for wildlife management activities in each state based on the ratio of the state's land area to the total U.S. land area, and the number of paid hunting license holders in the state compared to the total number of paid hunting license holders in the U.S.), the apportionment is finite and therefore CWD research and management activities occur at the expense of other wildlife management activities. In short, there is no fiscal incentive at the state or federal level driving or motivating the department's CWD management efforts. The department further responds that allegations the rules promulgated by the Texas Parks and Wildlife Commission are or are part of a government plot to control private property and food supplies are absurd on their face. No changes were made as a result of the comments.

Eight commenters opposed adoption of the rules as proposed and stated in various ways that the rules are unsupported by science generally or peer-reviewed science in particular, or that the science upon which the department bases the rules is flawed. The department disagrees with the comments and responds that its CWD management policy and regulatory stance are driven by and reflect the best available science, which is publicly available from any number of sources, but which the department is nevertheless happy to share with interested parties upon request. In addition, department staff, CWD experts, researchers, and academics briefed the commission on the state of science on CWD during a specially scheduled open public work session on October 5, 2022, and a regularly scheduled open public work session on November 1, 2023. No changes were made as a result of the comments.

Eight commenters opposed adoption of the rules as proposed and stated displeasure with provisions that acknowledge statutory provisions regarding the removal of the permanent, visible identification of breeder deer required by statute. The commenters seemed to be under the impression that the commission possesses the discretion to prescribe alternatives to statutory law and that the legislature has forbidden the department from enforcing statutory provisions that do not allow permanent identification to be removed from breeder deer upon or following release. The department disagrees with the comments and responds that it is a settled matter of law that all indigenous wildlife (including white-tailed and mule deer) anywhere in Texas are at all times the property of the people of state. White-tailed and mule deer can be possessed in captivity only under a deer breeders permit issued by the department pursuant and subject to the provisions of Parks and Wildlife Code, Chapter 43, Subchapter L and rules of the commission adopted under authority delegated to the commission by Parks and Wildlife Code, Chapter 43, Subchapter L. Under Parks and Wildlife Code, §43.3561 all breeder deer are required by March 1 of the year following the birth year to be permanently identified by an eartag and electronic identification (EID). Parks and Wildlife Code, §43.3561(h) requires deer breeders to replace eartags that are damaged, missing, or dislodged. Parks and Wildlife Code, §43.3561(i) allows a deer breeder to remove an ear tag only for the purpose of immediate replacement with another tag that meets the requirements of the section. No other provision of Parks and Wildlife Code, Chapter 43, Subchapter L, allows or can be construed as to allow the removal of an eartag upon liberation. The department presumes that if the legislature intended to allow a tag to be removed for any reason other than to replace it, it would be so provided or otherwise expressly or implicitly allowed under the regulatory authority delegated to the commission by the legislature. Although the commission is authorized to make rules governing the possession of breeder deer held under the subchapter, the precepts of code construction and legal interpretation dictate, in the absence of explicit permission to do so, that the commission's rulemaking authority with respect to permanent identification cannot be understood as to allow the nullification or contradiction of those statutory provisions. The rules as adopted do not create a new requirement of law, but repeat the statutory requirements governing the removal of required eartags. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that "requiring tags for deer that test negative will impact the hunting industry that deer breeders rely on." The department disagrees with the comment and responds that rules as adopted do not impose a requirement that does not already exist in statute, the commission does not possess the regulatory authority to eliminate statutory requirements, and that there is no reason to believe that the presence or absence of an ear tag influences hunting behavior. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the rules reflect a "Lord and Master" perspective with no regard for "their common-sense impact" on deer breeders. The department disagrees with the comment and responds that the department has a statutory duty to protect the wildlife resources belonging to the people of the state of Texas and the rules as adopted, as has been the case with all regulations involving deer breeding for over a decade, were painstakingly developed with the intensive involvement of and input from subject matter experts including landowners, land managers, hunters, biologists, veterinarians, epidemiologists, other scientists and academics, and members of the regulated community. Further, the rules were promulgated in faithful compliance with all applicable provisions of the Administrative Procedure Act. Therefore, the department disputes the notion that the regulations constitute any kind of diktat, arbitrary imposition of authority, or other, extralegal exercise. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated, "the individuals from the Texas Deer Association (TDA) negotiating these rule changes did not accurately represent the best interests or desires of the breeders at large." The department disagrees with the comment and responds that the internal dynamics and membership relations within a trade association are none of the department's business and shouldn't be; however, the department also responds that TDA for decades

has been acknowledged as the premier trade association representing deer breeders, as it has been a ubiquitous advocacy presence at the department, TAHC, and the Texas Legislature. As such, TDA's involvement has long been solicited by the department to provide a significant voice for the regulated community with respect to agency rulemaking. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the rules as adopted are a "game of semantics" because although current CWD management zones are being eliminated, the proposed rules have the effect of creating de facto zones that would "still greatly restrict the movement of deer indefinitely for many deer breeding facilities regardless of whether there has been confirmed CWD positive deer at that facility, and would also restrict movement of deer in many free range areas as well." The department disagrees with the comment and responds that the rules as adopted replace a disease-management model based on surveillance of free-ranging deer in zones around any location where CWD has been detected (free-range or deer breeding facility). The zones were implemented individually by rule on a case-by-basis and their boundaries were based on the use of the best available science and data to determine the geographic size of the area around each positive case within which additional CWD detections were either probable or could reasonably be expected. Within those zones, the rules imposed carcass movement restrictions and testing requirements on all deer harvested and placed limited restrictions on deer breeding facilities within those zones (provided the facilities were not positive facilities or epidemiologically linked to a positive facility). The rules as adopted replace that disease management model with one predicated on the discovery of CWD only in free-range populations. The rules as adopted do away with all current CWD zone designations, completely eliminate all carcass movement and testing requirements for hunters, and do not affect any deer breeding facility that is not within five miles of a location where CWD has been discovered in a free-ranging white-tailed deer (or, 25 miles from a positive mule deer). As noted in the preamble to the proposed rules, the rules would eliminate 37 CWD management zones without affecting a single deer breeder (neither of the two deer breeders that could have been affected by the rules as adopted utilizes a business model that would trigger the components of the rules as adopted). With respect to the semantics of the word "zones," the department respectfully replies that any rules that implement movement and/or testing requirements for breeder deer must necessarily relate to a facility's proximity to the location of disease and associated epidemiological risk, because they are regulatory measures that apply to specific places, namely, deer breeding facilities (as opposed to all places that are not deer breeding facilities). Irrespective of semantics, the directive of the commission was to eliminate the CWD management zones in current rule, which the rules as adopted accomplish. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the rules exchange the elimination of CWD management zones for something worse - requiring positive facilities to make a choice between killing all the deer in the facility or entering into a department herd plan. The commenter stated that despite federal CWD program standards that allow Texas to shorten quarantine periods and no meaningful data to support a five-year timeline, the department insists on the "five-year quarantine," which the commenter states will "destroy" any deer breeding business and property values, which is indicative of "a Lord and Master" approach. The department disagrees with the comment and responds, first, that the provisions addressing depopulation activities and herd plans are not intended to and were never purported to be a measure in lieu of CWD management zones, which are a separate regulatory matter. Next, the department responds that with respect to depopulation orders, the rules as adopted do not create, remove, or alter any remedy currently in effect under statutory or administrative law for deer breeding facilities where CWD is discovered. Under Parks and Wildlife Code, §43.953, the department may order the depopulation of a facility upon a determination that the deer within the facility pose a threat to the health of other deer or other species, including humans, and department rules have always provided the alternative of entering into a herd plan (which the department notes is not the same thing as a quarantine). The department further notes that the federal USDA herd certification program mandates a minimum five-year period with no evidence of CWD before a herd can be considered for certification as low risk. Additionally, as stated by the department earlier in this preamble and in many other rule actions, there is no credible evidence to indicate or even suggest that department rules, rather than the presence of a fatal and highly transmissible wildlife disease, result in any effect, positive or negative, on real property values. Finally, the department responds that it does not regard the relationship between the department and the public or the department and the regulated community as that of "Lord and Master," as the department has a statutory duty to conserve public wildlife resources and does so in a conscientious and ethical manner. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the rules, by implementing certain infrastructure and testing requirements for deer breeding facilities in proximity to free-range positives, would create the risk of "de facto one-to-three-year quarantines" for deer breeding facilities in which CWD has not been detected, which is a "new way of imposing a Containment Zone" on breeding facilities, contrary to the claims that the concept of CWD management zones had been eliminated. The commenter stated that the rule "serves no practical purpose and appears designed solely to discourage new breeders." The department disagrees with the comment and responds that the comment is similar in substance and implication to an earlier comment regarding semantic distinctions and the department's response to the earlier comment is appropriate in this instance as well. The department also notes that the rules as adopted absolutely and intentionally provide for a pathway to full movement status for all breeding facilities that are free of CWD and that the presence of CWD itself is and should be a factor in any prospective permittee's decision-making process. Finally, the department responds that the rules as adopted do indeed have a practical purpose, which is to prevent the spread of CWD. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated the rules could result in a "one-year quarantine" if the department staff "in their sole discretion" determine that the facility's infrastructure and fencing standards have not been in place for at least one year prior to notice by the department that a positive deer has been discovered in proximity to the breeding facility. The comment further stated that the notice responsibilities are not specified, which leaves the rule "vague and open to arbitrary interpretation." The department disagrees with the comment and responds that the provisions apply to CWD-free breeding facilities within the proximity distance of a free-range positive and condition the privilege of being able to transfer breeder deer any-

where in the state on the presence of a "double fence" around the facility for at least one year prior to being notified by the department that a positive white-tailed deer has been discovered within five miles (or, in the case of a mule deer, 25 miles away). The department is confident that it will be able to determine whether or not a fence meeting the regulatory requirements has been in place at a breeding facility for the requisite length of time, primarily because all permittees have, since 2003, have been required by rule (31 TAC §65.603) to notify the department of any physical alterations to a facility's infrastructure prior to making the alterations and to provide the department with a diagram illustrating the changes. The department is similarly confident in the process by which deer breeders would be notified, in the event that CWD is detected in a free-range deer within a proximity distance, as it will be the same process the department has used since 2013 to immediately notify deer breeders of any and all changes in movement status. That process, to the department's knowledge, has not been the source of complaints from the regulated community. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the rules do not identify or describe how the location of a free-range positive will be determined by the department, which will allow the department to assert the locations of positive deer without oversight criteria or uniform standards for "searches." The commenter went on to question if the "the department will begin actively searching for CWD-positives cases in natural free-range habitats as often as they search in roadkill," and asked, "will they search anywhere, or only near facilities they wish to shut down." The commenters stated that "this unchecked discretion far lacks accountability and fairness" and stated that the department was acting as "Lord and Master." The department first disagrees strenuously with any allegation that it somehow selects or is looking for a reason to "shut down" any deer breeding facility. All department actions affecting movement status for deer breeding facilities are completely predicated on documented epidemiological or law enforcement investigations, or other mechanisms as provided by law, and any assertions otherwise are not credible. The department further responds that the rules as adopted do not provide for "searches" for CWD (whatever is meant by that term) in response to the discovery of CWD in a free-range deer or susceptible species. The rules as adopted instead implement movement restrictions in some cases at deer breeding facilities upon discovery of CWD within the proximity distances. The department further responds that the department does not actively "search" for CWD per se; it until now has relied on two passive mechanisms for assessing the prevalence and distribution of CWD, if it is present, on the landscape (i.e., outside of deer breeding facilities): the CWD zone system (which implemented mandatory testing of all hunter harvested deer in areas surrounding CWD discoveries, which is eliminated by this rulemaking) and a continuous statewide monitoring effort, consisting of voluntary submission of hunter harvested deer and other mortalities, supported by opportunistic acquisition, such as roadkill. In other words, there is no directed, purposeful, intensive detection effort around deer breeding facilities as opposed to free-range populations. No changes were made as a result of the comments.

Seven commenters opposed adoption and stated that the components of the rules regarding fencing and inspections have the potential to cause significant problems for breeders because they contain no guidelines for compliance and enforcement, which the commenter stated would provide the department "with another tool to target breeders unfairly." The commenters went on to provide a list of various fence-related construction materials and methods that are not specifically addressed by rule, such as standards for posts, materials, and fasteners, which the commenters posited could be used to "shut down" breeding facilities. The department disagrees with the comments and responds that the provisions of 31 TAC §65.605(a) govern the fencing requirements at deer breeding facilities. That section mandates that "the entire perimeter fence of a facility containing breeder deer, including medical facilities, shall be no less than seven feet in height, and shall be constructed of department-approved net mesh, chain link or welded wire that will retain breeder deer." Those provisions are straightforward, easy to understand, easy to comply with, easy to enforce, and have been in effect since 1995 without complaints from the regulated community. The department further responds that it is unnecessary to prescribe additional, detailed standards for fencing materials and construction methods, as the department presumes the regulated community, motivated by the desire to protect investment, will do whatever is desirable beyond the requirements of the rule in order to reduce or eliminate the likelihood of the loss of valuable breeder deer and to ameliorate maintenance and upkeep costs. Finally, the department responds, again, that it is motivated solely and exclusively by its statutory duty to conserve public wildlife resources, not by any desire to persecute or attack deer breeders, and that it is demonstrably true that no deer breeder has been unfairly treated by the department. No changes were made as a result of the comments.

Seven commenters opposed adoption of the rules as proposed and stated that the provisions regarding fence inspections and fence inspectors were problematic in that they could be used by the department to "target" deer breeders. The commenters expressed concern that the rules did not address the question of licensure for fence inspectors, the licensing entity, training and reporting requirements, timeframes for completion of inspections, fees for fence inspections, and the lack of guidance for ensuring "ADA compliance for fence inspectors." The department disagrees with the comments and responds, first, that the commenters appear to be confusing provisions that apply to deer breeding facilities with provisions that apply to release sites. In the case of the former, the department's rules have for 30 years required an inspection of all prospective deer breeding facilities by and a letter of endorsement from a qualified third-party facility inspector, the criteria for which have also been stipulated by rule (31 TAC §65.603, concerning Application and Permit Issuance). In the case of the latter, the rules as adopted simply alter the existing provisions for facility inspectors to include fence inspections. Because the criteria for authorized facility/fence inspectors are set forth by rule, there is no need to create an additional license for that purpose or prescribe training and continuing education requirements, which would, in the department's view, create unnecessary administrative complexity. Similarly, the department believes that it is unnecessary to stipulate either a timeframe for the completion of fence inspections or a fee for the service. The department will not authorize the transfer of breeder deer to a release site unless and until the inspection has been performed, and the department believes that a fee for fence inspections is best left as a matter between landowner and inspector. The department reasons that it is the prerogative of the landowner to determine such matters, depending on the degree of urgency that exists for the release of deer. Finally, compliance with ADA (the Americans with Disabilities Act of 1990, a federal law that protects people with disabilities from discrimination) with

respect to facility/fence inspectors is not within the purview of the department, as facility/fence inspectors are not department employees or representatives and their engagement is a matter between private citizens. No changes were made as a result of the comments.

Six commenters opposed adoption of the rules as proposed and stated that the rules are unconstitutional, a violation of constitutional rights, or an infringement of private property rights. The department disagrees with the comments and responds that the rules are not violative of any provision of the state or federal constitutions and do not affect private property rights in any way. No changes were made as a result of the comments.

Four commenters opposed adoption of the rules as proposed and stated that CWD can be bred out of deer in the same fashion that scrapie was bred out of sheep. The department disagrees that scrapie has been bred out of sheep, mainly on the basis that scrapie cases continue to occur and be reported, but more importantly, sheep are livestock, not wildlife. Humans have a long history of utilizing linebreeding to improve disease resistance in livestock, but it is nearly impossible with free-ranging populations because the animals are not domesticated or confined. In any case, the comment is not germane to the rules as proposed or adopted. No changes were made as a result of the comments.

Three commenters opposed adoption of the rules as proposed and stated that CWD doesn't or cannot harm and poses no risk to humans. The department disagrees and responds that the rules as adopted are intended to address the management of CWD in deer populations. There is currently no scientific evidence to indicate that CWD is transmissible to humans; however, both the CDC and the World Health Organization strongly recommend avoiding consumption of meat from CWD-infected deer. In any case the comment is not germane to the rules as proposed or adopted. No changes were made as a result of the comments.

Three commenters opposed adoption of the rules as proposed and stated or suggested that the department and the commission are engaging in a political agenda/conspiracy with or acting in the interests of wealthy landowners to eliminate deer breeders because they do not want market competition for hunting opportunity. The department disagrees with the comments and responds it is difficult to conceive, given the extremely small percentage of breeder deer in the overall deer population or the total harvest, and the fact that not all landowners depend on or in some cases even use hunting as an income source, that there would be sufficient economic incentive for anyone, wealthy or not, to eliminate deer breeding. No changes were made as a result of the comments.

Three commenters opposed adoption of the rules as proposed and stated that deer breeders are the best option for eliminating CWD because they are breeding CWD out of deer. The department disagrees with the comments and responds that at the present time there is no indication that there are any deer genetically immune to CWD and in any case it is highly unlikely and probably impossible for genetic resistance or immunity to CWD to be introduced to wild populations, given the size of the state and the broad distribution of deer across the landscape; further the United States Department of Agriculture (Wildlife Services and Veterinary Services) does not support the release of breeder deer into free-ranging populations for the purpose of manipulating CWD genetic susceptibility; however, the department does believe there is some merit to investigating the idea of breeding for reduced CWD genetic susceptibility with respect to captive populations, since the majority of CWD detections occurred in breeding facilities and movement of breeder deer is a primary risk for spreading CWD in Texas; consequently, the department has funded research projects to investigate genetic approaches to combating CWD. No changes were made as a result of the comments.

Three commenters opposed adoption of the rules as proposed and stated disapproval of depopulation orders, and 18 commenters stated that depopulation events killing thousands of deer achieve nothing. The department disagrees with the comment and responds that CWD is an infectious disease that kills 100 percent of the deer that contract it. It cannot be treated and it cannot be eradicated or destroyed. As such, it is without argument a serious threat to free-range populations and an existential threat to captive populations. Other species of farmed animals and livestock are faced with similar threats, such as avian influenza, tuberculosis, and brucellosis, and those producers are required to comply with movement restrictions, quarantines, testing requirements, disposal requirements, permanent identification requirements, and other disease mitigation measures. Such measures protect animal health and productivity and the marketability of products. When such diseases are detected in herds and flocks, those herds and flocks are often killed to prevent disease outbreaks that could have severe impacts on economic activity or human health and safety. The department believes that depopulation of facilities where CWD is detected is one of the most effective means of disease mitigation, but notes that depopulation is not mandatory and disagrees that the depopulation of CWD positive facilities "achieves nothing" as it is especially critical for CWD management in contexts where such measures can result in effective containment, compared with response options to detections in free-ranging populations. No changes were made as a result of the comments.

Three commenters opposed adoption of the rules as proposed and stated that the department should "let the market decide." The department is unable to determine the meaning of the comment, as the rules as adopted impose disease testing requirements only for deer breeders and only when CWD is confirmed within five miles of a free-range positive (white-tailed deer and exotic susceptible species) or within 25 miles of a free-range positive (mule deer) and enhance surveillance at trace-out release sites and will not affect the supply of nor demand for captive deer. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that the rules make deer breeders responsible for events and situations that are beyond their control, namely, the discovery of CWD within five miles of a breeding facility. The department disagrees with the comments and responds that the rules do not assume, assign, or intimate responsibility of any kind to any person, but prescribe enhanced disease-control protocols at deer breeding facilities proximally situated to locations where CWD is confirmed in free-range populations. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that the rules are "a waste of time" and the department should "let nature take its course." The department disagrees with the comments and responds that given the existential threat that CWD poses to native deer, hunting, and the economies that depend upon deer hunting, the rules are certainly not a waste of time. In addition, a deer breeding permit authorizes the artificial concentration of deer and subjects deer to translocation at distances far in excess

of their natural range. No changes were made as a result of the comments.

Two commenters opposed adoption of the rules as proposed and stated that the current rules should be kept because they are working. The department agrees that the current rules are epidemiologically defensible, but the direction of the commission was to replace the current rules and develop a disease-management strategy that eliminates zones and their perceived stigma. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the rules punish the many for the acts of a few. The department disagrees with the comments and responds that the rules are not in any way punitive or intended to function as a penal or retaliatory response to a criminal or civil offense; rather, they constitute a logical, prudent, and reasonable response to the detection of a disease that is a proven threat to native deer populations. No changes were made as a result of the comments.

Two commenters opposed adoption of the rules as proposed and stated that transfer/transport of breeder deer should be prohibited. The department disagrees with the comment and responds that although the department is charged with protecting and conserving wildlife, deer breeders have a statutory permit privilege to transfer deer in a healthy condition for purposes of release. No changes were made as a result of the comments.

One commenter opposed adoption of the rules on the basis that the severity of the threat of CWD justifies the prohibition of deer breeding altogether. The department responds that under Parks and Wildlife Code, Chapter 43, Subchapter L, the department must issue a deer breeding permit to a qualified person; thus, the commission cannot prohibit deer breeding. No changes were made as a result of the comments.

One commenter opposed adoption of the rules as proposed and stated that the rules constituted "a scheme to infiltrate businesses for tax purposes." The department disagrees with the comment and responds that the department does not possess the statutory authority to levy taxes in the first place. No changes were made as a result of the comment

One commenter opposed adoption of the rules as proposed and stated that CWD is scrapie, which doesn't harm deer, and therefore no response is warranted. The department disagrees with the comments and responds that CWD is a cervid disease that without question is related to scrapie, a similar disease found in sheep; however, it is not the same disease. In any case, this distinction is irrelevant in the context of disease surveillance, response, and management actions, as scrapie is itself a reportable disease under state and federal law and flocks infected with scrapie are often required to be destroyed. Further, the department has worked with prion researchers and made extensive efforts to identify prion strains within Texas; with over 1,000 samples analyzed, two strains have been identified as CWD and none have been identified as scrapie. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the rule's five-mile delimiter for the imposition of certain infrastructure and disease-testing standards at deer breeding facilities is unfair. The department disagrees with the comment and responds that the five-mile proximity distance represents the average natural dispersal range of free-range buck white-tailed deer, which, epidemiologically, is a credible demarcation of the extent, in relation to the location of any given positive animal, at which CWD could reasonably be expected to be detected if it existed and was spreading in a population. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the rules were "bad for conservation." The department disagrees with the comment and responds that the rules as adopted are not without conservation merit, as they will function by imposing enhanced disease-prevention measures at deer breeding facilities in proximity to locations where CWD has been discovered in free-range populations. The rules as adopted are intended to limit the further spread of CWD via anthropogenic movement so as to conserve and protect CWD-susceptible populations. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the testing requirements of the rules place burdens on veterinarians. The department disagrees with the comment and responds that the rules do not require any veterinarian to provide services to any person. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that they constitute "a waste of taxpayer money." The department disagrees with the comment and responds that the expense of combating CWD, although not insignificant, pales in comparison to the economic damage that could be inflicted were it to become widespread on the landscape, and that in any case, the department has a statutory duty to protect the wildlife resources of the state and does so with fiscal and budgetary resources appropriated to it by the legislature. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that a double-fenced deer breeding facility that has not accepted deer for years and is in compliance with all applicable testing requirements should not be required to conduct whole-herd ante-mortem testing just because CWD has been discovered in a free-range deer within five miles of the facility. The department disagrees with the comment and responds that it is prudent to impose enhanced disease testing requirements near locations where CWD has been confirmed, particularly with respect to deer breeding facilities, where deer are artificially concentrated and subject to translocation at distances far in excess of the natural range of deer, which presents a clear potential for spread. The department further responds that the rules are intended to provide deer breeders with an alternative to an absolute ban on deer transfers in areas where CWD is known to exist in free-range populations. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that because public comment was overwhelmingly in opposition to adoption, the rules should therefore not be adopted. The commenter also stated that department staff were urging members of the public to comment in support of adoption in an attempt to make the disparity less apparent. The department disagrees with the comment and responds that the right thing to do is not always the popular thing to do, that it is not at all uncommon for staff to explain to the public the rationale behind and the goals of rulemaking, and to remind interested parties of existing public comment opportunity and the importance of participation. The department also notes that a significant portion of public comment opposed to adoption is notable for verbatim repetition of statements that are either untrue, not germane, or that reflect unfamiliarity with the issues. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the methods and conduct of department depopulation efforts at a specific location where CWD has been detected were evidence of a double standard because of purported shoddy methodology and alleged lapses in biosecurity measures, including improper transport and disposal of deer carcasses, proving the department doesn't actually believe that CWD is a problem and is simply using it as a pretext to persecute the owner of the facility where the depopulation event took place. The department disagrees with the comment and responds that although there is absolutely no merit whatsoever to the accusations as they are demonstrably false, the comment in any event is not germane to the rules as proposed, as they did not and do not contemplate, set forth, or establish measures, standards, or protocols to be employed at depopulation events. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and presented historical examples of state agencies that for one reason or another were believed to have incurred the displeasure of the legislature with unpleasant budgetary results and suggested that the commission should delay action for 90 days. The department disagrees with the comment and responds that it has a statutory duty to conserve, manage, and protect the wildlife resources of Texas and enjoys a transparent and productive relationship with the legislature. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that testing should be a landowner discretion. The department disagrees with the comment and responds that it infers the comment to be in regard to landowner obligations imposed by the rules at locations that are release sites for breeder deer and subsequently become epidemiologically linked to a positive deer breeding facility. If so, the department responds that current rules already condition further approval of releases on compliance with testing requirements and the rules as adopted are, regrettably, a direct result of many examples of release site owners failing to comply with testing requirements or cooperate with the department. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that there is no reason to kill deer on the basis of a rectal tissue sample because rectal tissue is not the same as brain tissue. The department disagrees with the comment and responds that the rectal tissue test in question (as well as the obex tissue used for post-mortem testing) is approved by the United States Department of Agriculture for the diagnosis of CWD in deer. No changes were made as a result of the comment.

One commenter opposed adoption and stated that CWD tests are unreliable. The department agrees in part that ante-mortem CWD tests are not generally accepted as a test to determine that an individual is definitively uninfected with CWD, but are useful when used for herd surveillance; however, post-mortem testing or serial ante-mortem testing can increase confidence that an animal is not infected. Ante-mortem and post-mortem testing are highly specific for CWD and false positive results are exceedingly rare. Regardless, the United States Department of Agriculture has approved both ante-mortem and post-mortem testing for the diagnosis of CWD. No changes were made as a result of the comment.

One commenter opposed adoption and stated that breeder deer are farm animals no different than cattle on a ranch or feed lot and should be left alone. The department disagrees with the comment and responds that deer are in fact wildlife, not livestock, and the department as a consequence has a statutory duty to manage and conserve both captive and free-ranging populations of native deer. The department further notes that farmed animals and livestock are faced with disease threats, such as avian influenza, tuberculosis, and brucellosis, and those producers are required to comply with movement restrictions, quarantines, testing requirements, disposal requirements, permanent identification requirements, and other disease mitigation measures. Such measures protect animal health and productivity and the marketability of products. When such diseases are detected in herds and flocks, those herds and flocks are often killed to prevent disease outbreaks that could have severe impacts on economic activity or human health and safety. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that deer breeders "monitor better and more successfully than TPWD." The department disagrees with the comment and responds that comparisons of testing efforts in captive herds and free-ranging populations are not useful. Deer breeders must monitor for CWD because it is required under department rules for holding a deer breeding permit; the department, meanwhile, has a statutory duty to protect wildlife resources in the state and therefore monitors CWD at both local and landscape scale to ascertain the prevalence and distribution of CWD in those environments. The department believes it is pointless to argue about who tests "better" or "more successfully," because such comparisons are not objectively meaningful. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that "countless" private biologists "have proven TPW doesn't have information to make the decision." The department is unsure as to what, exactly, the comment refers to, but disagrees that the department lacks, lacks access to, or does not use the best available science in assisting department efforts to combat CWD; is not aware of any authoritative, credible scientific evidence or peer or jury-reviewed technical literature produced by any biologist, anywhere, that validates or confirms the assertion made by the commenter. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that CWD is not naturally transmissible to deer and exists in deer populations only because of direct inoculation of research subjects. The department disagrees with the comment and responds that there is ample irrefutable evidence of natural transmission in deer and to suggest otherwise is irresponsible and incorrect. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that deer breeders and release site owners "protect the deer better than TPW." The department disagrees with the comment and responds that the recent increase in detections of CWD in captive breeding facilities refutes the notion that self-regulation of deer breeding is effective at slowing the spread of CWD. The department notes that deer breeders and release site owners are integral stakeholders in the management of CWD and the department has and will continue to rely on their input through the various committees and task forces created to address CWD. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the zone management and testing rules are based on fictional informa-

tion. The department disagrees with the comment and responds that all CWD management rules promulgated by the department have been sound in scientific design and principle and are a response to the irrefutable spread of CWD. The department also responds that the rules as proposed and adopted repeal the provisions in question. No changes were made as a result of the comment.

One commenter opposed adoption and stated that more research is needed on free-range deer. The department agrees with the comment but disagrees that the need for more research negates the need for the rules. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that breeders should be "left alone to test deer prior to release." The department agrees with the comment and responds that the rules as adopted do not require a representative of the department to be present or involved in any way with testing activities conducted in compliance with the rules. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rules constitute an unacceptable relaxation of current levels of protection. The department agrees that the rules as adopted are, in a purely epidemiological sense, a relaxation in comparison with the rules they replace; however, the department disagrees that the rules are unacceptably so and responds that the direction of the commission was to develop a disease-management strategy to replace the current rules that implement a zone system. In the absence of a zone system, the department implements an approach that requires disease management protocols at deer breeding facilities based on the proximity of a breeding facility to a location where CWD has been detected, which is intended to prevent the disease, if it is present, from entering nearby breeding facilities and being transferred elsewhere. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the current administration of "herd plans" is unworkable because current "herd plans" are "generic," do not treat small acreages differently than large acreages, and are not "tailored" to properties in question. The department disagrees with the comment and responds that herd plans are absolutely tailored to individual properties and thus are not generic. The department further responds that from an epidemiological perspective, the size of a property is irrelevant, since herd plans are based on statistical models that dictate the particular goals for achieving confidence that CWD is not present within a certain population size at a specific prevalence. No changes were made as a result of the comment.

One commenter opposed adoption and stated that breeder deer should be considered liberated "upon transfer." The department is unsure exactly what the point of the comment might be, but disagrees that the distinction between liberation and captivity has or should have any bearing upon disease-management strategies, primarily because such distinctions are irrelevant with respect to disease status. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the rules are difficult to enforce and have resulted in unjust actions. The department disagrees with the comment and responds that the department is confident the rules as adopted can be enforced by department law enforcement personnel and that the accusation that the rules have resulted in unjust actions is impossible, as the rules as adopted have yet to take effect. No changes were made as a result of the comment.

One commenter opposed adoption of the rules as proposed and stated that the rules lack inclusion of basic due process and do not provide an opportunity to contest "unchecked decisions" by department staff. The commenter specifically identified proposed §65.99(i) and stated that the provision's requirement for a deer breeder where CWD has been confirmed to either sign a TPWD/TAHC herd plan or depopulate the facility does not include an opportunity for the permittee to contest the outcome. The commenter further states opposition to conditions imposed under department herd plans, contending that signing a herd plan is tantamount to surrendering control of the facility to agency staff. The commenter stated that the rules should grant permittees the right to an administrative hearing before the State Office of Administrative Hearings (SOAH) and allow the commission to decide the final outcome of contested cases "as is done every day in every agency in Texas." The department disagrees with the comment and responds that department rules are promulgated in compliance with all applicable provisions of the Texas Administrative Procedure Act and no employee or officer of the department enjoys or exercises "unchecked" or extralegal decision-making authority. The department further responds that native deer species are the property of the people of the state, even when in possession of a permittee under the privileges granted under a deer breeding permit. Repeated litigation on the issue has affirmed the department's rules governing deer breeding are not violative of any due process rights. The department further notes that under Parks and Wildlife Code, Chapter 43, Subchapter L, the department may depopulate a deer breeding facility upon finding that the facility is a threat to other deer, and that when CWD is confirmed in a breeding facility, that facility is immediately prohibited by existing rule from receiving or transferring deer unless explicitly authorized to do so in a herd plan. A permittee's refusal to sign a herd plan is completely voluntary. No changes were made as a result of the comment.

The department received 248 comments supporting adoption of the rules as proposed.

No groups or associations commented in opposition to adoption of the rules as proposed.

State Senator Bob Hall, State Representative Richard Curry, State Representative Wes Virdell, State Representative Richard Raymond, State Representative Carrie Isaac, State Representative Stan Gerdes and Commissioner of Agriculture Sid Miller commented in opposition to adoption of the rules as proposed.

State Representative Drew Darby commented in support of adoption of the rules as proposed.

The Texas Deer Association, The Texas Wildlife Association, the Texas and Southwest Cattle Raisers Association, the Texas Chapter of The Wildlife Society, the Texas Nature Conservancy, the Texas Foundation for Conservation, the Texas Conservation Alliance, and the Boone and Crockett Club commented in support of adoption of the rules.

SUBCHAPTER B. DISEASE DETECTION AND RESPONSE

DIVISION 1. CHRONIC WASTING DISEASE (CWD)

31 TAC §§65.80, 65.81, 65.88

The amendments and new section are adopted under the authority of Parks and Wildlife Code, Chapter 43, Subchapter E, which authorizes the commission to make regulations governing the trapping, transporting, and transplanting of game animals, Parks and Wildlife Code, Chapter 43, Subchapter L, which authorizes the commission to make regulations governing the possession, transfer, purchase, and sale of breeder deer held under the authority of the subchapter; Subchapter R, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that white-tailed deer may be temporarily detained in an enclosure; Subchapter R-1, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that mule deer may be temporarily detained in an enclosure (although the department has not yet established a DMP program for mule deer authorized by Subchapter R-1); and §61.021, which provides that no person may possess a game animal at any time or in any place except as permitted under a proclamation of the commission.

§65.88. Deer Carcass Movement Restrictions.

(a) In addition to the provisions of §65.10 of this title (Possession of Wildlife Resources) and except as may be otherwise prohibited by this subchapter, a department herd plan, or a quarantine or hold order issued by TAHC, a white-tailed deer or mule deer or part of a white-tailed or mule deer killed in this state or a susceptible species or part of a susceptible species harvested outside of Texas may be transported from the location where the animal was killed as provided in this section. The parts of the animal not retained for cooking, storage or taxidermy purposes shall be disposed of as quickly as practicable by one of the following methods:

(1) by transport, directly or indirectly, to a landfill permitted by the Texas Commission of Environmental Quality to receive such wastes;

(2) interment, to be accomplished by the placement of the carcass parts at a depth of no less than three feet below the natural surface of the ground, followed immediately by the placement of earthen material in such a fashion as to completely cover the carcass parts with at least three vertical feet of earthen material; or

(3) return to the property where the animal was harvested for disposal.

(b) The rendering of carcass parts is not a lawful method of disposal.

(c) The carcass of a white-tailed or mule deer may be deboned at any location prior to transportation to a final destination, provided:

(1) the meat from each deboned carcass is placed in a separate package, bag, or container;

(2) proof-of-sex and any required tag is retained and accompanies each package, bag, or container of meat; and

(3) the remainder of the carcass is disposed of in accordance with the provisions of subsection (a) of this section. Carcasses and carcass parts not disposed of immediately shall be protected from being scattered, consumed, or removed until disposal occurs.

(4) For purposes of this subsection, "deboning" means the detachment and removal of all musculature described by Parks and Wildlife Code, §42.001(8), from the bone. Muscles must remain intact (except for physical damage occurring as a result of take) and may not be processed further (i.e, ground, chopped, sliced, etc.).

(5) Proof-of-sex and any required tag must accompany the meat from the time of harvest until the meat reaches a final destination.

(6) It is an offense for any person to possess:

(A) meat from a carcass possessed under this subsection that has been processed further than whole muscles;

(B) meat from more than one carcass in a single package, bag, or container.

(d) It is an offense for any person to dispose of those parts of an animal that the possessor does not retain for cooking, storage, or taxidermy purposes except as follows:

(1) by transport, directly or indirectly, to a landfill permitted by the Texas Commission of Environmental Quality to receive such wastes; or

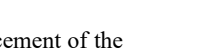
(2) interment, to be accomplished by the placement of the carcass parts at a depth of no less than three feet below the natural surface of the ground, followed immediately by the placement of earthen material in such a fashion as to completely cover the carcass parts with at least three vertical feet of earthen material; or

(3) return to the property where the animal was harvested.

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

Filed with the Office of the Secretary of State on March 24, 2025.

TRD-202500993
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: April 13, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 389-4775



31 TAC §§65.81 - 65.85

The repeals are adopted under the authority of Parks and Wildlife Code, Parks and Wildlife Code, §42.0177, which authorizes the commission to modify or eliminate the tagging, carcass, final destination, or final processing requirements or provisions of §§42.001, 42.018, 42.0185, 42.019, or 42.020, or other similar requirements or provisions in Chapter 42; Chapter 43, Subchapter L, which authorizes the commission to make regulations governing the possession, transfer, purchase, and sale of breeder deer held under the authority of the subchapter; Subchapter R, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that white-tailed deer may be temporarily detained in an enclosure; Subchapter R-1, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that mule deer may be temporarily detained in an enclosure (although the department has not yet established a DMP program for mule deer authorized by Subchapter R-1); and §61.021, which provides that no person may possess a game animal at any time or in any place except as permitted under a proclamation of the commission.

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

Filed with the Office of the Secretary of State on March 24, 2025.

TRD-202500994
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: April 13, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 389-4775

♦ ♦ ♦

DIVISION 2. CHRONIC WASTING DISEASE - COMPREHENSIVE RULES

31 TAC §§65.90, 65.92, 65.94, 65.95, 65.99

The amendments are adopted under the authority of Parks and Wildlife Code, Chapter 43, Subchapter L, which authorizes the commission to make regulations governing the possession, transfer, purchase, and sale of breeder deer held under the authority of the subchapter; Subchapter R, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that white-tailed deer may be temporarily detained in an enclosure; Subchapter R-1, which authorizes the commission to establish the conditions of a deer management permit, including the number, type, and length of time that mule deer may be temporarily detained in an enclosure (although the department has not yet established a DMP program for mule deer authorized by Subchapter R-1); and §61.021, which provides that no person may possess a game animal at any time or in any place except as permitted under a proclamation of the commission.

§65.99. Breeding Facilities Epidemiologically Connected to Deer Infected with CWD; Positive Deer Breeding Facilities.

(a) Effectiveness. To the extent that any provision of this section conflicts with any provision of this division, the provisions of this section prevail.

(b) No deer from a facility subject to the provisions of this section may be transferred or liberated except as provided in this section or expressly authorized in a herd plan and then only in accordance with the provisions of this division and the herd plan.

(c) Deer transferred under the provisions of this section must be tagged in one ear with a button-type RFID tag approved by the department.

(d) Category A trace-out breeding facility.

(1) A Category A facility is a trace-out breeding facility:

(A) in which all trace deer are alive in the facility; or

(B) for which post-mortem test results of "not detected" have been returned for trace deer that have died and all other trace deer are alive and present in the facility.

(2) Immediately upon notification by the department of Category A status, a facility is automatically NMQ. Except as provided in paragraph (3) of this subsection, a permittee shall, upon notification by the department of Category A status:

(A) within seven days euthanize all trace deer in the breeding facility and submit test samples for each of those deer for post-mortem testing within one business day;

(B) inspect the facility daily for mortalities;

(C) immediately report all test-eligible mortalities that occur within the facility; and

(D) immediately collect test samples from all test-eligible mortalities that occur within the facility and submit the samples for post-mortem testing within one business day of collection.

(3) In lieu of the testing requirements prescribed in paragraph (2)(A) of this subsection, a permittee may request the development of a custom testing plan as provided in subsection (h) of this section; provided however, the permittee must comply with the requirements of paragraph (2)(B) - (D) of this subsection.

(4) The department in consultation with TAHC may decline to authorize a custom testing plan under subsection (h) of this section if an epidemiological assessment determines that a custom testing plan is inappropriate.

(5) The department will not restore MQ status unless CWD "not detected" test results are obtained for all required sample submissions and the permittee has complied with all applicable requirements of this subsection and this division.

(e) Category B trace-out breeding facility.

(1) A Category B facility is a trace-out breeding facility in which less than 100% of the trace deer that department records indicate were received by the facility are for whatever reason (including but not limited to transfer, release, or escape) available for testing.

(2) Immediately upon notification by the department of Category B status; a facility is automatically NMQ and the permittee shall:

(A) within seven days euthanize all trace deer in the breeding facility and submit test samples for each of those deer for post-mortem testing within one business day;

(B) inspect the facility daily for mortalities;

(C) immediately report all test-eligible mortalities that occur within the facility;

(D) immediately collect test samples from all test-eligible mortalities that occur within the facility and submit the samples for post-mortem testing within one business day of collection; and

(E) conduct ante-mortem testing of all test-eligible deer in the facility as specified in the following:

(i) for a facility for which the date of last known exposure is within the immediately preceding 18 months:

(I) submit rectal or tonsil biopsy samples; and

(II) submit tonsil biopsy samples collected no earlier than 24 months from the date of last known exposure;

(ii) for a facility for which the date of last known exposure is not within the immediately preceding 18 months and not at a time prior to the immediately preceding 36 months: collect and submit tonsil biopsy samples no earlier than 24 months from the date of last known exposure; and

(iii) for a facility for which the date of last known exposure occurred at a time after the immediately preceding 36 months: collect and submit rectal or tonsil biopsy samples collected no earlier than 36 months from the date of last known exposure.

(F) The tissues samples required by subparagraph (E) of this paragraph shall be submitted within 60 days of notification by the department of Category B status.

(3) In lieu of the testing requirements prescribed by paragraph (2)(A) and (2)(E) of this subsection, a permittee may request the development of a custom testing plan as provided in subsection (h) of

this section; provided, however, the permittee must comply with paragraph (2)(B) - (D) of this subsection.

(4) Samples required by paragraph (2)(E) of this subsection shall be submitted no later than 45 days after the applicable last known exposure period, or other date as determined by the department.

(5) The department in consultation with TAHC may decline to authorize a custom testing plan under subsection (h) of this section if an epidemiological assessment determines that a custom testing plan is inappropriate.

(6) The department will not restore MQ status unless CWD "not detected" test results are obtained for all required sample submissions and the permittee has complied with all applicable requirements of this subsection and this division.

(f) The department shall, provided the provisions of this subchapter do not otherwise prevent restoration of MQ status, restore MQ status to a breeding facility that has been designated NMQ under the provisions of subsection (e) of this section as provided in this paragraph.

(1) MQ status may be restored for a facility in which all trace deer available for testing are tested in accordance with subsection (e) of this section and trace deer unavailable for testing were received by the trace facility less than 36 months prior to the date of detection in the positive breeding facility, provided:

(A) the facility was fenced as specified in §65.605 of this title (relating to Facility Standards and Care of Deer) prior to notification of Category B status;

(B) a minimum of 25 percent of the total number of test-eligible deer in the facility have been tested (ante-mortem or post-mortem) with test results of "not detected" during each of the two reporting years immediately preceding notification of Category B status;

(C) all unavailable trace-out deer were in the facility for at least 20 months prior to being the subject of an ante-mortem test with results of "not detected"; and

(D) beginning two reporting years prior to the designation as a trace facility, the facility has been in continuous compliance with all requirements of:

(i) Parks and Wildlife Code, Chapter 43, Subchapter L;

(ii) this subchapter; and

(iii) Subchapter T of this chapter.

(E) Compliance with the requirements of this subsection does not relieve any person of any obligation or requirement of a herd plan.

(2) MQ status may be restored for a facility in which:

(A) all trace deer available for testing are tested in accordance with subsection (e) of this section; and

(B) trace deer unavailable for testing:

(i) were received by the trace facility not less than 36 months prior to the date of detection in the positive breeding facility; and

(ii) have been the subject of an ante-mortem "not detected" test result within 60 months prior to the date of detection in the positive breeding facility and through the time period the trace deer is no longer available for testing;

(C) the facility has been fenced as specified in §65.605 of this title prior to the notification of Category B status; and

(D) beginning two reporting years prior to the designation as a trace facility, the facility was in continuous compliance with all requirements of:

(i) Parks and Wildlife Code, Chapter 43, Subchapter L;

(ii) this subchapter; and

(iii) Subchapter T of this chapter.

(E) Compliance with the requirements of this subsection does not relieve any person of any obligation or requirement of a herd plan.

(g) Trace-in breeding facility. Immediately upon notification by the department of trace-in facility status, a facility is automatically NMQ.

(1) A permittee shall, upon notification by the department of trace-in facility status:

(A) inspect the facility daily for mortalities;

(B) immediately report all test-eligible mortalities that occur within the facility; and

(C) immediately collect test samples from all test-eligible mortalities that occur within the facility and submit the samples for post-mortem testing within one business day of collection.

(2) The department may restore MQ status to a trace-in facility if all trace deer have been post-mortem tested with results of "not detected."

(3) For a trace-in facility for which the provisions of paragraph (2) of this subsection cannot be satisfied, the department may restore MQ status upon:

(A) submission of tonsil biopsy ante-mortem test results of "not detected" for all test-eligible deer within the facility, provided the date of the last transfer to a positive facility occurred within the 36 months preceding notification of trace-in facility status by the department; or

(B) submission of tonsil or rectal biopsy test results of "not detected" for all test-eligible deer within the facility, provided the date of the last transfer to a positive facility occurred at a time greater than 36 months from notification of trace-in facility status.

(C) The test samples required to satisfy the requirements of this paragraph must be submitted within 45 days of notification by the department of trace-in facility status. (4) In lieu of the testing requirements prescribed in this subsection, a permittee may request the development of a custom testing plan as provided in subsection (g) of this section; provided however, the permittee must comply with the requirements of paragraph (1) of this subsection.

(4) The department in consultation with TAHC may decline to authorize a custom testing plan under subsection (g) of this section if an epidemiological assessment determines that a custom testing plan is inappropriate.

(5) The department will not restore MQ status unless CWD "not detected" test results are obtained for all required sample submissions and the permittee has complied with all applicable requirements of this subsection and this division.

(h) Custom Testing Plan. Within seven days of being notified by the department that a breeding facility has been designated a Cat-

egory A, Category B, or trace-in facility, a permittee may, in lieu of meeting the applicable testing requirements of subsections (d) - (g) of this section, request the development of a custom testing plan by the department in consultation with TAHC based upon an epidemiological assessment conducted by the department and TAHC. A custom testing plan under this subsection is not valid unless it has been approved by the department and TAHC.

(1) The department shall temporarily suspend the applicable testing provisions of subsections (d)(2)(A), (e)(2)(A) and (E), and (f) of this section while the epidemiological assessment and custom testing plan development under this subsection take place.

(2) Upon the development of a custom testing plan under the provisions of this subsection, the department shall provide the permittee with a copy of the custom testing plan and the permittee shall, within seven days:

(A) agree in writing to comply with the provisions of the custom testing plan; or

(B) notify the department in writing that the permittee declines to participate in the custom testing plan.

(C) If a permittee chooses to decline participation in a custom testing plan under this subsection, the provisions of subsections (d)(2)(A), (e)(2)(A) and (E), and (f) of this section take effect as of the date of the notification required by subparagraph (B) of this paragraph and all time-dependent calculations of those subsections begin.

(D) If a permittee agrees in writing to comply with the provisions of a custom testing plan under this subsection, the custom testing plan replaces the testing provisions of subsections (d)(2)(A), (e)(2)(A) and (E), and (f) of this section.

(3) A breeding facility designated by the department as Category A, Category B, or trace-in is NMQ as of the date of such notification and remains NMQ until the provisions of the custom testing plan under this subsection have been satisfied.

(4) If for any reason the permittee does not comply with the provisions of a custom testing plan under this subsection, the provisions of subsections (d) - (f) of this section resume applicability.

(5) The terms of a custom testing plan under this subsection are non-negotiable and final.

(i) Positive Facility.

(1) Upon notification by the department that CWD is suspected in a deer in a facility, the facility is automatically NMQ and the permittee shall:

(A) within 14 days, conduct and submit to the department a pen-by-pen inventory of all deer within the breeding facility, including the location of the pen in which the suspected positive deer was kept at the time the suspect CWD detection occurred;

(B) immediately cease all internal movement of animals between pens within the facility, unless such movement is expressly authorized in writing by the department;

(C) euthanize the positive deer within seven days of confirmation of the positive test result, if the detection was a result of antemortem testing;

(D) euthanize all trace deer within seven days of confirmation of the positive test result, unless authorized by the department or in a herd plan;

(E) submit post-mortem test samples from breeder deer euthanized under this subsection within one business day of euthanasia, to include both ears and the identification tag required under Parks and Wildlife Code, Chapter 43, Subchapter L; and

(F) inspect the facility daily for mortalities; and

(i) immediately report each mortality to the department;

(ii) immediately collect test samples from all test-eligible mortalities that occur within the facility; and

(iii) submit samples collected under this subsection for post-mortem testing within one business day of the discovery of the mortality.

(2) Unless otherwise provided in writing by the department, a permittee must enter into a herd plan within six months of being designated a positive facility or agree to conduct a depopulation of the breeder deer within the facility.

(3) Fencing meeting the specifications in §65.605 of this title shall be installed around a positive facility no later than the completion of the herd plan and removal of a quarantine unless the owner of the facility conducts a complete depopulation of the breeder deer.

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

Filed with the Office of the Secretary of State on March 24, 2025.

TRD-202500995
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: April 13, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 389-4775

SUBCHAPTER T. DEER BREEDER PERMITS

31 TAC §§65.602 - 65.605, 65.610, 65.611

The amendments are adopted under the authority of Parks and Wildlife Code, Chapter 43, Subchapter L, which authorizes the commission to make regulations governing the possession, transfer, purchase, and sale of breeder deer held under the authority of the subchapter.

§65.605. Facility Standards and Care of Deer.

(a) Except as provided in subsection (h) of this section, the entire perimeter of a permitted deer breeding facility, including medical facilities, shall be within a fence of no less than seven feet in height, which shall be constructed of department-approved woven wire, field fence, net mesh, chain link or welded wire that will retain breeder deer. The fence required by this subsection shall at no point be within:

(1) five feet of a pen or other structure containing breeder deer; or

(2) ten feet of the exterior fence of another deer breeding facility.

(b) A permittee shall submit to the department a letter of confirmation by a person authorized by the department to conduct facility inspections under the provisions of §65.603 of this title (relating to Application and Permit Issuance), that the perimeter fence required by subsection (a) of this section exists and is compliant with the requirements of this section.

(c) A deer breeding facility consists of the entirety of the area within the fence required by subsection (a) of this section.

(d) Within the perimeter fence required by subsection (a) of this section, breeder deer shall at all times be kept completely contained within internal fencing meeting the requirements of subsection (a) of this section, except as provided by subsection (e)(2) of this section.

(e) Within the space or area between the fence required by subsection (a) of this section and the fencing required by subsection (d) of this section:

(1) no supplemental food or water is permitted; and

(2) no animals of any kind shall have free-choice access to or be present, except what is necessary for the limited, transient period of time necessary to drive or move breeder deer in an immediate fashion between pens or structures within the facility. If breeder deer are moved within a facility under the provisions of this subsection, a person must be present and actively engaged in urging or driving the breeder deer in a direct and prompt fashion to the destination pen. It is an offense for breeder deer to be present in the space or area between the two fences of the double fence required by this section if a person is not present and actively engaged in keeping the breeder deer in constant motion from the source pen to the destination pen.

(f) Except as provided in this section, no deer, livestock, exotic livestock, or similar animals may be present in, confined in, or have access to a deer breeding facility other than: (1) the breeder deer reflected on the herd inventory for the facility; and

(2) deer that are not required to be identified and reported to the department under the provisions of Parks and Wildlife Code, Chapter 43, Subchapter L.

(g) An edifice, structure, building, working facility, barn, or similar infrastructure identified on a facility diagram required under this subchapter may be used on a temporary basis to handle animals other than susceptible species, provided the animals are at no point commingled with deer within the facility or allowed to access any space within the facility that is ever occupied or used by deer within the facility other than:

(1) the edifice, structure, building, working facility, barn, or similar infrastructure used to temporarily handle the animals; and

(2) travel corridors, alleyways, or other access avenues to and from edifice, structure, building, working facility, barn, or similar infrastructure used to temporarily handle the animals.

(3) For the purposes of this subsection, "temporary" means only the amount of time necessary to accomplish a specific short-term task and does not include any longer period of time or any period of time during which animals are unattended. The provisions of this subsection apply only to a facility permitted prior to the effective date of this subsection; following the effective date of this subsection, if a breeding facility permitted after the effective date of this subsection is not designed in such a fashion as to provide access to handling infrastructure that is external to the breeding facility, the use of such handling infrastructure for non-susceptible species is prohibited.

(h) An edifice, structure, building, working facility, barn, or similar infrastructure that is or is to be used or occupied by non-susceptible animals as well as the breeder deer reflected on the herd inventory for that facility is not required to be wholly within and separate from the perimeter fence required by subsection (a) of this section, but must be:

(1) configured and constructed in such a fashion so as to prevent direct contact of any kind (i.e., nose-to-nose contact through a fence) between deer within the facility and susceptible species outside the facility; and

(2) secured when not in use so as to prevent susceptible species from outside the facility from entering the edifice, structure, building, working facility, barn, or similar infrastructure.

(i) All deer breeding facilities located on a single property shall be separated by at least ten feet and facilities are prohibited from sharing infrastructure for any reason.

(j) The provisions of subsection (a)(2), (g), (h), and (i) of this section apply to all facilities on the effective date of this subsection; all other provisions of this section apply only to new facilities permitted on or after the effective date of this subsection. The provisions of this section in effect on the date this subsection took effect continue in force and effect for permits issued prior to the effective date of this subsection but do not control over the provisions of §65.81 of this title (relating to CWD Risk Mitigation Provisions).

(k) An indoor facility is acceptable if it meets the standards described in this section and provides permanent access to an outdoor environment that is sufficient for keeping the breeder deer in captivity.

(l) A permittee shall ensure that deer have access to adequate food, a continuous supply of water, and ample cover or shelter.

(m) Immediately upon discovering the escape of breeder deer from a facility, a permittee shall notify the department. The notification shall include a detailed description of the permittee's intended actions to recapture the escaped deer, including the methods that will be employed to recapture the deer and the dates and times that recapture will be attempted. The permit holder shall notify the department daily of the efforts to capture the escaped deer until the escaped deer are captured. If after ten days the permittee is unable to capture escaped breeder deer that have been reported in accordance with this subsection, the deer may not be recaptured or held in a deer breeding facility unless specifically authorized in writing by the department for purposes of disease management.

(n) If a permit holder is unable to recapture escaped breeder deer reported as provided under subsection (m) of this section and the breeding facility is designated as NMQ at the time of or subsequent to the time of escape under the provisions of Subchapter B, Division 2, of this chapter, the property on which the deer breeding facility is located and any tract of land contiguous to the property under common ownership shall be subject to a department disease-testing plan requiring mandatory CWD testing and reporting.

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

Filed with the Office of the Secretary of State on March 24, 2025.

TRD-202500996
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: April 13, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 389-4775

♦ ♦ ♦

TITLE 34. PUBLIC FINANCE

PART 4. EMPLOYEES RETIREMENT SYSTEM OF TEXAS

CHAPTER 67. HEARINGS ON DISPUTED CLAIMS

34 TAC §67.201

The Employees Retirement System of Texas (ERS) adopts amendments to 34 Texas Administrative Code (TAC) Chapter 67, concerning Hearings on Disputed Claims, by amending §67.201 (Procedures Governing Bid Protests), without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 631). The amendments were approved by the ERS Board of Trustees at its March 5, 2025 meeting. This rule will not be republished.

Section 67.201 is amended in order to clarify the rule and its interaction with other rules and statutes, to remove the requirement that copies of bid protests be sent to interested parties, and to enhance public understanding of the rule.

No comments were received on the proposed rule amendments.

The amendments are adopted under Tex. Gov't Code §815.102, which provides authorization for the ERS Board of Trustees to adopt rules necessary for the administration of the funds of the retirement system and regarding the transaction of any other business of the Board.

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

Filed with the Office of the Secretary of State on March 27, 2025.

TRD-202501047
Cynthia Hamilton
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Effective date: April 16, 2025
Proposal publication date: January 31, 2025
For further information, please call: (877) 275-4377

♦ ♦ ♦

CHAPTER 73. BENEFITS

34 TAC §73.21, §73.22

The Employees Retirement System of Texas (ERS) adopts amendments to 34 Texas Administrative Code (TAC) Chapter 73, concerning Benefits, by amending §73.21 (Reduction Factor for Age and Retirement Option) and adding §73.22 (Increasing Annuity Option), without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 632). The amendments and new rule were approved by the ERS Board of Trustees at its March 5, 2025 meeting. This chapter will not be republished.

Section 73.21 is amended in order to clarify that the tables described in the rule continue to govern benefits payable after August 31, 2022. Section 73.22 is added to clarify how ERS will administer the new increasing annuity option described in Tex. Gov't Code §814.110 for ERS retirees and their designated beneficiaries.

No comments were received on the proposed rule amendments and new rule.

The amendments and new rule are adopted under Tex. Gov't Code §814.110, which authorizes the ERS Board of Trustees to adopt rules for the implementation of the new increasing annuity option; §815.105, which requires the Board to adopt mortality, service, and other tables based on actuarial reports; and Tex. Gov't Code §815.102, which authorizes the Board to adopt rules necessary for the administration of the funds of the retirement system and regarding the transaction of any other business of the Board.

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

Filed with the Office of the Secretary of State on March 27, 2025.

TRD-202501048
Cynthia Hamilton
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Effective date: April 16, 2025
Proposal publication date: January 31, 2025
For further information, please call: (877) 275-4377

♦ ♦ ♦

CHAPTER 76. CASH BALANCE BENEFIT

The Employees Retirement System of Texas (ERS) adopts amendments to 34 Texas Administrative Code (TAC) Chapter 76, concerning Benefits, by repealing §76.6 (Optional Cash Balance Retirement Benefits), §76.7 (Change in Annuity Selection), and §76.8 (Partial Lump-Sum Option), and by amending §76.1 (Definitions), §76.3 (Proportionate Service Purchases), §76.4 (Optional Retirement Program), §76.5 (Factor Tables), §76.9 (Annual Interest Rate), §76.10 (Gain Sharing Interest Rate), §76.11 (Return of Excess Contributions), and §76.12 (Uniformed Services Employment and Reemployment Rights Act), without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 634). The amendments were approved by the ERS Board of Trustees at its March 5, 2025 meeting. This chapter will not be republished.

Sections 76.1, 76.3 - 76.5, and 76.9 - 76.12 are amended in order to incorporate changes resulting from the enactment of Tex. Gov't Code Chapter 840A and in order to clarify the intent of the rules and their interaction with other rules and statutes, thus enhancing public understanding. Sections 76.6 - 76.8 are repealed because the language is superfluous as a result of amendments to Tex. Gov't Code Chapter 820.

No comments were received on the proposed rule amendments.

34 TAC §§76.1, 76.3 - 76.5, 76.9 - 76.12

The amendments are adopted under Tex. Gov't Code §815.102, which authorizes the ERS Board of Trustees to adopt rules necessary for the administration of the funds of the retirement system and regarding the transaction of any other business of the board, and Tex. Gov't Code §820.004 and §840A.004, which authorize the board to adopt rules necessary to implement cash balance retirement benefits.

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

Filed with the Office of the Secretary of State on March 27, 2025.

TRD-202501045
Cynthia Hamilton
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Effective date: April 16, 2025
Proposal publication date: January 31, 2025
For further information, please call: (877) 275-4377

♦ ♦ ♦

34 TAC §§76.6 - 76.8

The repeals are adopted under Tex. Gov't Code §815.102, which provides authorization for the ERS Board of Trustees to adopt rules necessary for the administration of the funds of the retirement system and regarding the transaction of any other business of the Board, and Tex. Gov't Code §820.004 and §840A.004, which explicitly authorize the board to adopt rules as necessary to implement cash balance retirement benefits and include implied authority to repeal rules as necessary to implement cash balance retirement benefits.

No other statutes are affected by the proposed repeals.

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

Filed with the Office of the Secretary of State on March 27, 2025.

TRD-202501046
Cynthia Hamilton
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Effective date: April 16, 2025
Proposal publication date: January 31, 2025
For further information, please call: (877) 275-4377

♦ ♦ ♦