PROPOSED RULES

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

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

TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 33. LICENSING

SUBCHAPTER A. APPLICATION PROCEDURES

16 TAC §33.5

The Texas Alcoholic Beverage Commission proposes amendments to §33.5, relating to Food and Beverage Certificate.

Section 33.5 addresses requirements relating to qualifications for applying for and maintaining food and beverage certificates under Alcoholic Beverage Code §§25.13, 28.18, 32.23 and 69.16.

The commission has reviewed the section pursuant to Government Code §2001.039 and has determined that the need for a rule addressing food and beverage certificates continues to exist but that changes to the rule are appropriate. Proposed new subsection (a) sets forth the Alcoholic Beverage Code sections to which the rule relates. Subsequent subsections are renumbered.

Various non-substantive grammatical changes are made throughout the section.

Proposed new subsection (d) would authorize the use of a company check for payment of the biennial certificate fee, in addition to the forms of payment allowed under the current rule.

Proposed new subsection (e) contains definitions, including definitions of "premise" and "location" that clarify that for the purposes of this section the terms are used interchangeably to refer to the licensed premises.

Proposed new subsection (f) addresses the qualifications for a food and beverage certificate.

Proposed new subsection (g) addresses the hours of operation for the sale and service of food and alcoholic beverages.

Proposed new subsection (h) authorizes the executive director or the executive director's designee to approve an application if the applicant provides evidence that shows substantial compliance with certain provisions of the rule.

Proposed new subsection (j) addresses information that must be provided by an applicant for an original food and beverage certificate.

Proposed new subsection (n) addresses recordkeeping requirements applicable to holders of wine and beer retailer's permits and retail dealer's on-premise licenses.

Proposed new subsection (q) provides that in determining the primary business of holders of retail dealer's on-premise licenses and wine and beer retailer's permits for the purposes of proposed new subsection (f)(3), the receipts of all business entities sharing the premise (as identified in the original or a supplemental application) will be considered, and that, for audit purposes, the food and beverage certificate holder must provide financial and accounting records related to food and alcohol sales of all business entities sharing the licensed premise.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed amendments will be in effect, there will be no fiscal impact on local government attributable to the amendments. There should be no fiscal impact on state government.

The proposed amendments will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed amendments will be in effect, the public will benefit because qualifications for food and beverage certificate applicants and holders are clarified.

Comments on the proposed amendments may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, or by facsimile transmission to (512) 206-3280, or by email to *rules@tabc.texas.gov.* Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed amendments on Thursday, October 20, 2016, at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed amendments are authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed amendments affect Alcoholic Beverage Code §§5.31, 25.13, 28.18, 32.23 and 69.16, and Government Code §2001.039.

§33.5. Food and Beverage Certificate.

(a) This rule relates to §§25.13, 28.18, 32.23 and 69.16 of the Texas Alcoholic Beverage Code.

(b) [~~(a)~~] Each applicant for an original or renewal food and beverage certificate shall include all information required by the com-

mission to insure compliance with all applicable statutes and rules and regulations of the agency.

(c) [~~(b)~~] Application for the certificate shall be upon forms prescribed [~~provided~~] by the commission [~~agency~~].

(d) [~~(c)~~] The biennial [~~annual~~] certificate fee for each location is $200.00 [~~$100~~] and must be submitted in the form of a cashier's check, [~~or~~] U.S. postal money order, or company check made payable to the Texas Alcoholic Beverage Commission. The original certificate will expire upon expiration of the primary permit or license. No prorated certificate fees will be given and no refunds made for issuance of the food and beverage certificate for less than two years [~~one year~~].

(e) [~~(d)~~] The following words and terms, when used in this section [~~chapter~~], shall have the following meaning unless the context clearly indicates otherwise:

(1) Food service--cooking [~~Cooking~~] or assembling of food on the premise primarily for on-premise consumption. Commercially pre-packaged items purchased off-premise which require no cooking or assembly [~~and which may be purchased off-premise~~] do not constitute food service under this section.[~~;~~]

(2) Entrée [~~Entree~~]--main [~~Main~~] dish or course of a meal.

(3) Multiple entrées [~~entrees~~]--at least [~~No fewer than~~] eight different entrées [~~entrees~~] per meal period must be available to customers.

(4) Food service facilities--a [~~A~~] portion of the licensed premises where food is stored and prepared primarily for on-premise consumption.

(5) Premise--the licensed premise.

(6) Location--the licensed premise.

[~~(e) An applicant is not qualified for a food and beverage certificate unless the following conditions, in addition to other requirements, are satisfied:~~]

[~~(1) with respect to retail dealer's on-premise licenses and wine and beer retailer's permits, the applicant's primary business on the premises is food service and with respect to mixed beverage permits and private club registration permits, the applicant maintains food service on the premise;~~]

[~~(2) multiple entrees are available to customers;~~]

[~~(3) food service facilities are maintained on the premises;~~]

[~~(4) the hours of operation for sale and service of food and alcoholic beverages are the same except that food may be sold or served before or after the legal hours for sale of alcoholic beverages; and~~]

[~~(5) subject to the approval of the commission, an applicant may present evidence to the commission which demonstrates substantial compliance with subsection (e)(2) and (4) and that full compliance is limited by the nature of the business operation. Approval by the commission may be granted when the commission is satisfied that the operation is a food service establishment.~~]

(f) An applicant is qualified for a food and beverage certificate if the following conditions, in addition to other requirements, are satisfied:

(1) multiple entrées are available to customers;

(2) food service facilities are maintained on the premises;

(3) with respect to retail dealer's on-premise licenses and wine and beer retailer's permits, the primary business on the premises is food service, as determined in accordance with subsection (q); and

(4) with respect to mixed beverage permits and private club registration permits, the applicant maintains food service on the premise.

(g) The hours of operation for sale and service of food and of alcoholic beverages are the same except that food may be sold or served before or after the legal hours for sale of alcoholic beverages.

(h) An applicant may present evidence to the executive director or the executive director's designee which demonstrates substantial compliance with subsections (f)(1) and (g). Approval may be granted when the executive director or the executive director's designee is satisfied that the operation is a food service establishment.

(i) [~~(f)~~] If the applicant is a hotel that maintains separate area restaurants, lounges or bars, food service facilities must exist for each of the licensed premises.

(j) [~~(g)~~] An applicant for an original [~~originally issued~~] food and beverage certificate [~~shall submit a sworn statement attesting that food service is maintained on the premises and for holders of wine and beer retailer's permits and retail dealer's on-premise licenses, food service is the primary business on the premises. The applicant~~] shall furnish the following, as well as any other information requested [~~as may be deemed reasonably necessary~~] by the commission to ensure compliance:

(1) the menu or, if no menu is available, a listing of the food and beverage items;

(2) hours of operation of food service and hours of operation for sale or service of alcoholic beverages;

(3) sales data or, if not available, a projection of sales. The projection or data should include sufficient breakdown of revenues of food, alcoholic beverages and other major sales categories at the location;

(4) listing of equipment used in the preparation and service of food [~~versus the equipment used in preparation and service of alcoholic beverages~~]; and

(5) copies of floor plans of the licensed premises indicating areas devoted primarily to the preparation and service of food [~~and those devoted primarily to the preparation and service of alcoholic beverages~~].

(k) [~~(h)~~] Applicants for renewal of food and beverage certificates whose primary permits are a wine and beer retailer's permit or a retail dealer's on-premise license shall submit sales data described in subsection (o). The commission may request additional [~~information and other~~] information or documentation [~~documents required by the commission~~] to indicate the business at the licensed location is a food service establishment with food service facilities for the preparation and service of multiple entrées [~~entrees~~].

(l) [~~(i)~~] The commission may review the operation at the licensed premises to determine the applicant or holder of the food and beverage certificate has or is maintaining food service with food service facilities for the preparation and service of multiple entrées [~~entrees~~]. In doing so the commission may review such items as required in the original or renewal application as well as [~~and~~] advertising, promotional items, changes in operations or hours, changes in floor plans, prominence of food items on the menu as compared to alcoholic beverages, name of business, number of transactions with food components, copies of city or county permits or certificates relating to type of business operation, and any other item deemed necessary or applicable.

(m) [~~(j)~~] Failure to provide [~~submit~~] documentation requested or accurately maintain required records is prima facie evidence of non-compliance.

[~~(k) The certificate shall be posted in a conspicuous place adjacent to the primary permit or license at all times on the licensed premises.~~]

(n) [~~(l)~~] In verifying that the certificate holder is maintaining food service as the primary business on the premises, the commission may examine all books, papers, records, documents, supplies and equipment of the certificate holder.

(o) [~~(m)~~] The following recordkeeping [~~Recordkeeping~~] requirements apply to certificate [~~for~~] holders who hold a [~~of~~] wine and beer retailer's permit [~~permits~~], including railway cars and excursion boats, or a [~~and~~] retail dealer's on-premise license [~~licenses~~]:

(1) [~~each holder of a food and beverage certificate whose primary permit or license is a wine and beer retailer's permit, including those issued for railway cars and excursion boats, or a retail dealer's on-premise license shall maintain~~] records must be maintained to reflect separate totals for alcoholic beverage sales, food sales and other major sales categories at the location;[~~.~~]

(2) purchase [~~Purchase~~] invoices must be maintained to reflect the total purchases of alcoholic beverages, food and other major purchase categories at the location;

(3) [~~(2)~~] complimentary alcoholic beverages must [~~shall~~] be recorded and included in the total alcoholic beverage sales as if they were sold [~~it was a normal sale~~] and clearly marked as being complimentary; and

(4) [~~(3)~~] all records must [~~are required to~~] be maintained for four years and made available to authorized representatives of the commission upon reasonable request [~~; and~~]

[~~(4) in examining the alcoholic beverage sales, the commission may compute and determine the percentage of alcoholic beverage sales upon the basis of information filed with the commission or held by the certificate holder, but if such information is insufficient, the computation and determination of the percentage of sales may be based upon any records or information which is available].~~

(p) [~~(n)~~] In considering alcoholic beverage sales for holders of mixed beverage permits, private club registration permits, private club exemption certificate permits, and private club beer and wine permits, the dollar value of complimentary drinks shall be added to total sales or service of alcoholic beverages in determining the percentage of alcoholic beverage sales or service on the licensed premises.

(q) In determining the primary business of retail dealer's on-premise licenses and wine and beer retailer's permits under subsection (f)(3), the receipts of all business entities sharing the premise (as identified in the original or a supplemental application) will be considered. For audit purposes, it shall be the responsibility of the food and beverage certificate holder to provide financial and accounting records related to food and alcohol sales of all business entities sharing the licensed premise.

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

Filed with the Office of the Secretary of State on September 21, 2016.

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Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 206-3489

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16 TAC §33.11

The Texas Alcoholic Beverage Commission proposes the repeal of §33.11, relating to Application and Issuance.

Section 33.11 addresses the application and issuance of temporary licenses and temporary wine and beer retail permits.

The commission has reviewed the section pursuant to Government Code §2001.039 and has determined that the need for a rule addressing temporary licenses and temporary wine and beer retail permits continues to exist. However, the commission believes it is appropriate, given the extent of required revisions, to repeal the text of this section and replace it with new text, rather than indicate changes to the current version by strikethroughs and underlining. The subject will be addressed in a new §33.11, relating to Application and Issuance of Temporary Licenses and Permits, that is being proposed by the commission in a separate and simultaneous rulemaking proceeding.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed repeal will be in effect, there will be no fiscal impact on state or local government.

The proposed repeal will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed repeal will be in effect, the public will benefit because the new version of the rule being proposed in a separate and simultaneous rulemaking will provide more guidance and be clearer than this version that is being repealed.

Comments on the proposed repeal may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed repeal on Thursday, October 20, 2016 at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed repeal is authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed repeal affects §5.31 and Subchapter A of Chapter 27 of the Alcoholic Beverage Code, and Government Code §2001.039.

§33.11. Application and Issuance.

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

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Martin Wilson
Assistant General Counsel
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16 TAC §33.11

The Texas Alcoholic Beverage Commission proposes new rule §33.11, relating to Application and Issuance of Temporary Licenses and Permits.

Proposed new §33.11 relates to Temporary Wine and Beer Retailer's Permits and Special Three-Day Wine and Beer Permits under Chapter 27 of the Alcoholic Beverage Code, Daily Temporary Mixed Beverage Permits under Chapter 30 of the Alcoholic Beverage Code, Daily Temporary Private Club Permits under Subchapter B of Chapter 33 of the Alcoholic Beverage Code, and Temporary Licenses under Chapter 72 of the Alcoholic Beverage Code.

In a separate and simultaneous rulemaking proceeding the commission is proposing the repeal of current §33.11, relating to Application and Issuance, which by its terms currently addresses temporary licenses and temporary wine and beer retail permits. Many of the changes in the proposed new §33.11 are the result of the commission's experiences under the current rule and are an attempt to provide clear guidance regarding the application process for temporary licenses and permits.

Subsection (a) of proposed new §33.11 addresses the applicability of the rule.

Subsection (b) of proposed new §33.11 addresses the application process for temporary licenses and permits.

Subsection (c) of proposed new §33.11 provides that an application for a temporary license or permit should be filed at least ten calendar days prior to the event. This is based on the amount of time required for the routine processing of such applications, recognizing the obligation of staff to process other license and permit applications. Although the commission will try to accommodate applications filed less than ten calendar days before an event, the proposed new rule provides notice that such applications may not be processed in time for the event.

Subsection (d) of proposed new §33.11 provides a non-exclusive list of documents related to the event that may be required to determine qualifications for the requested temporary license or permit.

Subsection (e) of proposed new §33.11 clarifies that the temporary license or permit term must include the period when alcoholic beverages will be delivered or stored, in addition to the event itself.

Subsection (f) of proposed new §33.11 provides that a temporary license or permit will not be issued if a 60-day notice sign under Alcoholic Beverage Code §11.391 or §61.381 is posted at the location, or if a protest is pending against the location, person, or primary license or permit.

Subsection (g) of proposed new §33.11 provides that an applicant for a temporary license or permit may be required to take a course provided by the commission that describes the responsibilities attached to specific licenses and permits.

Subsection (h) of proposed new §33.11 clarifies that the signage requirements for a temporary license or permit are the same as those for a primary license or permit.

Subsection (i) of proposed new §33.11 requires the temporary license or permit and the approved diagram to be conspicuously displayed on the licensed premises.

Subsection (j) of proposed new §33.11 requires that invoices accompany all alcoholic beverages being transported.

Subsection (k) of proposed new §33.11 provides that the holder of a primary license or permit may return remaining alcoholic beverages to the primary licensed location. It also provides that the holder of a temporary license or permit is allowed to distribute remaining alcoholic beverage product to its organization or, if authorized to do so by Alcoholic Beverage Code §109.54, may resell the product if it is beer.

Subsection (l) of proposed new §33.11 provides that the executive director or executive director's designee may refuse to issue a temporary license or permit if there is reason to believe that its issuance would be detrimental to the public.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed new rule will be in effect, there will be no fiscal impact on local government attributable to the rule. There should be no fiscal impact on state government.

The proposed new rule will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed new rule will be in effect, the public will benefit because the process of applying for a temporary license or permit will be clarified.

Comments on the proposed new rule may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed new rule on Thursday, October 20, 2016, at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed new rule is authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed new rule affects §5.31, Chapters 27, 30, and 72, and Subchapter B of Chapter 33 of the Alcoholic Beverage Code

§33.11. Application and Issuance of Temporary Licenses and Permits.

(a) This rule relates to Chapter 27, Chapter 30, Subchapter B of Chapter 33 and Chapter 72 of the Alcoholic Beverage Code.

(b) The application for a temporary license or permit shall be made on forms provided by the commission and shall be signed and sworn to by the applicant. The application shall be accompanied by a

cashier's check, money order, or firm check payable to the order of the comptroller in the appropriate amount. The application shall be filed in the field office designated for the county where the temporary event will be held.

(c) To allow for the processing of the application and accompanying documents, the application should be submitted a minimum of ten calendar days prior to the event. The applicant assumes the risk that an application submitted less than ten calendar days may not be processed in time for the event.

(d) In addition to the application form, other documents related to the event that may be required include a letter from the property owner, sponsorship agreements, promoter agreements, concession agreements, management agreements, diagrams, site maps, local governmental authorization, and any other documents needed to determine qualification for the license or permit under the Alcoholic Beverage Code.

(e) The days and hours of the temporary license or permit must cover the period in which alcoholic beverages will be delivered or stored in addition to the event itself.

(f) A temporary license or permit will not be issued if:

(1) a notice sign (60 day sign) is posted at the location pursuant to Alcoholic Beverage Code §11.391 or §61.381; or

(2) a protest is pending against the location, person, or primary license or permit.

(g) The completion of a responsibilities course provided by the commission may be required prior to the issuance of the temporary license or permit.

(h) The signage requirements for a temporary license or permit are the same as those for a primary license or permit.

(i) The temporary license or permit and approved diagram must be displayed at all times in a conspicuous place on the permitted premises.

(j) All alcoholic beverages being transported shall be accompanied by invoices.

(k) The holder of a primary license or permit may return remaining alcoholic beverage products to the primary licensed location. The holder of a temporary license or permit may distribute remaining product to its organization, or may resell the product if it is beer and if the organization is authorized to do so by Alcoholic Beverage Code §109.54.

(l) The executive director or the executive director's designee may refuse to issue a temporary license or permit if there is reason to believe the issuance of a license or permit is detrimental to the public.

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

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Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
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For further information, please call: (512) 206-3489

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16 TAC §33.12

The Texas Alcoholic Beverage Commission proposes the repeal of §33.12, relating to Use of Caterer's Permits.

Section 33.12 addresses the activities of mixed beverage permit holders who also hold caterer's permits under Chapter 31 of the Alcoholic Beverage Code.

The commission has reviewed the section pursuant to Government Code §2001.039 and has determined that the need for a rule addressing the use of caterer's permits continues to exist. However, the commission believes it is appropriate, given the extent of required revisions, to repeal the text of this section and replace it with new text, rather than indicate changes to the current version by strikethroughs and underlining. The subject will be addressed in a new §33.12, relating to Use of Caterer's Permits and Request for Caterer Certificate, that is being proposed by the commission in a separate and simultaneous rulemaking proceeding.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed repeal will be in effect, there will be no fiscal impact on state or local government.

The proposed repeal will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed repeal will be in effect, the public will benefit because the new version of the rule being proposed in a separate and simultaneous rulemaking will provide more guidance and be clearer than this version that is being repealed.

Comments on the proposed repeal may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed repeal on Thursday, October 20, 2016 at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed repeal is authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code, and §31.03(b), which requires the commission to adopt rules governing the application for and the issuance and use of caterer's permits.

The proposed repeal affects §5.31 and Chapter 31 of the Alcoholic Beverage Code, and Government Code §2001.039.

§33.12. Use of Caterer's Permits.

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

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Martin Wilson
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Texas Alcoholic Beverage Commission
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16 TAC §33.12

The Texas Alcoholic Beverage Commission proposes new rule §33.12, relating to Use of Caterer's Permits and Request for Caterer Certificate.

Proposed new §33.12 relates to Caterer's Permits under Chapter 31 of the Alcoholic Beverage Code.

In a separate and simultaneous rulemaking proceeding the commission is proposing the repeal of current §33.12, relating to Use of Caterer's Permits. Many of the changes in the proposed new §33.12 are the result of the commission's experiences under the current rule and are an attempt to provide clear guidance regarding the use of caterer's permits, including the application process for caterer certificates.

Subsection (a) of proposed new §33.12 addresses the applicability of the rule.

Subsection (b) of proposed new §33.12 addresses the application process for caterer certificates.

It provides that an application for a caterer certificate should be filed at least ten calendar days prior to the event. This is based on the amount of time required for the routine processing of such applications, recognizing the obligation of staff to process other license and permit applications. Although the commission will try to accommodate applications filed less than ten calendar days before an event, the proposed new rule provides notice that such applications may not be processed in time for the event. Proposed new §33.12(b) also provides a non-exclusive list of documents related to the event that may be required to determine qualifications for the requested caterer certificate.

Subsection (c) of proposed new §33.12 requires that the issued certificate be conspicuously displayed at the location of the catered event.

Subsection (d) of proposed new §33.12 describes the conditions that must be met before a caterer certificate will be issued for a location that has been designated as the licensed premises in a pending application where all state fees, surcharges and securities have been submitted.

Proposed new §33.12(e) provides that, in such circumstances, the commission must have performed an initial review for qualification, there must not be a pending protest of the application, and there must not be a 60-day notice sign posted at the location. Furthermore, proposed new subsection (e) provides that the right to use a catering certificate in such circumstances will terminate when the commission either issues an order denying the pending application or issues the license or permit.

Under proposed new §33.12(e), no holder of a caterer's permit may provide alcoholic beverages at any licensed premises if a permit or license for that location is suspended

Subsection (f) of proposed new §33.12 provides that a caterer certificate may not be issued for a period of more than ten days unless the executive director or the executive director's designated representative, on the basis of a case-by-case review of the specific situation, grants additional time.

Subsection (g) of proposed new §33.12 provides that the executive director or executive director's designee may refuse to issue a caterer certificate if there is reason to believe that its issuance would be detrimental to the public.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed new rule will be in effect, there will be no fiscal impact on local government attributable to the rule. There should be no fiscal impact on state government.

The proposed new rule will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed new rule will be in effect, the public will benefit because the use of caterer's permits will be clarified.

Comments on the proposed new rule may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed new rule on Thursday, October 20, 2016 at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed new rule is authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code, and §31.03(b), which requires the commission to adopt rules governing the application for and the issuance and use of caterer's permits.

The proposed new rule affects §5.31 and Chapter 31 of the Alcoholic Beverage Code.

§33.12. Use of Caterer's Permits and Request for Caterer Certificate.

(a) This rule relates to Chapter 31 of the Alcoholic Beverage Code.

(b) The holder of a caterer's permit, or designated representative thereof, should submit a form provided by the commission at least ten calendar days prior to the catered event date. The applicant assumes the risk that an application submitted less than ten calendar days before the event may not be processed in time for the event. Other documents or agreements involved in the event that may be required include a letter from the owner of the property where the event will be held, sponsorship and/or promoter agreements, diagram or site maps, local governmental authorization, and any other documents or agreements needed to determine qualification under the code.

(c) The issued certificate shall be signed by a representative of the commission and shall be placed in a conspicuous place at the location of the catered function

(d) Use in Connection with Pending Applications. The holder of a caterer's permit may utilize that authority to provide alcoholic beverages for on-premises consumption at a location that has been designated as the licensed premises in a pending application only if the following conditions are met.

(1) There is no pending protest of the pending application.

(2) The commission has received an application for the proposed location and payment of all state fees, surcharges and securities, if applicable, has been submitted.

(3) The commission has performed an initial review for qualification.

(4) The right to use a catering certificate terminates when the commission either issues an order denying the pending application or issues the license or permit.

(5) A notice sign (60 day sign) pursuant to Alcoholic Beverage Code §11.391 or §61.381 is not posted at the location.

(e) Suspension. No holder of a caterer's permit shall utilize that authority to provide alcoholic beverages at any licensed premises if a permit or license for that location is suspended.

(f) A caterer certificate may not be issued for a period of more than ten days unless the executive director or the executive director's designated representative, on the basis of a case-by-case review of the specific situation, grants additional time.

(g) Ground for Denial. The executive director or the executive director's designated representative may refuse to issue a caterer certificate if there is reason to believe the issuance of a certificate would be detrimental to the public.

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

Filed with the Office of the Secretary of State on September 21, 2016.

TRD-201604883
Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 206-3489

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CHAPTER 45. MARKETING PRACTICES
SUBCHAPTER E. REGULATION OF CREDIT AND CASH TRANSACTIONS

16 TAC §45.121

The Texas Alcoholic Beverage Commission proposes amendments to §45.121, relating to Credit Restrictions and Delinquent List for Liquor.

Section 45.121 implements Alcoholic Beverage Code §§102.32, 11.61(b)(2), 11.66, and 109.64.

The commission has reviewed the section pursuant to Government Code §2001.039 and has determined that the need for a rule addressing credit restrictions and the delinquent list for sales of liquor continues to exist but that changes to the rule are appropriate.

The commission proposes to modify the title of the section to Credit Law and Delinquent List to reflect industry usage. The commission also proposes to modify the title of Subchapter E of its rules to more accurately reflect its content, and to eliminate the divisions in the subchapter.

Various non-substantive grammatical changes are made throughout the section.

Proposed new subsection (b)(7) would amend the definition of "seller" as used in the section to specifically include holders of local class B wholesaler's permits, holders of brewpub licenses when selling ale or malt liquor to a retailer, and holders of brewer's self-distribution permits.

Everyone defined as a seller in current subsection (b)(7) is still included in the proposed new subsection. However, since Alcoholic Beverage Code §102.31(a)(2) provides that local distributor permittees are subject to the requirements of that section when selling malt beverages to a mixed beverage permittee or a daily temporary mixed beverage permittee, the definition of "seller" in proposed new subsection (b)(7) is clarified to assure that local distributor permittees are subject to the provisions of the section only when making a sale that is not a sale of malt beverages to a mixed beverage permittee or a daily temporary mixed beverage permittee.

Proposed new subsection (c)(3) is amended to mirror the requirements of §45.131, relating to Payment Regulations for Certain Malt Beverages, which the commission is also amending in a separate rulemaking. The commission proposes to condition the allowance for retaining invoices off the licensed premises on the ability of the commission to access the records from the licensed premises during normal business hours.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed amendments will be in effect, there will be no fiscal impact on local government attributable to the amendments. There should be no fiscal impact on state government.

The proposed amendments will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed amendments will be in effect, the public will benefit because the issue of which permit and license holders are subject to credit law provisions, and when, is clarified.

Comments on the proposed amendments may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, or by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed amendments on Thursday, October 20, 2016, at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed amendments are authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed amendments affect Alcoholic Beverage Code §§5.31, 11.61(b)(2), 11.66, 102.32, and 109.64, and Government Code §2001.039.

§45.121. Credit Law [~~Restrictions~~] and Delinquent List [~~for Liquor~~].

(a) Purpose. This section implements §§102.32, 11.61(b)(2), 11.66, and 109.64 of the Texas Alcoholic Beverage Code (Code).

(b) Definitions. For purposes of this section, the following terms have the definitions given in this subsection.

(1) Alcoholic beverage--As used in this section includes only liquor, as that term is defined in §1.04 of the Code.

(2) Cash equivalent--A financial transaction or instrument that is not conditioned on the availability of funds upon presentment, including, money order, cashier's check, certified check or completed electronic funds transfer.

(3) Delinquent payment--A financial transaction or instrument that fails to provide payment in full or is returned to the Seller as unpaid for any reason, on or before the fourth business day after the date that payment is due under §102.32(c) of the Code, or is returned to the Seller [~~seller~~] as unpaid for any reason after the fourth business day after the date payment is due under §102.32(c) of the Code. A delinquent payment also occurs in the event the Retailer [~~retailer~~] fails to submit payment on or before the fourth business day after the date that payment is due under §102.32(c) of the Code.

(4) Event--A financial transaction or instrument that fails to provide payment to a Retailer and results in a Retailer making one or more delinquent payments to one or more Sellers.

(5) Incident--A single delinquent payment. Failure to submit payment also constitutes an incident.

(6) Retailer--A package store permittee, wine only package store permittee, private club permittee, private club exemption certificate permittee, mixed beverage permittee, or other Retailer [~~retailer~~], and their agents, servants and employees. For purposes of this section, the holder of a winery permit issued under Chapter 16 of the Code is a Retailer [~~retailer~~] when the winery permit holder purchases wine from the holder of a wholesaler's permit issued under Chapter 19 of the Code for resale to ultimate consumers in unbroken packages. For purposes of this section and pursuant to Code §109.64, the holder of an industrial permit under Chapter 38 of the Code is treated in the same manner as a Retailer [~~retailer~~] when the industrial permit holder makes a bulk purchase of liquor from the holder of a wholesaler's permit issued under Chapter 19 of the Code.

(7) Seller--As used in this section includes:

(A) the holder of a wholesaler's permit, a general class B wholesaler's permit, or a local class B wholesaler's permit;

(B) the holder of a winery permit or wine bottler permit;

(C) the holder of a brewpub license when selling ale or malt liquor to Retailers;

(D) the holder of a brewer's self distribution permit;

(E) the holder of a local distributor's permit when making a sale of an alcoholic beverage that is not the sale of a malt beverage to a mixed beverage permittee or a daily temporary mixed beverage permittee; and

(F) the agents, servants and employees of a permit or license holder identified in subparagraphs (A) - (E).

[~~(7) Seller--A wholesaler, class B wholesaler, winery, wine bottler or a local distributor permittee, and their agents, servants and employees.~~]

(c) Invoices. A delivery of alcoholic beverages by a Seller, to a Retailer, must be accompanied by an invoice of sale showing the name and permit number of the Seller and the Retailer, a full description of the alcoholic beverages, the price and terms of sale, and the place and date of delivery.

(1) The Seller's copy of the invoice must be signed by the Retailer to verify receipt of alcoholic beverages and accuracy of invoice.

(2) The Seller and Retailer must retain invoices in compliance with the requirements of §206.01 of the Code.

(3) Invoices may be created, signed and retained in an electronic or internet based inventory system, and may be retained on or off the licensed premise, as long as the records can be accessed from the licensed premises and made available to the commission during normal business hours.

(d) Delinquent Payment Violation. A Retailer who makes a delinquent payment to a Seller for the delivery of alcoholic beverages violates this section unless an exception applies.

(1) A Retailer who violates this section must pay a delinquent amount, and a Seller may accept payment, only in cash or cash equivalent financial transaction or instrument.

(2) A Retailer whose permit or license expires or is cancelled for cause, voluntarily cancelled, suspended or placed in suspension while on the Delinquent List [~~delinquent list~~] will be disqualified from applying for or being issued an original or renewal permit or license until all delinquent payments are satisfied. For purposes of this section, the Retailer includes all persons who were owners, officers, directors and shareholders of the Retailer at the time the delinquency occurred.

(e) Reporting Violation and Payment; Failure to Report.

(1) A report of a violation or payment must be submitted electronically to the commission on the commission's web based reporting system at www.tabc.texas.gov [~~www.tabc.state.tx.us~~].

(2) A Seller who cannot access the commission's web based reporting system must either:

(A) submit a request for exception to submit reports by paper; or

(B) contract with another Seller [~~seller~~] or service provider to make electronic reports on behalf of the Seller.

(3) All reports of violations or payment under this subsection must be made to the commission before the date the Delinquent List [~~delinquent list~~] is published.

(4) A Seller who fails to report a violation or a payment as required by this subsection is in violation of this section.

(f) Prohibited Sales and Delivery.

(1) Sellers are prohibited from selling or delivering alcoholic beverages to any licensed location of a Retailer who appears on the commission's Delinquent List from the date the violation appears on the Delinquent List until the Release Date on the Delinquent List, or until the Retailer no longer appears on the Delinquent List.

(2) A sale or delivery of alcoholic beverages prohibited by this section is a violation of this section.

(g) Prohibited Purchase or Acceptance.

(1) A Retailer who violates subsection (d) of this section is prohibited from purchasing or accepting delivery of alcoholic beverages from any source at any of Retailer's licensed locations from the date any violation occurs until all delinquent payment are paid in full.

(2) A prohibited purchase or acceptance of a delivery of alcoholic beverages is a violation of this section.

(h) Exception. A Retailer who wishes to dispute a violation of this section or inclusion on the commission's Delinquent List based on a good faith dispute between the Retailer and the Seller may submit a detailed electronic or paper written statement with the commission with an electronic or paper copy to the Seller explaining the basis of the dispute.

(1) The written statement must be submitted with documents and/or other records tending to support the Retailer's dispute, which may include:

(A) a copy of the front and back of the cancelled check of Retailer showing endorsement and deposit by Seller;

(B) bank statement or records of bank showing funds were available in the account of Retailer on the date the check was delivered to Seller; and

(C) bank statement or records showing:

(i) bank error or circumstances beyond the control of Retailer caused the check to be returned to Seller unpaid; or

(ii) the check cleared Retailer's account and funds were withdrawn from Retailer's account in the amount of the check.

(2) A disputed delinquent payment will not be removed from the List [~~delinquent list~~] until documents and/or other records tending to support the Retailer's dispute are submitted to the commission.

(3) The Retailer must immediately submit an electronic notice of resolution of a dispute to the commission under this subsection.

(i) Penalty for Violation. An action to cancel or suspend a permit or license may be initiated under §11.61(b)(2) of the Code for one or more violations of this section. The commission may consider whether a violation is the result of an event or incident when initiating an action under this subsection.

(j) Delinquent List.

(1) The Delinquent List is published bi-monthly on the commission's public web site at www.tabc.texas.gov [~~www.tabc.state.tx.us~~]. An interested person may receive the Delinquent List by electronic mail each date the Delinquent List is published by registering for this service online.

(2) Except as otherwise specified in subsection (k) of this section, the Delinquent List will be published on the fifth business day after the 25th day of the month for purchases made from the 1st to the 15th day of that month and for which payment was not received by the fourth business day after the 25th day of that month. Except as otherwise specified in subsection (k) of this section, the Delinquent List will be published on the fifth business day after the 10th day of the next month for purchases made between the 16th and the last day of the preceding month and for which payment was not received by the fourth business day after the 10th day of the next month.

(3) The Delinquent List is effective at 12:01 A.M. on the date of publication.

(4) The Delinquent List is updated hourly to reflect reports of payments submitted.

(k) Calculation of Time. A due date under this section or §102.32(c) of the Code or the publication date of the Delinquent List that would otherwise fall on a Saturday, a Sunday, a state or federal holiday (unless the commission is required to be open for business), or a standard Federal Reserve bank holiday (as published at http://www.frbservices.org/holidayschedules/index.html) will be the next regular business day. For purposes of this section, a business day means a day which is not a Saturday, a Sunday, a state or federal holiday (unless the commission is required to be open for business), or a standard Federal Reserve bank holiday (as published at http://www.frbservices.org/holidayschedules/index.html). A payment hand delivered to an individual authorized to accept payment on behalf of the Seller is deemed received when the authorized individual takes possession of the payment.

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

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TRD-201604964
Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
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For further information, please call: (512) 206-3489

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16 TAC §45.131

The Texas Alcoholic Beverage Commission proposes amendments to §45.131, relating to Payment Regulations for Certain Malt Beverages.

Section 45.131 implements Alcoholic Beverage Code §102.31.

The commission has reviewed the section pursuant to Government Code §2001.039 and has determined that the need for a rule addressing payment regulations for malt beverages continues to exist but that changes to the rule are appropriate.

The commission proposes to modify the title of the section to Cash Law to reflect industry usage.

The commission also proposes to eliminate the divisions in Subchapter E of its rules.

Various non-substantive grammatical changes are made throughout the section.

The commission proposes to amend subsection (b)(7), defining "seller" as used in the section, by reorganizing it to clarify the applicability of the rule. The removal of the reference to subsidiaries and affiliates is considered non-substantive because any such entities would need to have their own licenses and permits.

Martin Wilson, Assistant General Counsel, has determined that for each year of the first five years that the proposed amendments will be in effect, there will be no fiscal impact on local government attributable to the amendments. There should be no fiscal impact on state government.

The proposed amendments will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

Mr. Wilson has determined that for each year of the first five years that the proposed amendments will be in effect, the public will benefit because the applicability of the section to permit and license holders is clarified.

Comments on the proposed amendments may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alco-

holic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, or by facsimile transmission to (512) 206-3280, or by email to rules@tabc.texas.gov. Comments will be accepted for 30 days following publication in the *Texas Register.*

The staff of the commission will hold a public hearing to receive oral comments on the proposed amendments on Thursday, October 20, 2016, at 1:30 p.m. in the commission meeting room at the commission's headquarters, which is located at 5806 Mesa Drive in Austin, Texas.

The proposed amendments are authorized by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed amendments affect Alcoholic Beverage Code §5.31 and §102.31, and Government Code §2001.039.

§45.131. Cash Law [~~Payment Regulations for Certain Malt Beverages~~].

(a) Purpose. This rule implements §102.31 of the Texas Alcoholic Beverage Code (Code).

(b) Definitions. For purposes of this section, the following terms have the meaning given in this subsection.

(1) Cash equivalent--A financial transaction or instrument that is not conditioned on the availability of funds upon presentment, including [~~,~~] money order, cashier's check, certified check or completed electronic funds transfer.

(2) Cash payment--United States currency [~~Currency~~] and coins, or a cash equivalent financial transaction or instrument.

(3) Event--A financial transaction or instrument that fails to provide payment to a Retailer and results in one or more incidents to one or more Sellers.

(4) Incident--One financial transaction or instrument made by a Retailer that fails to provide payment in full for malt beverages delivered by a Seller to the Retailer. Failure to submit payment also constitutes an incident.

(5) Malt beverages--Ale or malt liquor containing more than four percent of alcohol by weight and beer containing one-half of one percent or more of alcohol by volume and not more than four percent alcohol by weight.

(6) Retailer--A license or permit holder and their agents, servants and employees, authorized to sell malt beverages for on or off premise consumption to an ultimate consumer.

(7) Seller--As used in this section means:

(A) the [~~The~~] holder of a local distributor's permit when selling malt beverages to a mixed beverage permittee or daily temporary mixed beverage permittee, or an agent, servant, or employee of a local distributor's permit holder when selling malt beverages to such permittees;

(B) the holder of a brewpub license when selling beer to Retailers; [~~,~~]

(C) the holder of a general, local or branch distributor's license; [~~, and~~]

(D) the holder of a manufacturer's self-distribution license; [~~,~~] and

(E) the [~~their~~] agents, servants, and employees of a license holder identified in subparagraphs (B) - (D) when selling beer[~~, or a subsidiary or affiliate, authorized to sell malt beverages~~] to a Retailer [~~retailer~~].

(c) Invoices. A delivery of malt beverages by a Seller, to a Retailer, must be accompanied by an invoice of sale showing the name and permit number of the Seller and the Retailer, a full description of the malt beverages, the price, the place and date of delivery.

(1) The Seller's copy of the invoice must be signed by the Retailer to verify receipt of malt beverages and accuracy of invoice and by the Seller to acknowledge payment was received on or before the delivery.

(2) The Seller and Retailer must retain invoices for four years from the date of delivery.

(3) Invoices may be created, signed and retained in an electronic or internet based inventory system, and may be retained on or off the licensed premise, as long as the records can be accessed from the licensed premise and made available to the commission during normal business hours.

(d) Cash Payment Violation. A Retailer who fails to make a cash payment to a Seller for the delivery of malt beverages violates this section unless an exception applies.

(1) A Retailer who violates this section must pay the amount due, and a Seller may accept payment, only in cash or cash equivalent [~~financial transaction or instrument~~].

(2) For purposes of this section, the Retailer includes all persons who are or were owners, officers, directors, managers or shareholders of the Retailer at the time a cash payment violation occurs.

(e) Reporting Violation and Payment; Failure to Report.

(1) A report of a violation must be submitted electronically on the forms provided on the commission's web based reporting system at www.tabc.texas.gov [~~www.tabc.state.tx.us~~].

(2) A Seller who cannot access the commission's web based reporting system must either:

(A) submit a request for exception to submit reports by paper; or

(B) contract with another Seller [~~seller~~] or service provider to make electronic reports on behalf of the Seller.

(3) All reports of violations under this subsection must be made to the commission within two business days from the date the violation is discovered by the Seller.

(4) A Seller who fails to report a violation as required by this subsection is in violation of this section.

(f) Exception. A Retailer who wishes to dispute a violation of this section, based on a good faith dispute between the Retailer and the Seller may submit supporting documents and a detailed written statement to the commission with a copy to the Seller explaining the basis of the dispute.

(1) The written statement must be submitted with documents and/or other records tending to support the Retailer's dispute, which may include:

(A) a copy of the front and back of the cancelled check of Retailer showing endorsement and deposit by Seller;

(B) bank statement or records of bank showing funds were available in the account of Retailer on the date the check was delivered to Seller; and

(C) bank statement or records showing:

(i) bank error or circumstances beyond the control of Retailer caused the check to be returned to Seller unpaid; or

(ii) the check cleared Retailer's account and funds were withdrawn from Retailer's account in the amount of the check.

(2) The Retailer must immediately submit a notice of resolution of a dispute to the commission under this subsection.

(g) Penalty for Violation. An action to cancel or suspend a permit or license may be initiated under the Code for one or more violations of this section. The commission may consider whether a violation is the result of an event or incident when initiating an action under this subsection.

(h) Calculation of Time. Sundays and legal holidays are not counted in determining time periods under this section.

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

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Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
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For further information, please call: (512) 206-3489

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TITLE 22. EXAMINING BOARDS

PART 22. TEXAS STATE BOARD OF PUBLIC ACCOUNTANCY

CHAPTER 501. RULES OF PROFESSIONAL CONDUCT

SUBCHAPTER E. RESPONSIBILITIES TO THE BOARD/PROFESSION

22 TAC §501.93

The Texas State Board of Public Accountancy (Board) proposes an amendment to §501.93, concerning Responses.

Background, Justification and Summary

The amendment to §501.93 helps clarify what constitutes a substantive response from a licensee to a Board communication requesting a response and/or Board records.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will provide a clearer understanding of what constitutes a substantive response to a Board investigation letter.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§501.93. Responses.

(a) A person shall substantively respond in writing, within 30 days, to any communication from the board requesting a response. It is not a substantive response for a person to simply reply that they do not intend to respond or provide the records or documents requested. The board may specify a shorter time for a response in the communication when circumstances so require. The time to respond shall commence on the date the communication was mailed, delivered to a courier or delivery service, faxed or e-mailed to the last address, facsimile number, or email address furnished to the board by the applicant or person.

(b) A person shall provide copies of documentation and/or work papers, within 30 days, in response to the board's request at no expense to the board. The board may specify a shorter time for response in the communication when circumstances so require. The time to respond shall commence on the date the request was mailed, delivered to a courier or delivery service, faxed or e-mailed to the last address, facsimile number or email address furnished to the board by a person. A person may comply with this subsection by providing the board with original records for the board to duplicate. In such a circumstance, upon request the board will provide an affidavit from the custodian of records documenting custody and control of the records.

(c) Failure to timely respond substantively to written communications, or failure to furnish requested documentation and/or work papers, constitutes conduct indicating lack of fitness to serve the public as a professional accountant.

(d) Each applicant and each person required to be registered with the board under the Act shall notify the board, either in writing or through the board's website, of any and all changes in either such person's mailing address or telephone number and the effective date thereof within 30 days before or after such effective date.

(e) Interpretive Comment. This section should be read in conjunction with §519.6 of this title (relating to Subpoenas).

(f) Interpretive Comment. In this section, the term board includes board staff.

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201605000
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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CHAPTER 519. PRACTICE AND PROCEDURE
SUBCHAPTER A. GENERAL PROVISIONS

22 TAC §519.2

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.2, concerning Definitions.

Background, Justification and Summary

The amendment to §519.2 removes independent consultants from the definition of Board staff and clarifies what constitutes direct administrative costs.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding of what constitutes board staff and administrative costs.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.2. Definitions.

In this chapter:

(1) "Address of record" means the last address provided to the board by a certificate or registration holder pursuant to §501.93 of this title (relating to Responses);

(2) "ALJ" means SOAH administrative law judge;

(3) "APA" means the Texas Administrative Procedure Act, Chapter 2001 of the Texas Government Code;

(4) "Board staff" means the agency's employees [~~or independent contractors of the board~~];

(5) "Committee" means an enforcement committee of the board;

(6) "Complaint" means information available to or provided to the board indicating that a certificate or registration holder may have violated the Act, board rules, or order of the board;

(7) "Complainant" means the person or entity who initiates a complaint with the board against a certificate or registration holder;

(8) "Direct Administrative Costs" means those costs actually incurred by the board through payment to outside vendors and the resources expended by the board in the investigation and prosecution of a matter within the board's jurisdiction, including but not limited to, staff salary, payroll taxes and benefits and other non-salary related expenses, expert fees and expenses, witness fees and expenses, filing fees and expenses of the support staff of [~~fees and expenses paid to~~] the Of-

fice of the Attorney General, filing fees, SOAH utilization fees, court reporting fees, copying fees, delivery fees, case management fees, costs of exhibit creation, technical fees, travel costs and any other cost or fee that can reasonably be attributed to the matter;

(9) "Petitioner" means the Texas State Board of Public Accountancy;

(10) "PFD" means the proposal for decision prepared by an ALJ;

(11) "Respondent" means a licensee or certificate holder, individual or entity against whom a complaint has been filed; and

(12) "SOAH" means the State Office of Administrative Hearings.

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

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
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22 TAC §519.7

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.7, concerning Misdemeanors that Subject a Licensee or Certificate Holder to Discipline by the Board.

Background, Justification and Summary

The amendment to §519.7 adds licensee's failure to file his personal tax return, obstructing a highway, and repeated violations of criminal laws as misdemeanors that could subject a licensee to disciplinary action.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be to inform the public of the misdemeanors the board considers discreditable acts.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.7. Misdemeanors that Subject a Licensee or Certificate Holder to Discipline by the Board.

(a) Final conviction or placement on deferred adjudication, deferred prosecution, withheld adjudication or community supervision may subject a licensee or certificate holder to disciplinary action pursuant to §501.90 of this title (relating to Discreditable Acts). Licensees and certificate holders are often placed in a position of trust with respect to client funds. The public including the business community relies on the integrity, morality and honesty of licensees and certificate holders in providing professional accounting services or professional accounting work. The board considers conviction or placement on deferred adjudication, deferred prosecution, withheld adjudication or community supervision for any crime relating to integrity, morality and honesty to relate directly to the practice of public accountancy and may subject the licensee or certificate holder to discipline. The board has determined that the following list of misdemeanor offenses that involve integrity, morality and honesty directly relate to the duties and responsibilities involved in providing professional accounting services or professional accounting work, pursuant to the provisions of Chapter 53 of the Occupations Code:

(1) dishonesty or fraud:

(A) Unlawful Use of Criminal Instrument;

(B) Unlawful Access to Stored Communications;

(C) Illegal Divulgence of Public Communications;

(D) Burglary of Coin-Operated or Coin Collection Machines;

(E) Burglary of Vehicles;

(F) Theft;

(G) Theft of Service;

(H) Tampering with Identification Numbers;

(I) Theft of or Tampering with Multichannel Video or Information Services;

(J) Manufacture, Distribution, or Advertisement of Multichannel Video or Information Services Device;

(K) Sale or Lease of Multichannel Video or Information Services Device;

(L) Possession, Manufacture, or Distribution of Certain Instruments Used to Commit Retail Theft;

(M) Forgery;

(N) Criminal Simulation;

(O) Trademark Counterfeiting;

(P) Stealing or Receiving Stolen Check or Similar Sight Order;

(Q) False Statement to Obtain Property or Credit or in the Provision of Certain Services;

(R) Hindering Secured Creditors;

(S) Fraudulent Transfer of a Motor Vehicle;

(T) Credit Card Transaction Record Laundering;

(U) Issuance of a Bad Check;

(V) Deceptive Business Practices;

(W) Rigging Publicly Exhibited Contest;

(X) Misapplication of Fiduciary Property or Property of Financial Institution;

(Y) Securing Execution of Document by Deception;

(Z) Fraudulent Destruction, Removal, or Concealment of Writing;

(AA) Simulating Legal Process;

(BB) Refusal to Execute Release of Fraudulent Lien or Claim;

(CC) Fraudulent, Substandard, or Fictitious Degree;

(DD) Breach of Computer Security;

(EE) Unauthorized Use of Telecommunications Service;

(FF) Theft of Telecommunications Service;

(GG) Publication of Telecommunications Access Device;

(HH) Insurance Fraud;

(II) Medicaid Fraud;

(JJ) Coercion of Public Servant or Voter;

(KK) Improper Influence;

(LL) Acceptance of Honorarium (by restricted government employees);

(MM) Gift to Public Servant by Person Subject to his Jurisdiction;

(NN) Offering Gift to Public Servant;

(OO) Perjury;

(PP) False Report to Police Officer or Law Enforcement Employee;

(QQ) Tampering with or Fabricating Physical Evidence;

(RR) Tampering with Governmental Record;

(SS) Fraudulent Filing of Financial Statement;

(TT) False Identification as Peace Officer;

(UU) Misrepresentation of Property;

(VV) Record of a Fraudulent Court;

(WW) Bail Jumping and Failure to Appear;

(XX) False Alarm or Report;

(YY) Engaging in Organized Criminal Activity; [~~and~~]

(ZZ) Violation of Court Order Enjoining Organized Criminal Activity; and

(AAA) Failing to file license holder's own tax return;

(2) moral turpitude:

(A) Public Lewdness;

(B) Indecent Exposure;

(C) Enticing a Child;

(D) Violation of a Protective Order Preventing Offense Caused by Bias or Prejudice;

(E) Failure to Identify;

(F) Hindering Apprehension or Prosecution;

(G) Improper Contact with Victim;

(H) Barratry and Solicitation of Professional Employment;

(I) Unauthorized Practice of Law;

(J) Hindering Proceedings by Disorderly Conduct;

(K) Abuse of Corpse;

(L) Prostitution;

(M) Promotion of Prostitution;

(N) Obscene Display or Distribution;

(O) Obscenity;

(P) Sale, Distribution, or Display of Harmful Material to Minor; and

(Q) Employment Harmful to Children;

(3) alcohol abuse or controlled substances:

(A) Possession of Substance in Penalty Group 3 (less than 28 grams), under the Texas Health and Safety Code;

(B) Possession of Substance in Penalty Group 4 (less than 28 grams), under the Texas Health and Safety Code;

(C) Manufacture, Delivery, or Possession with Intent to Deliver Miscellaneous Substances, under the Texas Health and Safety Code;

(D) Manufacture, Delivery, or Possession of Miscellaneous Substances, under the Texas Health and Safety Code;

(E) Delivery of Marijuana, under the Texas Health and Safety Code;

(F) Possession of Marijuana, under the Texas Health and Safety Code;

(G) Possession or Transport of Certain Chemicals with Intent to Manufacture Controlled Substance (for substance listed in a Schedule but not in a Penalty Group), under the Texas Health and Safety Code;

(H) Possession or Delivery of Drug Paraphernalia, under the Texas Health and Safety Code; [~~and~~]

(I) Obstructing Highway or Other Passageway; and [~~Any misdemeanor involving intoxication under the influence of alcohol or a controlled substance.~~]

(J) Any misdemeanor involving intoxication under the influence of alcohol or a controlled substance.

(4) physical injury or threats of physical injury to a person:

(A) Assault;

(B) Deadly Conduct;

(C) Terroristic Threat; and

(D) Leaving a Child in a Vehicle.

(b) A licensee or certificate holder is often placed in a position of trust with respect to client funds; and the public, including the business community relies on the integrity, morality and honesty of licensees and certificate holders in preparing reports and providing professional accounting services or professional accounting work. The board considers repeated violations of [~~any~~] criminal laws [~~law~~] to relate directly to a licensee or certificate holder providing professional accounting services or professional accounting work.

(c) A conviction or placement on deferred adjudication, deferred prosecution, withheld adjudication or community supervision for a violation of any state or federal law that is equivalent to an offense listed in subsection (a)(1) - (4) of this section is considered to directly relate to a licensee or certificate holder providing professional accounting services or professional accounting work and may subject a certificate or registration holder to discipline by the board.

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201604985
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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22 TAC §519.8

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.8, concerning Administrative Penalties.

Background, Justification and Summary

The amendment to §519.8 makes grammatical changes.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a more easily understood rule.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.8. Administrative Penalties.

(a) The board may impose an administrative penalty alone or in addition to other sanctions permitted under the Act. Board committees and the executive director are delegated the authority to determine if [~~that~~] any alleged violation warrants an administrative penalty under Subchapter L of the Act.

(b) The report of any such determination may be included in a notice of hearing.

(c) A request for a hearing under §901.554 of the Act (relating to Penalty to be Paid or Hearing Requested) shall clearly notify the staff that the hearing must address issues relevant to the assessment of an administrative penalty by including the language "RESPONDENT SPECIFICALLY REQUESTS A HEARING ON ADMINISTRATIVE PENALTIES" in capital letters. Failure to include such language shall be a waiver of the right to a hearing within the meaning of §901.554 of the Act.

(d) Pursuant to §901.551 of the Act (relating to Imposition of Administrative Penalty):

(1) the board imposes an administrative penalty on licensees or certificate holders who, in violation of §901.411 of the Act (relating to Continuing Professional Education):

(A) do not complete at least 120 hours of CPE in each three-year license period;

(B) do not complete at least 20 hours in each one-year license period;

(C) do not comply with board rules for the reporting of CPE; or

(D) fail to complete or report sufficient ethics hours as required by §523.112 of this title (relating to Required CPE Participation);

(2) considering the seriousness of violation of §901.411 of the Act, the hazard and potential hazard to the public from CPAs who are not trained in current accounting standards and practices, the amount necessary to deter future violations, and such other matters as the board considers justice may require, [~~the board sets~~] the administrative penalty for the violations described in paragraph (1) of this subsection is [~~at~~] a minimum of $100 per licensee [~~licensees~~] or certificate holder [~~holders~~] per license period;

(3) the penalty may be assessed only on licensees or certificate holders against whom a final board order is issued.

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

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J. Randel (Jerry) Hill
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22 TAC §519.9

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.9, concerning Administrative Penalty Guidelines.

Background, Justification and Summary

The amendment to §519.9 gives the board the discretion to not assess administrative costs when justified, to correct the cites in the references in the attached graphic and to remove the reference to possession of controlled substances.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be the correct understanding of the board's application of administrative costs, misdemeanors and controlled substance abuse.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.9. Administrative Penalty Guidelines.

(a) The following table contains guidelines for the assessment of administrative penalties in disciplinary matters. In determining whether a violation is minor, moderate or major, the board will apply

the factors to be considered set forth in §901.552(b) of the Act (relating to Amount of Penalty). In all cases where the board has determined a violation has occurred, administrative costs may [~~will~~] be assessed, regardless of any other sanction imposed by the board.
Figure: 22 TAC §519.9(a)

(b) The amounts specified in subsection (a) of this section are guidelines only. The board retains the right to increase or decrease the amount of an administrative penalty based on the circumstances of each case it considers.

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

Filed with the Office of the Secretary of State on September 23, 2016.

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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22 TAC §519.12

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.12, concerning Emergency Suspension.

Background, Justification and Summary

The amendment to §519.12 clarifies that the meaning of "day" is a business day, in subsection (e).

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a better informed public.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.12. Emergency Suspension.

(a) Whenever the board, through its executive committee, determines that a licensee or certificate holder is engaged in or about to engage in an act of fraud or a violation of the Act and the licensee's or certificate holder's continued practice constitutes an immediate threat to the public welfare, the board, through its executive committee, may issue an order temporarily suspending the licensee's or certificate holder's license without notice and without a hearing. An order temporarily suspending a license issued by the executive committee must be ratified by the board at its next regularly scheduled meeting.

(b) "Immediate threat to the public welfare" means a real and present danger to clients caused through the licensee's or certificate holder's lack of competence, impaired status, or failure to adequately service clients. A "real and present danger" exists if clients have a likely exposure to or significant risk of loss of funds or records or financial injury and is based on actual actions or inactions of the licensee or certificate holder. The executive committee may consider information that the licensee or certificate holder previously committed similar actions or inactions in determining whether the licensee or certificate holder poses an immediate threat to commit such actions or inactions in the future.

(c) Pursuant to Chapter 551 of the Texas Government Code (relating to Open Meetings), the executive committee may hold a meeting by telephone conference call if immediate action is required and the convening at one location of the executive committee is difficult or impossible. Whenever possible, the executive committee will attempt to provide the licensee or certificate holder with notice and an opportunity to be present at the emergency suspension proceeding.

(d) The determination of the executive committee may be based not only on evidence admissible under the Texas Rules of Evidence, but may be based on information of a type on which a reasonably prudent person commonly relies in the conduct of the licensee's or certificate holder's affairs. Presentations by the parties may be based on evidence or information and shall not be excluded on objection of a party unless determined by the chair that the evidence or information is clearly irrelevant or unduly inflammatory in nature; however, objections by a party may be noted for the record. Witnesses

may provide sworn statements in writing or verbally and may choose to provide statements that are not sworn. However, whether a statement is sworn may be a factor to be considered by the executive committee in evaluating the weight to be given to the statement. Questioning of witnesses by board staff, the respondent or executive committee members is under the control of the executive committee chair.

(e) The executive committee shall immediately serve notice of the suspension on the licensee or certificate holder in accordance with §901.5045(b) of the Act (relating to Emergency Suspension). The suspended licensee or certificate holder shall be provided the opportunity to request a hearing in accordance with §901.5045(c) of the Act. The hearing shall be conducted in the manner of a contested case pursuant to the Act, the APA, the board's rules and SOAH's rules; provided that time limits provided in §901.5045(c) of the Act shall control. At the close of the hearing, the ALJ shall recommend to the executive committee whether to uphold, vacate or modify the suspension order. If the ALJ's recommendation is to vacate the emergency suspension order, the executive committee shall determine whether to adopt that recommendation no later than the second business day after it receives that recommendation.

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

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J. Randel (Jerry) Hill
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Texas State Board of Public Accountancy
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For further information, please call: (512) 305-7842

SUBCHAPTER B. COMPLAINTS AND INVESTIGATIONS

22 TAC §519.21

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.21, concerning Investigations.

Background, Justification and Summary

The amendment to §519.21 makes it clear that the Board has the discretion to determine whether there is justification to open a complaint and clarifies what the Board considers to be a non-substantial response.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be to better understand that a complaint must be supported by evidence and what a non-substantial response is.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.21. Investigations.

(a) A board investigative file may [~~will~~] be opened when the board determines that there may be a potential violation of the Act, board rules, or board order and the subject matter of the complaint is within the board's jurisdiction.

(b) The board may open an investigative file on its own initiative.

(c) A licensee or certificate holder shall cooperate with the board in its investigation of a complaint. The respondent will receive notice of the investigation by certified mail return receipt requested at the respondent's mailing address on file with the board. Upon notice of an investigation from the board, the respondent shall respond to the investigation and any request by the board for information or records concerning the investigation in accordance with §501.93 of this title (relating to Responses).

(d) The respondent must provide the board with a detailed response to each allegation and the request for background information

contained in the notice of investigation. The response must be in writing and delivered to the board within 30 days of the date of the notice of the investigation. The respondent's response may include any additional information the respondent wants the board to consider. Failure to provide the detail sought by the board to each allegation or to the records or documents requested will be considered a non-substantive response as also required in §501.93 of this title.

(e) The board will provide the respondent and the complainant with quarterly notification of the status of an investigation.

(f) The board may request information from a person who is not the subject of an investigation.

(g) Withdrawal of a complaint by a complainant does not automatically cease an ongoing investigation.

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

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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22 TAC §519.23

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.23, concerning Informal Conferences.

Background, Justification and Summary

The amendment to §519.23 clarifies the Board procedures of an informal conference.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a better understanding of Board process.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.23. Informal Conferences.

(a) The committee, at its sole discretion, may invite the respondent and/or [~~and~~] the complainant to an informal conference. The purpose of the conference is to assist the committee in the investigation. An informal conference is voluntary and is not a prerequisite to a hearing in a disciplinary action.

(b) The committee will request the respondent to appear at a specified time and place for an informal conference. If the committee determines that the complainant's presence will aide in the investigation, then the committee will invite the complainant to appear at the informal conference.

(c) The notice of an informal conference will state the date, time and place [~~of the informal conference~~]. The notice will be mailed to the respondent and complainant at least 10 days prior to the informal conference.

(d) At an informal conference, the respondent may appear with legal representation but the respondent must agree to be the person responding to the committee's questions [~~in person and with counsel~~].

(e) During an informal conference, each party is given the opportunity to make a brief presentation to the committee. The committee may ask questions regarding the matter being investigated and any matter of interest to the committee related to the investigation. The committee chair may call upon board staff at any time for assistance during the informal conference.

(f) The committee may invite a non-party who has relevant information to the investigation to participate in the informal conference but the committee will determine who may attend and the process of the informal conference.

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201604990
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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22 TAC §519.24

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.24, concerning Committee Recommendations.

Background, Justification and Summary

The amendment to §519.24 confirms that a Board issued Letter of Comment is confidential.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a better understanding of Board actions.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.24. Committee Recommendations.

(a) At the conclusion of its investigation the committee may make a recommendation to the board regarding the disposition of the investigation.

(b) The committee may recommend dismissal of the complaint if the committee determines:

(1) the board lacks jurisdiction; or

(2) there is insufficient evidence of a violation of the Act, board rules or board order; or

(3) the respondent came into compliance with the Act, board rules or board order.

(c) The committee will inform the respondent of its recommendation but may, in its discretion, issue a confidential letter of comment stating the committee's concerns about respondent's practice and make suggestions that may improve respondent's practice. The committee's recommendation of dismissal is not final until it is ratified by the board in an open meeting.

(d) If the committee determines that there is a violation of the Act, board rules or board order, the committee may recommend disciplinary action. The committee may recommend any disciplinary sanction provided in §901.501 of the Act (relating to Disciplinary Powers of Board), singularly or in any combination. The respondent shall be notified of the committee's action.

(e) Upon a determination by the committee that there is a violation of the Act, board rule, or board order, the committee may offer respondent an agreed consent order containing the committee's findings of fact and conclusions of law, and proposed sanctions, administrative penalties and costs. The respondent shall be notified of the committee's determination by certified mail at the respondent's address on file with the board. The respondent shall have 20 calendar days to provide in writing Respondent's acceptance of the agreed consent order or request a hearing to contest the committee's determination in accordance with §519.3 of this chapter (relating to Computation of Time). Upon a showing of good cause, the 20 days may be extended. Failure to accept the proposed agreed consent order within the required time to respond shall be deemed a rejection.

(f) If the respondent does not accept the proposed agreed consent order and fails to request a hearing in writing within the required time, the executive director, after providing notice of hearing before the executive director and respondent failing to appear, may offer a proposed order containing the committee's findings of fact and conclusions of law and imposing disciplinary sanctions, and administrative penalties and costs for the board's consideration and ratification. A

proposed order offered by the executive director is not final until it has been approved by the board.

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

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22 TAC §519.26

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.26, concerning Complaint and Eligibility of an Applicant for Certification.

Background, Justification and Summary

The amendment to §519.26 removes the reference to "possession of a controlled substance" so that the public understands that abuse of a controlled substance is not limited to just possessing the controlled substance.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a better understanding of what the Board considers to be a crime that relates to the practice of public accountancy that justifies Board disciplinary action.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.26. Complaint and Eligibility of an Applicant for Certification. The board may, on its own motion, or on the complaint of any person, initiate proceedings to determine the eligibility of an applicant for the issuance of a certificate. Sufficient cause for this action includes, but is not limited to, any of the following instances:

(1) fraud or deceit by an applicant on the certification application;

(2) final conviction of a felony or of any crime, involving dishonesty, fraud, moral turpitude, alcohol abuse or [~~possession of~~] controlled substances, or physical injury or threats of physical injury to a person, under the laws of any state or of the United States, or the imposition of deferred adjudication in connection with the criminal prosecution of such an offense; or

(3) conduct indicating a lack of fitness to serve the public as a professional accountant.

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

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J. Randel (Jerry) Hill
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22 TAC §519.27

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.27, concerning Factors Considered in Certification Application.

Background, Justification and Summary.

The amendment to §519.27 removes the reference to "possession of" a controlled substance so that the public understands

that abuse of a controlled substance is not limited to just possessing the controlled substance.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a better understanding of what the Board considers to be a crime that relates to the practice of public accountancy that justifies Board disciplinary action.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis.

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.27. Factors Considered in Certification Application.

Unless otherwise determined by the board, the following are reasons why an applicant may not be certified as a CPA:

(1) An applicant has been convicted of a felony offense, which results in incarceration, probation, parole, mandatory supervision or deferred adjudication.

(2) An applicant has been convicted of a felony or misdemeanor offense, or granted a deferred adjudication which directly relates to the practice of public accountancy.

(3) The applicant applying for the issuance of a certificate who can be identified in paragraph (1) or (2) of this section has the right to a hearing before the board, to present evidence relative to the conviction. As a part of the hearing, the board's consideration shall include the following issues before reaching a decision:

(A) the nature and seriousness of the crime as it applies to the board's statutory responsibility to ensure that a person maintains high standards of competence and integrity;

(B) the extent to which the applicant might have an opportunity to repeat criminal activity of the same type as that in which the applicant was previously involved;

(C) the relationship of the crime to the ability, capacity, or fitness required to perform the duties and discharge the responsibilities of a CPA; and

(D) the additional factors provided in §53.023 of the Texas Occupations Code.

(4) Because a licensee is often placed in a position of trust, and because the public in general, and the business community in particular, rely on the reports and other services of the licensee, the board considers that the following crimes directly relate to the practice of public accountancy:

(A) a felony offense or misdemeanor offense of which dishonesty or fraud is an element;

(B) a felony offense or misdemeanor offense which results in the suspension or revocation of the right to practice before any state or federal agency for a cause which in the opinion of the board warrants its action; and

(C) crimes involving moral turpitude, alcohol abuse or [~~possession of~~] controlled substances, or physical injury or threats of physical injury to a person.

(5) The following procedures shall apply in the processing of the application for certification:

(A) The applicant shall respond, under penalty of perjury, to the question, "Have you ever been convicted of a felony or a misdemeanor, placed on probation, or granted deferred adjudication in any state or by the federal government?"

(B) The board shall obtain criminal history record information on an applicant about whom the executive director finds evidence to warrant a record search.

(C) The board shall review the application, statements made by the applicant relating to criminal activity, criminal history record information, and shall approve or disapprove the application as the evidence warrants. All applications disapproved under these conditions shall be scheduled for a hearing upon written request of the applicant.

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

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22 TAC §519.28

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.28, concerning Action Relating to Investigation.

Background, Justification and Summary

The amendment to §519.28 incorporates the language contained in the Public Accountancy Act that identifies the actions the Board may take at the conclusion of an investigation of an applicant to take the CPA exam or be certified.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be identification of the actions that may be taken when a determination has been made that an applicant has violated Board rules.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted; finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.28. Action Relating to Investigation.

(a) The board, having conducted an investigation under this title, may reach the following conclusions:

(1) deny an applicant the opportunity for issuance of a certificate;

(2) deny an applicant's application to take the uniform CPA examination;

(3) [~~(2)~~] prohibit an applicant from certification or from taking the uniform CPA examination for a period not to exceed five years;

(4) [~~(3)~~] issue an applicant a certificate with conditions and requirements imposed by the board; [~~or~~]

(5) void an applicant's uniform CPA examination grades; or

(6) [~~(4)~~] close the case without adverse action against an applicant.

(b) The board shall refund the issuance fee submitted by an applicant for certification if the applicant is denied the issuance of a certificate.

(c) An applicant may petition the board in writing for a reversal of the board's findings. After notice and hearing the board may:

(1) approve an application for certification that was previously denied;

(2) uphold its prior findings;

(3) overturn its prior findings; or

(4) modify its prior findings.

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

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J. Randel (Jerry) Hill
General Counsel
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For further information, please call: (512) 305-7842

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22 TAC §519.29

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.29, concerning Voluntary Surrender of Certificate.

Background, Justification and Summary

The amendment to §519.29 identifies the circumstances under which a voluntary surrender will be accepted by the Board, notices that the CPA exam is not a prerequisite to reinstatement, makes the voluntary surrender effective on the date of the agency's approval, establishes circumstances under which a reinstatement may be denied, requires a four-hour Board approved ethics course as part of the required CPE prior to reinstatement and removes the reference to "possession" of a controlled substance to clarify that conviction of abuse of a controlled substance may be a disqualifier to reinstatement.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding of the requirements associated with: 1) a voluntary surrender, 2) ethics; and 3) abuse of controlled substances.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.29. Voluntary Surrender of Certificate.

(a) A certificate holder [~~who is not under investigation by the board~~] may voluntarily surrender his certificate by submitting [~~delivering the certificate to the board along with~~] a written statement of intent to voluntarily surrender the certificate. Once a certificate holder has surrendered his certificate, he is no longer eligible to hold a license under §901.402 of the Act (relating to Eligibility Requirements; General Prohibition) and licensing exemptions will no longer apply.

(b) A former certificate holder who has voluntarily surrendered his certificate under subsection (a) of this section may apply for a new certificate upon completion [~~of the examination requirement for a new certificate. The board may waive the examination requirement for a former certificate holder upon submission~~] of the following requirements [~~to the board~~]:

(1) evidence of completion of all CPE that would have been required to be completed up to a maximum of 120 hours over the three years immediately preceding the application including a four-hour board approved ethics course;

(2) a sworn affidavit in the form provided by the board stating that the former certificate holder has not been convicted of, placed on community supervision or accepted deferred adjudication for any felony crime or for any misdemeanor crime involving dishonesty, fraud, moral turpitude, alcohol abuse or [~~possession of~~] controlled substances, or physical injury or threats of physical injury to a person under the laws of any state or the United States and that the former certificate holder did not surrender the certificate to avoid disciplinary action by the board or to avoid administrative revocation under board rules adopted pursuant to §§901.159, 901.411 or 901.502 of the Act (relating to Peer Review; Continuing Professional Education; or Grounds for Disciplinary Action); and

(3) payment of all fees that would have been paid if the former certificate holder's license had been active since the date of surrender and all applicable late fees.

(c) A new certificate issued to a former certificate holder will bear the same certificate number as the original certificate.

(d) If an individual, subject to the approval of the board, voluntarily surrenders and resigns the certificate or registration during the course of a disciplinary investigation or proceeding conducted by the board, this fact shall be disclosed in any later application for a new certificate, and shall be considered before the issuance of a new certificate.

(e) A voluntary surrender is effective on the date of this agency's approval letter or other written notification. The voluntary surrender may be disapproved when doing so is in the best interest of the public.

(f) If a certificate holder voluntarily surrenders his certificate after being charged with a crime for which he subsequently receives a conviction or deferred adjudication, or voluntarily surrenders his certificate subsequent to the filing of a civil suit alleging fraud or dishon-

esty which subsequently results in a finding by a court of fraud or dishonesty, the voluntary surrender may be set aside by the board upon a finding by the board that the criminal or civil adjudication warrants disciplinary action.

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

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
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For further information, please call: (512) 305-7842

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SUBCHAPTER C. PROCEEDINGS AT SOAH

22 TAC §519.40

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.40, concerning General Provisions.

Background, Justification and Summary

The amendment to §519.40 establishes the rate of reimbursement for a fact witness to be equivalent to state employee reimbursement and establishes a fee of $50.00 per day for a fact witness.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding of fact witness reimbursement

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.40. General Provisions.

(a) The board appoints SOAH to be its finder of fact in contested cases pursuant to §901.508 of the Act (relating to Right to Hearing). The board does not delegate to the ALJ and retains for itself the right to determine the sanctions and make the final decision in any contested case.

(b) SOAH hearings of contested cases shall be conducted in accordance with the APA by an ALJ assigned by SOAH. Jurisdiction over the case is acquired by SOAH when the board staff files a request to docket case.

(c) For administrative hearings or proceedings covered by the APA a witness called by the board is entitled to receive reimbursement from the board for meals, lodging and mileage while going to and returning from the place of the hearing or proceeding if the hearing or proceeding is more than 25 miles from the place of residence of the witness, and such reimbursement will be at the rate:

(1) provided by law for state employees if the witness uses their personally owned or leased motor vehicle to attend the hearing or proceeding;

(2) provided by law for state employees if the witness does not use their personally owned or leased motor vehicle to attend the hearing or proceeding; and

(3) for meals and lodging provided by law for state employees.

(d) The board will pay the witness a $50.00 fee for each day or portion of day the witness appears on behalf of the board at a SOAH docketed administrative hearing or related proceeding the witness attends.

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

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J. Randel (Jerry) Hill
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Texas State Board of Public Accountancy
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For further information, please call: (512) 305-7842

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SUBCHAPTER D. PROCEDURES AFTER HEARING

22 TAC §519.72

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.72, concerning Final Decisions and Orders.

Background, Justification and Summary

The amendment to §519.72 identifies the section of the rules that are referenced as disciplinary matters including the assessment of sanctions.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be a clearer understanding of which sections of the Public Accountancy Act are being referenced.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.72. Final Decisions and Orders.

(a) All final decisions and orders of the board shall be made during a public meeting duly noticed pursuant to the Chapter 551 of the Texas Government Code (relating to Open Meetings). The board's decisions and orders shall be in writing and reported in the minutes of the meeting. A final order of the board shall include findings of fact and conclusions of law, separately stated.

(b) A copy of the final decision or order of the board shall be delivered or mailed to all parties or, if represented by counsel, to their attorney of record.

(c) The board may change a finding of fact or conclusion of law made by the ALJ, or may vacate or modify an order issued by the ALJ, only if the board determines:

(1) that the ALJ did not properly apply or interpret applicable law, agency rules, written policies provided to the ALJ with a written statement of applicable rules or policies, or prior administrative decisions;

(2) that a prior administrative decision on which the ALJ relied is incorrect or should be changed; or

(3) that a technical error in a finding of fact should be changed.

(d) If the board modifies, amends, or changes the ALJ's recommended order, an order shall be prepared reflecting the board's changes and the board's specific reason and legal basis for the changes.

(e) A final order or board decision is administratively final when:

(1) there is no filing of a timely motion for rehearing, upon the expiration of 20 days from the date the final order or board decision is entered; or

(2) a timely motion for rehearing is filed and the motion for rehearing is denied by board order or operation of law.

(f) The board shall make the final decision in assessing the discipline provided for in §901.501 of the Act (relating to Disciplinary Powers of Board) and §519.41 of this chapter (relating to Disciplinary Powers of the Board) [~~in all disciplinary matters, including the assessment of sanctions~~].

(g) Interpretive comment. Section 2001.058 of the APA provides the standards that a governmental agency must follow in changing a recommendation of an ALJ of SOAH. Case law makes it clear that the standards must be strictly adhered to in order to be valid. The above language addresses the required standards.

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

Filed with the Office of the Secretary of State on September 23, 2016.

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 305-7842

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SUBCHAPTER E. POST BOARD ORDER PROCEDURES

22 TAC §519.93

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.93, concerning Publication of Disciplinary/Administrative Sanctions.

Background, Justification and Summary

The amendment to §519.93 eliminates language regarding the publication of disciplinary actions in newspapers.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding that the agency will not publish its disciplinary actions in newspapers.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.93. Publication of Disciplinary/Administrative Sanctions.
The board may publish [~~cause to be published~~] in the board's official publication, the Texas State Board Report, [~~and may publish in newspapers of general distribution in the state,~~] the name of any licensee or certificate holder who is the subject of a disciplinary or administrative action. Such publication shall not occur until a final board order has been issued. The publication may contain a narrative factual summary of the actions giving rise to the disciplinary or administrative action.

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

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
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For further information, please call: (512) 305-7842

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22 TAC §519.95

The Texas State Board of Public Accountancy (Board) proposes an amendment to §519.95, concerning Reinstatement.

Background, Justification and Summary

The amendment to §519.95 helps to clarify the reinstatement process.

Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result

of adoption of the proposed amendment will be a better understanding of the process for reinstatement.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses, therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on November 7, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

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

§519.95. Reinstatement.

(a) A person whose certificate has been revoked because of a criminal conviction may not request a reinstatement prior to having provided the board with sufficient evidence of the following [~~when the following terms have been met~~]:

(1) successful completion of all obligations to the criminal justice system; and

(2) [~~the person shall report that they have had~~] no criminal convictions, within a two-year period, beginning from the date the terms set forth in paragraph (1) of this subsection were satisfied.

(b) All requests for reinstatement must be in writing to the board.

(c) Reinstatement will be at the sole discretion of the board. [~~The request for reinstatement shall include proof that the terms set forth in subsection (a)(1) of this section have been successfully completed, with the request for reinstatement.~~]

[~~(d) Reinstatement will be at the sole discretion of the board.~~]

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

Filed with the Office of the Secretary of State on September 23, 2016.

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J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
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For further information, please call: (512) 305-7842

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The Texas Department of Insurance proposes the repeal of Title 28 TAC, Chapter 11, relating to Health Maintenance Organizations. In conjunction with this proposal, the department is proposing to replace the existing chapter with a new Title 28 TAC, Chapter 11, relating to Health Maintenance Organizations.

This repeal and new chapter are necessary to implement changes required by HB 1485 and HB 2017, 79th Legislature, Regular Session (2005); HB 1594, HB 1847, HB 1919, and SB 1731, 80th Legislature, Regular Session (2007); HB 389, HB 451, HB 806, HB 1290, HB 1357, HB 2000, HB 4290, SB 39, and SB 1771, 81st Legislature, Regular Session (2009); HB 438, HB 1405, HB 1951, HB 2292, SB 554 and SB 1431, 82nd Legislature, Regular Session (2011); SB 365 and SB 632, 83rd Legislature, Regular Session (2013); and HB 574, HB 1514, HB 1624, SB 94, SB 332, SB 481, and SB 684, 84th Legislature, Regular Session (2015).

The proposed new Chapter 11 updates provisions contained in existing Chapter 11 to clarify existing rule requirements for industry and consumers; reduces the costs of reporting, compliance, and oversight for regulated entities; provides clear direction for examination requirements; and corrects numbering, codification changes, references to statutes and rules, and grammatical errors identified during the review of the existing chapter. Definitions for terms that are not used in the rules are not included in the proposed new chapter, and advisory committees that are no longer statutorily required are not reestablished in the new chapter.

Changes made in the proposed chapter will bring the health maintenance organization (HMO) rules into alignment with the recently adopted holding company rules in 28 TAC Chapter 7, Subchapter B, and allow for modernization of filing processes including the use of electronic formats. Other changes will more closely align the handling of access plans, out-of-network claims, and disclosure requirements with those in the Preferred and Exclusive Provider Plans rules at 28 TAC §§3.3704 - 3.3711.

The department reviewed all sections of the current Chapter 11 to assess whether the reasons for initially adopting the sections continue to exist in accordance with the Texas Government Code

§2001.039. The department determined that in most, but not all, cases, the reasons for initially adopting the sections continue to exist. In those cases the department is proposing to readopt those sections with amendments. Following its review, the department determined that the reasons for adopting §§11,510, 11.706, 11.707, 11.1202 - 11.1206, 11.1301 - 11.1306, 11.2207, 11.2301 - 11.2315, and 11.2404 no longer exist, so these sections are not proposed for readoption.

The department relied on staff expertise throughout the rulemaking process, and the department also considered and incorporated stakeholder feedback on an informal draft of the rule posted on the department's website in December 2015, including comments received at a public stakeholder meeting and receipt of written stakeholder comments on the posted informal draft of rule text.

EXPLANATION. Proposed Chapter 11 is a revision of the existing Chapter 11 and is accompanied by a proposed repeal of the existing chapter. A description of significant differences between the existing sections and the proposed new sections follows.

SUBCHAPTER A. The proposed new subchapter generally updates the existing subchapter, and revises some definitions for clarity and to comply with changes in statutes or in other rules.

Section 11.1. General Provisions. The proposed new section shortens the existing section by removing unnecessary language listing specific statutes that Chapter 11 implements and stating that a violation of lawful rules or orders of the commissioner under the chapter constitutes an administrative violation. The proposed section also includes nonsubstantive changes from the existing section to conform to agency style and usage guidelines.

Section 11.2. Definitions. The proposed new section changes a general reference to terms defined in the Insurance Code to a reference to terms defined in chapters specifically applicable to Chapter 11.

Proposed §11.2:

--changes the definition of "adverse determination" to follow amendments to Insurance Code §4201.002(1) by HB 1357 and clarify that a denial of health care services due to a failure to request prospective or concurrent utilization review is not included in that definition;

--changes the definition of "affiliate" to refer to the definition of that term in 28 TAC §7.202 to simplify the department's rules and make them more consistent;

--changes the definition of "control" to refer to the definition of that term in 28 TAC §7.202 to simplify the department's rules and make them more consistent;

--adds a definition for "department";

--adds a definition for "emergency care" by referring to Insurance Code §843.002 (concerning Definitions) because the term is used in the rules and not defined in the existing rule;

--adds a definition for "facility-based physician" to track that definition in Insurance Code §1467.001 (concerning Definitions) since its amendment by SB 481;

--adds a definition of "freestanding emergency medical care facility" to follow HB 1357 amendments to Insurance Code §4201.002(1) (concerning Definitions);

--adds a definition of "insert page" to cover the use of the term in the proposed chapter;

--adds "freestanding emergency medical care facilities" to the definition of "institutional provider" to follow HB 1357 amendments to Insurance Code §4201.002(1);

--adds a definition of "Insurance Code" to refer to the Texas Insurance Code to clarify the term's use in the proposed chapter;

--adds definitions of "NAIC UCAA" and "NCQA" to cover their use in the proposed chapter;

--adds a definition of "net worth" to clarify the term's use in the proposed chapter;

--adds a definition of "preauthorization" referring to Insurance Code §843.348 (concerning Preauthorization of Health Care Services) to cover the term's use in the proposed chapter;

--changes the definition of "subsidiary" to refer to the definition of that term in 28 TAC §7.202 in the Insurance Holding Company Systems rules to simplify the department's rules and make them more consistent;

--adds a definition of "telehealth service" referring to Government Code §531.001 (concerning Definitions) to cover the term's use in the proposed chapter;

--changes the definition of "utilization review" and adds a definition of "utilization review agent or URA" to follow amendments to Insurance Code §4201.002(1) (concerning Definitions) by HB 1357;

--deletes unnecessary definitions of "pathology services," "qualified HMO," "RBC," "RBC formula," "RBC report," "reference laboratory," and "reference laboratory specimen procurement services," because these terms are not used in the proposed chapter; and

--makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER B. The proposed subchapter generally updates the existing subchapter.

Section 11.101. How to Obtain Forms. The proposed new section corrects address information in the existing section and adds a reference to the department's website. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.102. Information Required. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.104. Criteria. This section duplicates the existing section.

Section 11.105. Use of the Term "HMO," Service Marks, Trademarks, and Assumed Name. The proposed new section adds language to the existing section to make it clear that new or changed trademarks or service marks must be filed with the commissioner. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.106. Time Limits; Extension Requirements. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.107. Effect of Filing for or Receiving Certificate of Authority. The proposed new section makes nonsubstantive

changes to the existing section to conform to agency style and usage guidelines.

Section 11.108. Effect of Withdrawing Application for Certificate of Authority. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.109. Situations in Which Name Applications Will Cease. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER C. The proposed new subchapter generally clarifies and updates the existing subchapter, allows electronic filing, and revises and clarifies the process for submitting an application for a certificate of authority.

Section 11.201. Filing Fee. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.202. Binding, Indexing, and Numbering Requirements. The proposed new section updates the existing section to provide for electronic filing and allow the department and the regulated community to adopt more efficient systems. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Sections 11.203. Revisions During Review Process. The proposed new section updates the existing section to provide for electronic filing and allow the department and the regulated community to adopt more efficient systems. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.204. Contents. The proposed new section updates the existing section to provide that the contents of the application for a certificate of authority be in a specific order to aid review. The proposed section updates the existing section to:

--require the fingerprints of directors, officers, and executives, to be consistent with 28 TAC Chapter 1, Subchapter D;

--standardize requirements for financial statements and balance sheets to simplify the application and evaluation process for the department and the regulated community;

--require actuarial certification meeting the requirements of proposed §11.702;

--clarify that filed contracts, including subcontracts, must contain a hold-harmless provision and all other provisions specified in proposed §11.901;

--make it more understandable by reorganizing it;

--clarify that copies of the member handbook for Children's Health Insurance Program (CHIP) plans, as approved by the Texas Health and Human Services Commission, must be filed with the department for information;

--clarify that the requirement for network configuration information that applies to each of an HMO's physician or provider networks also applies to limited-provider networks;

--provide for more detailed information to be submitted in a more useful Excel-compatible format to make it simpler to evaluate the information provided;

--require URA names and certificate numbers in order to improve the application evaluation process;

--require documentation of claim systems and procedures; and

--make nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.205. Additional Documents to be Available for Review. The proposed new section renames and updates the existing section to simplify the applicant's provision of records by requiring that certain documents must be made available for review at the applicant's office in Texas or another location within Texas agreed to by the department. The proposed section eliminates the phrase "qualifying examination" to avoid confusion with financial examinations. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.206. Review of Application; Examination. The proposed new section changes the title and makes nonsubstantive changes to the existing section to conform the section to agency style and usage guidelines.

Section 11.207. Withdrawal of an Application. The proposed new section makes clear the distinction between an applicant withdrawing an application and the department closing it by using the word "close" instead of "withdraw" when referring to the latter. The proposed section also makes nonsubstantive changes to the existing section for brevity and conformity with agency style and usage guidelines.

SUBCHAPTER D. The proposed subchapter generally updates the existing subchapter to allow electronic filing and reorganizes and clarifies filing requirements.

Section 11.301. Filing Requirements. The proposed new section updates the existing section to allow electronic filings and filings through the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing or other methods acceptable to the department to ease the administrative burden on the department and the regulated community. The proposed section separates filings into categories to clarify what items can be filed in what formats. The proposed section provides for filings for approval (paragraph (4)) and filings for information, the latter of which may be subject to review for compliance with Texas law and consistency with other HMO documents (paragraph (5)). Filings are generally grouped by the type of filing allowed:

--electronically through the NAIC's System for Electronic Rate and Form Filing;

--on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department;

--as provided in 28 TAC §7.201; and

--as provided in 28 TAC §11.203(a).

The proposed section makes it clear that copies of the member handbook for CHIP plans approved by the Texas Health and Human Services Commission must be filed for information. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.302. Service Area Expansion or Reduction Applications. The proposed new section updates the existing section to eliminate filing requirements duplicating those already required by proposed §11.301. The proposed section also makes non-

substantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.303. Examination. The proposed new section revises the existing section to update the list of applicable statutes and changes a reference to the old Article 1.15, recodified as Insurance Code Chapter 401 (Concerning Audits and Examinations) by HB 2017, 79th Legislature, Regular Session (2005). The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER F. The proposed new subchapter generally updates the existing subchapter to allow electronic filing and reorganizes some sections; clarifies filing requirements; incorporates requirements for consumer choice health benefit plan agreements in anticipation of simplification in future rulemaking of the consumer choice health benefit plan rule in 28 TAC §§21.3515 - 21.3518, and the repeal of some of those provisions; and clarifies that emergency transport is a basic health care service.

Section 11.501. Contents of the Evidence of Coverage. Rather than maintaining the title of the existing section, "Forms Which Must be Approved Prior to Use," the title of the proposed new section is proposed as the more appropriate "Contents of the Evidence of Coverage." The schedule of benefits has been added to the contents list for clarity and for consistency with the proposed §11.506. The proposed section changes the existing section to make filing fees consistent with those required in 28 TAC §7.1301. The proposed section also makes nonsubstantive changes to the existing section to conform the section to agency style and usage guidelines.

Section 11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority. Rather than readopt the title of the existing section, "Filing Requirements for Evidence of Coverage," the title of new §11.502 is proposed as the more appropriate "Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority" to more clearly distinguish it from proposed §11.503. The proposed section makes it clear that the filing and formatting requirements of proposed §11.301(1)(B) and (2)(A) apply to these filings. The proposed section requires an applicant to file a clean, final version of the evidence of coverage after approval of a certificate of authority, along with a "redline" version showing the changes to the original. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.503. Filing Requirements for Evidence of Coverage after Receipt of Certificate of Authority. The proposed new section makes it clear that an evidence of coverage filing may be withdrawn. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.504. Disapproval of an Evidence of Coverage. The proposed new section makes it clear that a violation of applicable law or regulations is grounds for disapproval of an evidence of coverage, and drops a time limit on the scheduling of hearings in favor of a reference to Insurance Code §1271.102 (concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval) which sets that time limit. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.505. Specifications for Evidence of Coverage Including Insert Pages and Matrix Filings. The proposed new section updates the section title and simplifies and revises the existing section to eliminate formatting requirements in favor of proposed §11.301, which governs form formatting in general. The proposed section makes it clear that changeable language must be accompanied by an explanation of how and under what circumstances the information will vary, and clarifies the current practice on insert pages. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate. The proposed new section alters existing §11.506 to make it clear that an HMO may deliver an evidence of coverage to an enrollee electronically, but must provide a paper copy on request. The proposed section adds a requirement that the website address of the HMO appear on the face page of the evidence of coverage, and reiterates that the HMO must provide the notices required by proposed §11.1610 and §11.1611. The proposed section updates provisions from existing §11.506 to reflect legislative action since 2007. Proposed §11.506 does not include the provision in the existing section allowing cancellation "for failure of the enrollee and a plan physician to establish a satisfactory patient-physician relationship," because termination should be at the option of the enrollee, and no current statute provides for this as a basis for a carrier to terminate coverage. Proposed §11.506 does not include provisions no longer needed in light of the recent amendments to 28 TAC Chapter 21, Subchapter SS. Proposed §11.506 also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.507. Additional Mandatory Contractual Provisions: Conversion and Individual Agreements. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.508. Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements. The proposed new section changes existing §11.508 by making it clear that emergency transport is a basic health care service. The proposed section also makes it clear that coverage of the cost of whole blood is also a basic health care service. The department estimates that emergency transport is currently covered by all applicable plans, and that this provision should have little or no economic impact. The proposed section also makes nonsubstantive changes to the existing section to shorten it and conform to agency style and usage guidelines.

Section 11.509. Additional Mandatory Benefit Standards: Individual and Group Agreements. The proposed new section reorganizes and retitles the existing section to show requirements for agreements in general and for group agreements. The proposed section has been shortened from the existing section, without substantively changing the department's review standards, by removing requirements concerning Insurance Code Chapters 1355, 1360, 1361, and 1368 and replacing them with a more general requirement concerning Insurance Code Title 8, Subtitle E (concerning Benefits Payable Under Health Coverages), which contains those and other applicable chapters. The proposed section incorporates requirements for consumer choice health benefit plan agreements in anticipation of simplification of the consumer choice health benefit plan rules in 28 TAC §§21.3515 - 21.3518, and the possible repeal of some of

those provisions. The proposed section also makes nonsubstantive changes to the existing section to shorten it and conform to agency style and usage guidelines.

Section 11.510. Mandatory Offers. The proposal does not readopt §11.510 because the removal of requirements concerning Insurance Code Chapters 1355, 1360, 1361, and 1368, replacing them with a reference to Insurance Code Title 8, Subtitle E, (concerning Benefits Payable Under Health Coverages) in proposed §11.509 makes current §11.510 unnecessary.

Section 11.511. Optional Provisions. The proposed new section changes the existing section to reflect statutory changes by: allowing coordination of benefits subject to the requirements of Insurance Code Chapter 1203 (concerning Coordination of Benefits Provisions) and 28 TAC Chapter 3, Subchapter V; allowing subrogation subject to and limited by the provisions of Civil Practice and Remedies Code Chapter 140 (concerning Contractual Subrogation Rights of Payors of Certain Benefits); and eliminating a reference to the former Texas Health Insurance Risk Pool. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.512. Optional Benefits. The proposed new section updates the existing section to reflect amendments by HB 4290 to Insurance Code Chapter 4201; amendments by HB 1847 to Insurance Code §1701.061 (concerning Noninsurance Benefits); and the department's adoption of 28 TAC Chapter 21, Subchapter NN. The proposed section drops "whole blood and blood plasma, except as required by §11.508 of this title" from the list of optional benefits because they are required as basic health care services under proposed §11.508(a)(2). Proposed §11.512 also drops ambulance services from the list of optional benefits because of the addition of emergency transport to the emergency services required as a basic health care service in proposed §11.508(a)(1)(J). The proposed section also makes nonsubstantive changes to the existing section to shorten it and conform to agency style and usage guidelines.

SUBCHAPTER G. The proposed new subchapter generally updates the existing subchapter.

Section 11.602. HMOs Subject to Insurance Code Chapters 541, 542, and 547, and Related Rules. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.603. Filings. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER H. The proposed new subchapter generally updates the existing subchapter, shortens the subchapter by eliminating redundant provisions, and simplifies and more closely aligns requirements with those now contained in 28 TAC Chapter 7.

Section 11.701. Schedule of Charges Must be Filed Before Use. The proposed new section updates the section title and eliminates some existing requirements for filings, which are replaced by more detailed requirements laid out in the proposed new §11.703, and removes the requirement that each filing must be accompanied by the HMO reconciliation of benefits to schedule of charges form. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.702. Actuarial Certification. The proposed new section changes existing §11.702 by providing that an actuary is considered qualified to render an actuarial certification by reason of membership in both the American Academy of Actuaries and the Society of Actuaries. Membership in the Society is required for membership in the Academy, as are actual experience qualifications. Proposed §11.702 conforms to the definition of a qualified actuary used by the NAIC. The proposed section adds the phrase "in good standing" to make it clear that lapsed or terminated membership does not constitute a qualification. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.703. Filings and Supporting Documentation. The proposed new section refines the section title and clarifies existing §11.701 and §11.703 to make requirements more transparent to the regulated community by requiring a more detailed actuarial memorandum in support of initial rates and rate increases. This includes a description and source of each actuarial assumption; a listing of retention components; the target loss ratio; a description of the experience used in developing the initial rates; and for rate adjustments, the actual experience supporting the revised rates. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.704. Conversion Rates. The proposed new section updates the section title and changes the existing section by deleting the phrase "group community rate," because it is no longer relevant. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.705 Enrollment Fees. The proposal does not include current §11.705 for readoption because the section is no longer relevant.

Section 11.706. Determination of Reasonability of Rates. The proposal does not include current §11.706 for readoption because it is no longer relevant because it is largely duplicative of the procedures in 28 TAC Chapter 7, which is applicable to evaluate accounting matters.

Section 11.707. Subsequent Review of the Formula or Method for Calculating the Schedule of Charges. The proposal does not include current §11.707 for readoption because it is no longer relevant and it is no longer permissible for an HMO to simply file an annual certification that its rates are compliant.

SUBCHAPTER I. The proposed new subchapter reorganizes and renumbers the existing subchapter. Existing §11.807 is not proposed for readoption because the subject it addresses is now regulated under Insurance Code Chapter 823 (concerning Insurance Holding Company Systems). The other sections in Subchapter I are renumbered as proposed for readoption. The proposed subchapter simplifies requirements to more closely align them with those in 28 TAC Chapter 7.

Section 11.801. Accounting Guidance. The proposed new section updates the section title and requires HMOs to follow the accounting guidance given in 28 TAC §7.18.

Section 11.802. Minimum Net Worth. The proposed new section simplifies some asset requirements in existing §11.801, which are replaced by references to Insurance Code §843.403 (concerning Minimum Net Worth), and does not include for readoption a now-duplicative reference to that section. The proposed

section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.803. Statutory Deposit Requirements. The title of proposed new §11.803 comes from existing §11.802, and the section simplifies some of the asset requirements in existing §11.802, which are replaced by reference to Insurance Code §843.405 (concerning Deposit with Comptroller). Proposed §11.803 updates provisions from the existing section to conform to changes to the rules in 28 TAC Chapter 7 and to forms adopted in 28 TAC Chapter 13. Proposed §11.803 simplifies filings and review of financial statements by the department and the regulated community by allowing certain filings with the NAIC and the Securities Exchange Commission to substitute for filings with the department. Proposed §11.803 also allows the investment of assets supporting uncovered medical expenses with a waiver from the commissioner, and allows the payment of interest on statutory deposit funds to HMOs. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.804. Invested Assets. The title of proposed new §11.804 reflects its content, which differs from current §11.804. This proposed section refers to provisions on the investment of assets supporting uncovered medical expenses outlined in proposed §11.803. Proposed §11.804 generally restates the provisions of existing §11.803(1), (2), (4), (5), and (6). Proposed §11.804 also provides for the valuation of assets in compliance with proposed §11.801, or at a fair value; provides for the demonstration of ownership of securities by complying with 28 TAC §7.86; provides that 28 TAC §7.4 applies to investments not specifically allowed under the proposed Subchapter I; and provides that the commissioner may order the sale of an investment under certain conditions. Proposed §11.804 also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.805. Other Assets. The proposed new section generally restates the provisions of existing §11.803(3) regarding assets an HMO may generate in its operations, and makes nonsubstantive changes to the existing subsection to shorten it and conform to agency style and usage guidelines.

Section 11.806. Investment Management by Affiliate Companies. The proposed new section is renamed, and generally restates the provisions of the existing §11.804. The proposed section adds Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) to the list of statutes mentioned in the existing section. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.807. Fiduciary Responsibility. Proposed new §11.807 is proposed with a title different from that of existing §11.807, and the proposed section generally restates the provisions of existing §11.805. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.808. Liabilities. The proposed new section generally readopts the provisions of the existing §11.806, though it shortens the section by referring to proposed §11.801 rather than separately describing liabilities that must be disclosed. The proposed section adds Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) to the list of statutes taken from existing §11.806. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.810. Guarantee from a Sponsoring Organization. The proposed new section incorporates the name and generally restates the provisions of the existing §11.808. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.811. Action under Insurance Code §843.157 and Insurance Code §843.461. Proposed new §11.811 generally restates the provisions of existing §11.810 relating to action under Insurance Code §843.157 (concerning Rehabilitation, Liquidation, Supervision, or Conservation of Health Maintenance Organizations) and Insurance Code §843.461 (concerning Enforcement Actions), and shortens the existing section by eliminating a list of conditions relating to hazardous condition in favor of a reference to 28 TAC §8.3. The proposed section is also proposed with a title that accurately reflects its content. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER J. The proposed subchapter generally updates the existing subchapter in light of recent legislative action.

Section 11.900. Nonprimary Care Physician Specialist as Primary Care Physician. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.901. Required and Prohibited Provisions. The proposed new section is reorganized with the aim of making it easier to follow than existing §11.901. The proposed section changes the existing section to comply with the enactment of Insurance Code §843.3115 (concerning Contracts with Dentists) by SB 554, and proposes a new title of the section to include an express reference to prohibited provisions." The proposed section changes the existing §11.901 to clarify that requirements for contracts apply to subcontracts as well. The proposed section also changes the existing §11.901 by correcting the mailing and website addresses from which notices may be obtained and adding the department's web address. To accommodate present and future changes in coding systems, the proposed §11.901 adds ICD-10-CM and successor codes to items to be listed on the fee schedule. The proposed section does not include the statement that a failure to comply with a paragraph of the proposed section is a violation of Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs. The statement is superfluous, and does not affect whether or not an action is a violation of 28 TAC Chapter 11, Insurance Code Chapter 843, or any other law. The proposed section changes the existing section to provide that the processes contained in Insurance Code §843.306 (concerning Termination of Participation; Advisory Review Panel) and §843.307 (concerning Expedited Review Process on Termination or Deselection) must be followed. The proposed section makes changes to the existing section to implement the addition of Insurance Code §1451.156 by SB 684. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.902. Prohibited Actions. The proposed new section changes the existing section to comply with the amendments made to Insurance Code §843.3115 (concerning Contracts with Dentists) by SB 554 and to Insurance Code §1451.156 by SB 684. The proposed section makes nonsubstantive changes to

the existing section to conform to agency style and usage guidelines.

Section 11.903. Physician or Provider Communication. The proposed new section changes the existing section to comply with the amendments made to Insurance Code §1301.067 (concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited) by HB 574, and to provide that the exclusions from the advisory review panel process prescribed in Insurance Code §843.306(b) (concerning Termination of Participation; Advisory Review Panel) apply to the section as well. The proposed section also makes nonsubstantive changes to the existing §11.903 to conform to agency style and usage guidelines.

Section 11.904. Provision of Services Related to Immunizations and Vaccinations. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER K. The proposed new subchapter generally updates the existing subchapter in light of recent legislative action.

Section 11.1001. Required Forms. The proposed new section changes the existing section to include the department's web address, revise form names, and update references to forms. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER M. Most of the existing subchapter (§§11.1202 - 11.1206) is not proposed for readoption because the material covered in the subchapter is now regulated under Insurance Code Chapter 823, (concerning Insurance Holding Company Systems) and Insurance Code Chapter 824 (concerning Merger and Consolidation of Stock Insurance Corporations). The name of the proposed subchapter is changed from the name of the current section to conform to agency style and usage guidelines.

Section 11.1201. Acquisition, Control, or Merger of a Domestic HMO. The proposed name of the new section is changed from the name of the current section to conform to agency style and usage guidelines. The proposed section provides that an HMO is subject to the requirements of Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) and Insurance Code Chapter 824 (concerning Merger and Consolidation of Stock Insurance Corporations), and 28 TAC Chapter 7.

SUBCHAPTER N. The existing subchapter is not proposed for readoption because of the repeal of Insurance Code §§843.435 - 843.440 by HB 1951, which removed the statutory basis of the solvency surveillance committee, the subject of the subchapter.

SUBCHAPTER O. The proposed new subchapter generally updates the existing subchapter in light of recent legislative action.

Section 11.1401. Commissioner's Authority to Require Additional Information. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1402. Notification to Physicians and Providers. The proposed new section changes existing §11.1402 to lengthen the filing period for published notices from 15 days to 30 days because Insurance Code §843.305 (concerning Annual Application Period for Physicians and Providers to Contract) does not require the shorter time period contained in the existing section. Allowing additional time to make the filing will prevent violations that are sometimes beyond the HMO's control. The proposed section changes existing §11.1402 to allow publication of the notice on a website and provide a method for proof of that publication because Insurance Code §843.305 does not require publication in a newspaper, and the existing HMO practice of recruiting via websites appears to be effective. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers. The proposed new section changes the existing section to eliminate the one-time requirement in existing §11.1403 to provide notice "in their next available newsletter," while retaining the notice to new subscribers because existing enrollees have already received the notice. The proposed section also makes nonsubstantive changes to the existing section and figure to conform to agency style and usage guidelines.

Section 11.1404. Pharmacy Application and Recertification. The proposed new section includes changes from the existing section to comply with the fee prohibition in Insurance Code §1369.402 (concerning Certain Fees Prohibited), added by SB 94, and makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER P. The proposed new subchapter generally updates the existing subchapter.

Section 11.1500. Discrimination Based on Health Status-Related Factors. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER Q. The proposed new subchapter generally updates the existing subchapter, and more closely aligns the handling of access plans, out-of-network claims, and disclosure requirements with those in the Preferred and Exclusive Provider Plans rules at 28 TAC §§3.3704 - 3.3711.

Section 11.1600. Information to Prospective and Current Contract Holders and Enrollees. The proposed new section updates the existing section by adding provisions to comply with amendments made to Insurance Code §843.201 (concerning Disclosure of Information About Health Care Plan Terms) and Insurance Code Chapter 1456 (concerning Disclosure of Provider Status) to require more detailed information; to require that the information be listed on the HMO's website, as required by proposed §11.1600 and Insurance Code §843.2015 (concerning Information Available Through Internet Site); and to require the provision of a paper copy of the required information on request. The section also includes new language in proposed §11.1600 (b)(14) to require that additional explanatory information be provided to consumers in the context of point-of-service coverage added to an HMO plan. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1601. Enrollee Identification Cards. The proposed new section updates the existing section by updating statutory references in the section; adding language to comply with Insurance Code §1693.002 (concerning Required Information), added by HB 1514; and making nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1602. Enrollment Form and Access to Certain Information. The proposed new section includes a title different

from that of existing §11.1602, permits electronic delivery of the member handbook, and requires that a paper copy be provided on request. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1603. Notification of Change in Payment Arrangements. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1604. Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs. The proposed new section no longer includes references to no longer applicable Texas Health Care Council standards and reporting requirements. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1605. Pharmaceutical Services. The proposed new section updates existing §11.1605 by removing references to §11.1605 (c) - (e), which refer to requirements in Insurance Code Chapter 1369 (concerning Benefits Related to Prescription Drugs and Devices and Related Services). Chapter 1369 applies regardless of the section or subsections. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1606. Organization of an HMO. The proposed new section updates existing §11.1606 to require that clinical directors be full-time employees and to set out credentialing requirements. The amendments also make nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1607. Accessibility and Availability Requirements. The proposed new section updates and reorganizes existing §11.1607, and includes references to proposed §11.1610 and §11.1611. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1610. Annual Network Adequacy Report. The proposed new section requires annual network adequacy reports and specifies their contents. The proposed new section also provides for enforcement under Insurance Code Chapter 82 and Insurance Code Chapter 83. This will promote consistency in health plan regulation by aligning the requirements for network adequacy and access plans more closely with those required in the Preferred and Exclusive Provider Plans rules in 28 TAC §3.3709 and §3.3710.

Section 11.1611. Out-of-Network Claims; Non-Network Physicians and Providers. The proposed new section promotes consistency in health plan regulation by aligning the handling of out-of-network claims more closely with the requirements in 28 TAC §3.3708. Since Insurance Code §1271.155 (concerning Emergency Care), existing §11.204(20) (proposed to be readopted as §11.204(21)), and existing §11.506(14) (proposed to be readopted as §11.506(14)) already provide for payment at the negotiated or usual and customary rate, and since HMOs are required to hold their enrollees harmless for these charges, the impact on actual practice should be minimal.

Section 11.1612. Mandatory Disclosure Requirements. The proposed new section incorporates the HB 1624 requirements of Insurance Code Chapter 1451, Subchapter K, (concerning Health Care Provider Directories) and adds additional required disclosures for the benefit of consumers. The proposed new section promotes consistency in health plan regulation by aligning disclosure requirements more closely with those in 28 TAC §3.3705.

SUBCHAPTER R. The proposed new subchapter generally updates the existing subchapter to allow electronic provision of the member handbook.

Section 11.1702. Requirements for Issuance of Certificate of Authority to an ANHC. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority. The proposed new section updates the existing section to permit electronic delivery of the member handbook and requires that a paper copy be provided on request. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER S. The majority of the existing subchapter (§§11.1802(b) and 11.1803 - 11.1805) is deleted because the material is now regulated under Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) and 28 TAC Chapter 7.

Section 11.1801. Entities Covered. The proposed new section changes the existing section by removing material now regulated under Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) and 28 TAC Chapter 7. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1806. Additional Information that May be Requested from an MCO Participating in Medicaid. The proposed new section changes existing §11.1806 by requiring the filing of financial projections with an application for a service area expansion, and requiring that information be filed with the department's financial analysis section in the financial regulation division. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER T. The proposed new subchapter makes changes to the existing to clarify that single service HMOs are subject to quality improvement requirements, and updates provisions from the existing subchapter to conform to amendments made to Insurance Code Chapter 1452 (concerning Physician and Provider Credentials) by HB 1594 and HB 389.

Section 11.1901. Quality Improvement Structure for Basic, Single Service, and Limited Service HMOs. The proposed new section changes the existing section by adding single service HMOs, to consolidate requirements for all HMOs in proposed §11.1901 and §11.902, instead of having a separate section for single service HMOs. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.1902. Quality Improvement Program for Basic, Single Service, and Limited Service HMOs. The proposed new section changes the existing section by adding single service HMOs, to consolidate requirements for all HMOs in proposed §11.1901 and §11.1902 instead of having a separate section for single service HMOs. The proposed section is updated from the exist-

ing section to conform to amendments made to Insurance Code Chapter 1452 (concerning Physician and Provider Credentials) by HB 1594 and HB 389. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER V. The proposed new subchapter generally updates the existing subchapter.

Section 11.2101. Community Health Maintenance Organization (CHMO). The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2102. General Provisions. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2103. Requirements for Issuance of Certificate of Authority to a CHMO. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2104. Minimum Standards for Community Health Centers. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER W. The proposed new subchapter generally updates the existing subchapter.

Section 11.2200. Definitions. The proposed new section updates the existing section to add hospitals, freestanding emergency clinics, and urgent care clinics to the definition of "comparable facility," since enrollees may use these facilities under Insurance Code Chapter 843. The proposed section changes the existing section to make updating the rules simpler in the future by referring to the definition of "qualified actuary" in proposed §11.702 instead of repeating the definition. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2201. General Provisions. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2202. Limitations and Exclusions. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2203. Minimum Standards - Dental Care Services and Benefits. The proposed new section updates the existing section to add a requirement for certification of codes referenced in the evidence of coverage areas specified in the existing version of the Current Dental Terminology. The proposed section updates the existing section to allow the treatment of dental pain in a comparable facility and to allow evidences of coverage to provide the provision of secondary dental care services and benefits. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2204. Minimum Standards - Vision Care Services and Benefits. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2205. Prohibited Practices. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2206. Mandatory Disclosure Statements; Certification of Compliance. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2207. Quality Improvement Structure and Program for Single Service HMOs. Existing §11.2207 is not readopted, and instead of having a separate section for single service HMOs. The requirements for all HMOs are consolidated in proposed §11.1901 and §11.1902.

Section 11.2208. Single Service Accessibility and Availability. The existing section is shortened to simply require compliance with proposed §11.1607 rather than list requirements separately. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER X. No entity has been regulated under existing Subchapter X in more than a dozen years. The department has therefore concluded that there is no need for a separate certificate of authority for provider sponsored organizations, and the subchapter is not proposed for readoption.

SUBCHAPTER Y. The proposed new subchapter generally updates the existing subchapter.

Section 11.2401. Definitions. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2402. General Provisions. The proposed new section updates the existing section by adding a requirement for a limited service HMO to develop and maintain an ongoing quality improvement structure and program that complies with proposed Subchapter T. The proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2403. Prohibited Practices. The proposed new section is renamed and includes the provisions of existing §11.2403, because both sections prohibit certain conduct. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2404. Prohibited Practices. Section 11.2404 is included in the new proposed §11.2403, and is therefore not proposed for readoption.

Section 11.2405. Minimum Standards - Mental Health and Chemical Dependency Services and Benefits. The proposed section updates the existing section by adding a requirement for a limited service HMO to comply with 28 TAC Chapter 21, Subchapter P, and also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2406. Minimum Standards - Long Term Care Services and Benefits. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER Z. The proposed subchapter generally updates the existing subchapter.

Section 11.2501. Definitions. The new proposed section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2502. Issuance of Point-of-Service Riders. The proposed new section updates the existing section by eliminating separate requirements for point-of-service riders in

favor of shorter requirements making an HMO that issues a point-of-service rider subject to the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and 28 TAC §7.402. Similarly, the proposed section updates the existing section by eliminating separate requirements for point-of-service riders in favor of shorter requirements that an HMO must comply with all state and federal laws and rules applicable to termination, cancellation, and renewability of a point-of-service rider plan. The proposed section also makes nonsubstantive changes to existing §11.2502 to conform to agency style and usage guidelines.

Section 11.2503. Coverage Relating to Point-of-Service Rider Plans. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

SUBCHAPTER AA. The proposed new subchapter generally updates the existing subchapter.

Section 11.2601. General Provisions. The proposed new section updates the existing section by not including unnecessary purpose and severability clauses, and it now incorporates the applicability provision of existing §11.2612, which is proposed to be readopted. The proposed section also makes nonsubstantive changes to existing §11.2601 to conform to agency style and usage guidelines.

Section 11.2602. Definitions. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2603. Requirements for Delegation by HMOs. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2605. Delegation Agreements- Information to be Provided by HMO to Delegated Entity. The proposed section new makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2606. Reporting Requirements. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2607. Examinations of Delegated Entities. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2608. Department May Order Corrective Action. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2609. Reserve Requirements for Delegated Networks. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2610. Penalties for Noncompliance. The proposed new section makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

Section 11.2611. Filing of Delegation Agreements. The proposed new section updates the existing section by providing for filings under proposed §11.307, and by requiring every agreement to include as an attachment a completed Delegated Entity Data form. The proposed section also makes nonsubstantive changes to the existing section to conform to agency style and usage guidelines.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Debra Diaz-Lara, director, Managed Care Quality Assurance Office, has determined that for each year of the first five years the proposed new sections are in effect, there will be no fiscal impact on state or local governments as a result of enforcing or administering the sections, other than that imposed by the statute. There will not be any measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. Ms. Diaz-Lara has also determined that for each year of the first five years the proposed new sections are in effect, there are several public benefits anticipated because of the enforcement and administration of the proposal, as well as potential costs for persons required to comply with the proposal. The department drafted the proposed rules to maximize public benefits consistent with the intent of the authorizing statutes while mitigating costs.

ANTICIPATED PUBLIC BENEFITS. The public benefit anticipated as a result of administration and enforcement of repeal of the existing chapter and adoption of the proposed chapter will be:

(i) implementation of changes required by HB 1485 and HB 2017, 79th Legislature, Regular Session (2005); HB 1594, HB 1847, HB 1919, and SB 1731, 80th Legislature, Regular Session (2007); HB 389, HB 451, HB 806, HB 1290, HB 1357, HB 2000, HB 4290, SB 39, and SB 1771, 81st Legislature, Regular Session (2009); HB 438, HB 1405, HB 1951, HB 2292, SB 554 and SB 1431, 82nd Legislature, Regular Session (2011); SB 365 and SB 632, 83rd Legislature, Regular Session (2013); and HB 574, HB 1514, HB 1624, SB 94, SB 332, SB 481, and SB 684, 84th Legislature, Regular Session (2015);

(ii) clarification of existing rule requirements for industry and consumers;

(iii) reduction in the costs of reporting, compliance, and oversight for regulated entities;

(iv) provision of clear direction for examination requirements;

(v) correction of numbering, codification, and grammatical errors;

(vi) removal of definitions for terms that are not used in the rules;

(vii) deletion of advisory committees from the rules that are no longer statutorily required;

(viii) increased alignment of the HMO rules with the recently adopted holding company rules in 28 TAC Chapter 7, Subchapter B;

(ix) simplifying regulation by repealing provisions duplicative of or at odds with 28 TAC Chapter 7;

(x) simplifying regulation and the conduct of business by regulated entities by more closely aligning the HMO rules with the Preferred and Exclusive Provider Plans in 28 TAC Subchapter X, §§3.3704 - 3.3711; and

(xi) providing for electronic filing.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL. The department anticipates that there will be probable costs to persons required to comply with changes from the existing chapter to the proposed new chapter during each year of the first five years that the rules will be in effect. The department has

identified a number of requirements of the proposal that may result in compliance costs for entities subject to new §§11.204, 11.301, 11.302, 11.501, 11.508, 11.902, 11.1600, 11.1606, 11.1611, 11.1612, and 11.2611.

Repetitive Cost Note Information.

There are cost components and analyses used throughout this cost note numerous times. For purposes of readability and brevity, the department included under this part of the cost note the detail for these repetitive cost components and analyses. The cost note has been prepared in accordance with the requirements in Government Code §2001.024(a)(5) and Government Code Chapter 2006.

(i) Staff wages. The number of hours that will be required to comply with a particular proposed requirement will vary, and as a result, any total cost, as well as other possible relevant factors, is addressed in the cost note discussion for the individual proposed requirement. The department's analysis of the cost for staff wages to perform required compliance tasks is based on the following factors, figures for which are available from the Labor Market and Career Information Development Department of the Texas Workforce Commission at the addresses below.

(I) A general operations manager working in Texas earns a median hourly wage of approximately $61.99, according to: www.texaswages.com/socDetails.aspx?soc=11-1021.

(II) An administrative assistant working in Texas earns a median hourly wage of approximately $15.76, according to: www.texaswages.com/socDetails.aspx?soc=43-6014.

(III) A computer programmer working in Texas earns a median hourly wage of $41.66, according to: www.texaswages.com/socDetails.aspx?soc=15-1131.

(IV) An attorney working in Texas earns a median hourly wage of approximately $68.98, according to: www.texaswages.com/socDetails.aspx?soc=23-1011.

(V) A medical director working in Texas earns a median hourly wage of approximately $94.91, according to: www.texaswages.com/socDetails.aspx?soc=29-1069.

(VI) A registered nurse working in Texas earns a median hourly wage of approximately $33.60, according to: www.texaswages.com/socDetails.aspx?soc=29-1141.

(VII) A desktop publisher working in Texas earns a median hourly wage of approximately $17.25, according to: www.texaswages.com/socDetails.aspx?soc=43-9031.

(VIII) A paralegal working in Texas earns a median hourly wage of approximately $25.57, according to: www.texaswages.com/socDetails.aspx?soc=23-2011.

(ii) Printing costs. The department's analysis of standard printing and paper costs in this cost note is based on several factors. The department estimates that the cost of printing could range from approximately 6 cents to 8 cents per page for printing and paper. The department anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including the number of pages that will need to be printed, and whether in-house printing costs or out-of-house printing costs will be incurred. The printing costs may vary or be slightly higher if in-house printing is not used, or both.

(iii) Mailing costs. The department's analysis of standard mailing costs in this cost note is based on several factors. According to the U. S. Postal Service business price calculator, available at: www.dbcalc.usps.gov, the cost for "bulk" mailing to mail machinable letters in the AADC category in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP code in the United States is 29 cents. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the 29-cent cost; this estimate is based on six pages of standard 20-lb printing paper, which weighs one ounce. The department determined that the cost of a standard business envelope is 2 cents. Accordingly, for each additional mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than 31 cents. For first-class mailings, the current cost of a first class stamp is 47 cents, and the metered cost for a first class letter is 46.5 cents for the first ounce, and 21 cents for each additional ounce. The department anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including the number of mailings and the number of pages to be mailed.

Estimated Costs for Entities Subject to the Proposed Chapter. The following proposed provisions may result in compliance costs for entities subject to the proposed chapter:

Section 11.204. Contents. The department anticipates that there will be a minimal increase in administrative costs to regulated entities to comply with changes from the existing §11.204 to the proposed new §11.204 for including additional documents in the application for certificate of authority, some of which previously only had to be available on request. This slight increase in cost is offset by allowing electronic filing and by a corresponding decrease in cost expected by limiting some filings by affiliates. The department anticipates that the total estimated cost could vary based on the cost of general operations manager wages; cost of administrative assistant wages; and cost to mail and print new policies, procedures, and additional paperwork.

(i) Cost of general operations manager wages. The department anticipates that a regulated entity's general operations manager will review filings. Adding additional, already prepared documents to a filing would likely require less than an hour of review time.

(ii) Cost of administrative assistant wages. The department anticipates that a regulated entity's administrative assistant will make copies of additional documents for filing. The department anticipates that these required tasks will take less than one hour.

(iii) Cost to mail additional paperwork. The department anticipates that a regulated entity might incur a cost for mailing additional documents, if it elects not to submit them electronically. That cost should not be more than $1 per document.

Section 11.301. Filing Requirements. The department anticipates that changes from the existing §11.301 to the proposed new §11.301 regarding network configuration include access plans which may result in additional costs to the regulated entities. The proposal requires member handbooks to be filed for approval rather than for information. This will result in minimal compliance cost increase, in line with the costs estimated for new §11.204 addressed previously. Currently, informational filings have a filing fee of $50, while filings submitted for approval have a filing fee of $100. Again, these costs should be offset to some extent by allowing electronic filing of many documents.

Section 11.302. Service Area Expansion or Reduction Applications. The department anticipates that changes from the existing §11.302 to the proposed new §11.302 may result in additional

costs to the regulated entities that expand or reduce an existing service area or add a new service area. These documents are required only if the service area expansion or reduction changes the current network configuration. The associated expansion or reduction costs would be dependent on each plan's marketing plans. It is not feasible for the department to estimate the total increased costs attributable to compliance resulting from differences between the proposed rule and the existing rule because there are numerous factors involved that are not suited to reliable quantification, including the size of the insurer's service area, the extent of changes to that plan, the effect of those changes on network configuration, and the marketing plan of regulated entities. The department anticipates that the total estimated cost could vary based on the following cost components: (i) general operations manager wages; (ii) computer programmer wages; (iii) administrative assistant wages; (iv) staff attorney wages; (v) medical director wages; (vi) registered nurse wages; (vii) desktop publisher wages; (viii) administrative assistant wages; and (ix) cost to mail and print new policies, procedures, and additional paperwork. The department estimates that each regulated entity has the information necessary to determine the time required for each, and thus the individual costs necessary to meet the requirements of the proposed rule.

Section 11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority. The department anticipates that changes from the existing §11.502 to the proposed new §11.502 may result in minimal cost increase to the applicant due to a change in filing requirements for certificate of authority applications. Once licensed, an HMO will now file a final version of the evidence of coverage with revisions, and a copy of the original version of the evidence of coverage showing the new or revised text as "redlined." The cost of this filing should be minimal, because of the existing requirement that an applicant must submit each new page or form reflecting any revisions and because the department anticipates that each applicant already keeps clean and "redlined" versions of the evidence of coverage. The department anticipates that the total estimated cost could vary based on the cost of general operations manager wages; cost of administrative assistant wages; and cost to mail and print new policies, procedures, and additional paperwork.

(i) Cost of general operations manager wages. The department anticipates that a regulated entity's general operations manager will review filings. Adding additional, already prepared documents to a filing would likely require less than an hour of review time.

(ii) Cost of administrative assistant wages. The department anticipates that a regulated entity's administrative assistant will make copies of additional documents for filing. The department anticipates that these required tasks will take less than two hours.

(iii) Cost to mail additional paperwork. The department anticipates that a regulated entity might incur a cost for mailing additional documents, if it elects not to submit them electronically. That cost should not be more than $5 per document.

Section 11.508. Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements. The department anticipates that changes from the existing §11.508 to the proposed new §11.508 may increase costs as a result of the following additions to the list of basic health care services: whole blood, including cost of blood, blood plasma, and blood plasma expanders, that is not replaced by or for the enrollee; and emergency transport. The department cannot realistically estimate costs of blood because they will be variable, based on the number of enrollees that access the services, the geographic location, the services accessed, the number of units an enrollee receives, and whether all or some of those units are replaced by the enrollee. The department can only state that the cost will vary depending on those factors.

Similarly, the department cannot precisely estimate increased costs for emergency transport. The cost of compliance will depend on a number of factors, which will be known or subject to estimation by the HMO, including the insurer's current rate of reimbursement of claims and how often such claims occur. HMOs may reduce this expense by working to increase their networks or by ceasing to market in areas where they are unable to contract for complete networks. Should it be required, the department anticipates that a simple amendment of all explanations of benefits issued by the HMO would require two to 10 hours of work by a computer programmer. More specific programming would potentially require additional time. The department estimates that any additional costs resulting from the proposed rule will be largely mitigated by the fact that HMOs appear to already cover these costs and the existing statutory requirement that HMOs hold their enrollees harmless from balance billing associated with these out-of-network claims, which the department believes will generally result in payments at or near a usual or customary rate.

Section 11.902. Prohibited Actions. Costs of complying with differences between the proposed new §11.902 and the existing §11.902 regarding assistant surgeons, advanced practice nurses, optometrists, and therapeutic optometrists are necessary to comply with statutory changes, not the proposed rule. The department anticipates that there may be an increase in cost associated with the addition of the prohibition regarding arranging or providing for care through groups not included in Insurance Code §843.101 (concerning Providing or Arranging for Care). However, since §843.101 already contains this prohibition, there should not be any additional costs as a result of the rule clarification.

Section 11.1600. Information to Prospective and Current Contract Holders and Enrollees. The department anticipates that changes from the existing §11.1600 to the proposed new §11.1600 may result in little or no compliance cost increases due to changes in filing requirements for written plan descriptions. The proposal requires member handbooks to be filed for approval rather than for information. Currently, informational filings have a filing fee of $50, while filings submitted for approval have a filing fee of $100. Changes in the proposed rule concerning point-of-service arrangements and formulary information involve information that already must be reported. Other differences in proposed new §11.1600 to comply with Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan) result from the statute rather than the rule, including disclosure of hospital-based providers and website maintenance. Again, allowing for electronic submissions should lower costs for regulated entities.

To the extent that proposed new §11.1600 may require additional information to be furnished, the department anticipates that an HMO may incur a cost to comply with the proposed rule based on the cost of administrative staff to draft the information. The department anticipates that an HMO could incur cost for drafting of the annual report access plan. The department anticipates that an HMO is likely to have either an administrative assistant, a general operations manager, or a combination of both, draft

the information. The department anticipates that it could take approximately 10 to 15 hours to draft the required information. The department anticipates that this cost will vary for each HMO depending on the formulary and point-of-service information involved, and whether an administrative assistant, a general operations manager, or a combination of both, perform the tasks. The department further anticipates that each HMO has the information necessary to determine its estimated total annual cost to comply with the proposed rule based on these factors and any other factors that the HMO is aware of that will impact the HMO's total annual cost to comply.

Section 11.1606. Organization of an HMO. The department anticipates that changes from the existing §11.1606 to the proposed new §11.1606 may result in additional costs to the HMO. The proposed clarification in this section (the requirement for the clinical director be employed full time) prohibits an applicant from using a clinical director in another state to fill in the gaps created by a part-time clinical director. Physician services at the median wage statewide are $192,744, according to the Texas Workforce Commission website. Depending on the number of hours required of a part-time clinical director versus full time clinical director, the increased cost for a full-time clinical director located in Texas could be $96,372 per year. The credentialing requirements by NCQA or American Accreditation HealthCare Commission, Inc., may also have cost implications if an HMO is not already accredited. Several of the accreditation programs are priced based on tiers, ranging from 0 to 99,000 covered lives at $64,900, to 100,000 to 250,000 covered lives at $104,900, to 250,000 to 499,999 covered lives at $158,900. The $104,900 figure would appear to be a reasonable estimate, since accredited health plans typically average around 200,000 covered lives.

Section 11.1610. Annual Network Adequacy Report. The department anticipates that an HMO may incur a cost to comply with the proposed new §11.1610 based upon the cost of administrative staff to draft the annual adequacy report, including network data and the access plan, and the cost of programming for necessary reports and increased requirements for complaint tracking.

(i) Cost of administrative staff to draft the annual network adequacy report, including local market access plan. The department anticipates that an HMO could incur cost for drafting of the annual report access plan. The department anticipates that an HMO is likely to opt to have either an administrative assistant or a general operations manager, or a combination of both, draft the requisite reports. The department anticipates that it could take from approximately 10 to 15 hours annually to draft the required annual report and an additional 20 to 40 hours annually to draft any required local market access plan. The department anticipates that this annual cost will vary for each HMO depending on the size of the HMO's service area, the adequacy of its network, the number of specific inadequacies identified in its network, and whether the tasks are performed by an administrative assistant, a general operations manager, or a combination of both.

(ii) Cost of programming for necessary reports and increased requirements for complaint tracking. The department anticipates that an insurer could incur a one-time cost for programming its systems to be able to produce required data to be included in the annual network adequacy and any necessary access plan reports. The department anticipates that a programmer could require from 10 to 100 hours for the requisite programming. The department anticipates that an HMO's total one-time cost for the requisite programming will vary for each HMO depending upon the number of hours of programming that is needed and whether the HMO uses a company staff programmer or a contract programmer.

The department further anticipates that each HMO has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the HMO is aware of that will impact the HMO total annual cost to comply.

Section 11.1611. Out-of-Network Claims; Non-Network Physicians and Providers. The department anticipates that changes from the existing §11.1611 to the proposed new §11.1611 might result in additional costs to the HMO for the handling of out-of-network claims by aligning requirements to those in the Preferred and Exclusive Provider Plans rules in 28 TAC §3.3708. The cost of compliance with these requirements will depend on a number of factors, which will be known or subject to estimation by the HMO, including the insurer's current rate of reimbursement of claims, and how often such claims occur. HMOs may reduce this expense by working to increase their networks or by ceasing to market in areas where they are unable to contract for complete networks. Should it be required, the department anticipates that a simple amendment of all explanations of benefits issued by the HMO would require two to 10 hours work by a computer programmer. More specific programming would potentially require additional time. The department estimates that any additional costs resulting from the proposed rule will be largely mitigated by savings from consistency in operations occasioned by aligning payment processes; the existing statutory requirement that HMOs hold their enrollees harmless from balance billing associated with these out-of-network claims, which the department believes will generally result in payments at or near a usual or customary rate; and the fact that existing §11.204(20) (proposed as new 11.204(21)) and existing §11.506(14) (proposed as new §11.506(14)) already provide for payment at the negotiated or usual and customary rate.

The department further anticipates that each HMO has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the HMO is aware of that will impact the HMO total annual cost to comply.

Section 11.1612. Mandatory Disclosure Requirements. The department anticipates that the proposed changes in new §11.1612 with respect to compliance with the mandatory notice and disclosure requirements may result in minimal cost increase to HMOs. These costs result from compliance with Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), and with Insurance Code Chapter 1451, Subchapter K, (concerning Health Care Provider Directories), added by HB 1624, rather than with the rule.

Section 11.2611. Filing of Delegation Agreements. The department anticipates that an HMO may incur a cost to comply with proposed new §11.2611 based on the number of delegation agreements filed and the cost of administrative staff to fill out the required form. The department anticipates that an HMO is likely to opt to have either an administrative assistant, a general operations manager, or a combination of both, draft the requisite reports. The department anticipates that it could take approximately one hour to do so. The department further anticipates that each HMO has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the HMO is aware of that will impact the HMO total annual cost to comply.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Analysis of Economic Impact

In accordance with Government Code §2006.002(c), the department determined that a few sections in the proposal may have an adverse economic impact on HMOs that qualify as small or micro businesses under Government Code §2006.001(1) and (2) and that must comply with the proposed rules. The department does not have information relating to the number of HMOs that qualify as a small or micro business under Government Code §2006.001(1) and (2), but believes that, less than 10 and possibly no HMOs, may qualify as a small business if they are still in the first year or two of their start-up phase. The department estimates that there are no HMOs that qualify as a micro business.

Regulatory Flexibility Analysis

The cost of compliance with these rules will not vary between large businesses and small or micro businesses. TDI's cost analysis of these requirements, which can be found in the Public Benefit/Cost Note section of this proposal, applies equally to small or micro business.

Under Government Code §2006.002(c), before adopting a rule that may have an adverse economic effect on small or micro businesses, an agency must prepare a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the proposed rule. For each of the proposed sections, the department considered other regulatory methods that accomplish the objectives of the proposal, minimize any adverse economic impact on HMOs that qualify as small or micro businesses under Government Code §2006.001(1) and (2), but still protect the health, safety, and environmental and economic welfare of the state.

Estimated Costs

The following provisions may result in compliance costs for HMOs subject to Chapter 11 of department rules:

Estimated Costs: HMOs

Sections 11.204 (Contents of Application); 11.301 (Filing Requirement Subsequent to Issuance of Certificate of Authority); 11.302 (Service Area Expansion or Reduction Applications); 11.502 (Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority); 11.508 (Basic Health Care Services and Mandatory Benefit Standards); 11.902 (Prohibited Actions); 11.1600 (Information to Prospective and Current Contract Holders and Enrollees); 11.1606 (Organization of an HMO); 11.1610 (Annual Network Adequacy Report); 11.1611 (Out-of-Network Claims; Non-Network Physicians and Providers); and 11.1612 (Mandatory Disclosure Requirements). The proposed differences between these proposed sections and the existing sections add new filing and disclosure requirements to the HMO application process. The department considered, as regulatory alternatives: (i) exempting small and micro business HMOs from the non-statutory requirements under the proposed sections; (ii) adopting different standards based on the size of the business; and (iii) establishing different compliance or reporting requirements for small entities.

The department determined that none of these alternatives would accomplish the objectives of the regulations; nor would they be consistent with the health, safety, and environmental and economic welfare of the state, for the following reasons: (i) the alternatives are inconsistent with legislative intent, (ii) the alternatives could result in some consumers receiving fewer health care services, and (iii) the requirements will have minimal economic impact.

In addition, the department determined that the costs for small and micro businesses to comply with the proposed sections are nominal. The adverse impact that would result for Texas consumers of small and micro business HMOs exempted from the nonstatutory requirements under these proposed sections outweigh any economic impact on small and micro business HMOs.

(i) The alternative options are inconsistent with legislative intent. The amendments and clarifications embodied in the proposed new sections are intended, in large part, to implement changes required by HB 1485 and HB 2017, 79th Legislature, Regular Session (2005); HB 1594, HB 1847, HB 1919, and SB 1731, 80th Legislature, Regular Session (2007); HB 389, HB 451, HB 806, HB 1290, HB 1357, HB 2000, HB 4290, SB 39, and SB 1771, 81st Legislature, Regular Session (2009); HB 438, HB 1405, HB 1951, HB 2292, SB 554 and SB 1431, 82nd Legislature, Regular Session (2011); SB 365 and SB 632, 83rd Legislature, Regular Session (2013); and HB 574, HB 1514, HB 1624, SB 94, SB 332, SB 481, and SB 684, 84th Legislature, Regular Session (2015). They are also intended to ensure adequacy, consistency, and uniformity of care delivered by HMOs and their affiliated entities. In establishing these standards the Legislature specified which entities they would apply to, and the Legislature did not exclude any entities based on size.

Exempting small or micro business HMOs from the non-statutory requirements of the proposed sections, adopting different standards based on the size of the business, or establishing different compliance or reporting requirements for small entities would compromise the department's ability to ensure the integrity of the HMO system in Texas. Any of these alternatives would hamper the department's effort to request and review all necessary documents to ensure that enrollees receive adequate health care services. The exemption would result in nonuniform screening criteria and review procedures that would not support the legislative goal of establishing consistent standards for all HMOs, and consistent treatment of enrollees, regardless of size.

(ii) The alternative options could result in compromising the integrity of the HMO system of delivering health care services and some consumers may receive less health care services if an exemption is granted. Provisions like requiring all applicants to follow the same application process and submit the same information in the form and manner required by the commissioner under the proposed sections for application for certificate of authority; updates to application materials after the issuance of a certificate of authority; application for approval before an HMO expands, reduces, or adds a new service area; consistent treatment of enrollees; consistent policies for coverage, provision and payment for services; and disclosure requirements regarding evidences of coverage and rights under an HMO plan are necessary to protect the integrity of the HMO system and the health and economic welfare of consumers. Absent these requirements, the department's ability to properly scrutinize, license, and oversee HMOs would be diminished. This diminished scrutiny, licensing, and oversight could lead to inconsistent standards for approval or denial of health care services depending on the size of HMO a person is covered by or inconsistent procedures available for consumers to appeal those standards of review.

For example, the differences between the proposed new and the existing §11.204 require all applicants to provide complaint and appeal procedures, templates of letters, and logs, including the

complaint log which must categorize each complaint as specified under this section of the rule. The proposal also requires the HMO applicant for certificate of authority to furnish information on documentation of claim systems and procedures that demonstrates the HMO's ability to pay claims timely and comply with applicable claim payment statutes and rules. A newly formed HMO business applying for a certificate of authority is required to provide a balance sheet reflecting the HMO's initial funding. All applicants are required to submit their projected financial information statements using the NAIC Uniform Certificate of Authority Application (UCAA) ProForma Financial Statements for Healthcare Companies. All applicants are also required to provide network configuration information including lists of credentialed and contracted facilities, physicians, and providers in an Excel-compatible format.

Exempting small and micro business HMOs from these requirements, adopting different standards based on the size of the business, or establishing different compliance or reporting requirements for small entities could result in consumers of these small and micro business HMOs (1) failing to receive the same health care services because of differing standards for approval or denial of health care services, (2) not having available remedies after receiving an adverse determination, or (3) not having the requisite information to pursue remedies after receiving an adverse determination. Additionally, the uniform submission of evaluation information to the department for a certificate of authority using NAIC forms and provider lists in an Excel-compatible format as an HMO under §11.204 promotes uniformity, consistency, and confidence in the department's decisions.

Adopting these types of requirements to apply to all HMOs, regardless of size, will result in consistent application of screening criteria and review procedures. This consistent application will, in turn, ensure that all consumers, including those that use small and micro business HMOs, have the requisite information to obtain necessary services. Requiring all HMOs, regardless of size, to follow the application requirements eliminates the possibility that the department would have to create a dual tracking system for obtaining a certificate of authority based on HMO business size.

(iii) The requirements will have a minimal economic impact which the alternative options are unlikely to change. While compliance with the application requirements in the proposed sections may have an adverse economic impact on small or micro business HMOs, the department anticipates that the adverse economic impact will be minimal. The department anticipates that only a minimal amount of additional time and work will be required to satisfy the amended application process because the application documents, even with the additional new requirements, will be substantially similar to the existing application that small and micro business HMOs must currently submit. This similarity will reduce the time and effort needed to prepare and submit an application.

Additional costs will be minimal because the HMO will already have some of the information available that the department requires under each of the referenced sections. For example, under §11.204, applicants must submit basic business organizational documents, and NAIC UCAA biographic data forms for all persons who are to be responsible for the day-to-day conduct of the applicant's affairs in the state. This document may include the original certificate of incorporation and bylaws. The applicant HMO should already have this required evidence because it would be subject at the time of formation to existing Texas statutory business formation requirements and fees.

Another example involves proposed new §11.301, which requires HMOs to file for approval, updates and amendments to the following documents after the issuance of certificate of authority: (1) member handbook; (2) any material change in network configuration; (3) the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care to the HMO's enrollees; (4) insurance contracts or amendments, guarantees, or other protection against insolvency; and (5) modification to any type of affiliate compensation arrangement. Under the current rules, HMOs filed these documents for information only. Informational filings have a filing fee of $50 while filings submitted for approval have a filing fee of $100. While compliance with the proposed filing requirements in §11.301 may have an adverse economic impact on small or micro business HMOs, the department anticipates that the required compliance will have a minimal adverse economic impact. The department anticipates that the added cost of filing the documents for approval, as opposed to filing for information only, is $50 per filing. This amount is minimal and no additional time and work will be required for completing the filing for approval as opposed to doing so for informational filing only.

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

REQUEST FOR PUBLIC COMMENT. The department invites the public and affected persons to comment on this proposal. Submit your written comments on the proposal no later than 5:00 p.m., Central Time, on November 7, 2016. Send written comments by mail to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov. You must simultaneously submit an additional copy of the comments by mail to Debra Diaz-Lara, Director, Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to MCQA@tdi.texas.gov. The commissioner will consider the repeal of the current 28 TAC Chapter 11 and the adoption of the proposed new 28 TAC Chapter 11 in a public hearing under Docket Number 2790 scheduled for 9:30 a.m., Central Time, on November 2, 2016, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The department will consider all written comments and public testimony presented at the hearing.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §11.1, §11.2

STATUTORY AUTHORITY. The repeals are proposed under Health and Safety Code §62.054; Insurance Code §§36.001, 38.001, 401.056, 404.005, 423.004, 423.104, 441.005, 541.401, 823.002, 823.012, 843.009(f), 843.051(g), 843.076, 843.080(a) and (b), 843.082, 843.102, 843.112, 843.151, 843.154, 843.2015, 843.251(b), 843.404, 843.406(b), 844.004, 1271.004(a) and (d), 1271.151, 1271.152, 1271.306(c), 1271.307(c), 1272.001, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055,

1367.105, 1367.154, 1367.207, 1368.007, 1369.0543, 1369.057, 1451.254, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1467.001, 1467.003, 1501.002, 1501.010, 1507.002, 1507.009, 1507.059, 4201.002, 4201.003, and 4201.057(d); and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001. Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §823.012 provides, in relevant part, that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.009(f) provides that the commissioner adopt rules, consistent with the section, relating to applications under the section and consideration of those applications that the commissioner considers advisable.

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system, and administer matters relating to the complaint system.

Insurance Code §843.404 provides that the commissioner may adopt rules, or by rule establish guidelines, requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMO's investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §1271.004(a) defines "Individual Health Care Plan."

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

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital; and provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.057 provides that the commissioner may adopt rules necessary to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1467.001 provides definitions for use in Insurance Code Chapter 1467, including a definition of "facility-based physician."

Insurance Code §1467.003 provides that the commissioner, the Texas Medical Board, and the chief administrative law judge adopt rules necessary to implement their respective powers and duties under Chapter 1467.

Insurance Code §1501.002 provides definitions for terms used in Insurance Code Chapter 1501.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to: (1) implement Chapter 1501; and (2) meet the minimum requirements of federal law, including regulations.

Insurance Code §1507.002 provides definitions for terms used in Insurance Code Chapter 1507.

Insurance Code §1507.009 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter A.

Insurance Code §1507.059 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter B.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

Insurance Code §4201.057(d) provides that the commissioner adopt rules for appropriate verification and enforcement of compliance with §4201.057(c).

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE. Section 11.1 implements Insurance Code §§36.001, 401.056, 404.005, 441.005, 541.401, 823.012, 843.009(f), 843.051(g) 843.076, 843.080(a), 843.082(1)(B) and (C), 843.102, 843.112, 843.151, 843.2015, 843.251, 843.404, 843.406, 844.004, 1271.004(d), 1271.151, 1271.152, 1271.306(c), 1271.307, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, 1369.0543, 1369.057, 1451.254, 1452.052, 1453.003, 1467.003, 1501.010, 1507.009, 1507.059, 4201.003, and 4201.057(d).

Section 11.2 implements Insurance Code §§823.002, 843.002, 1271.004(a), 1272.001, 1452.001, 1452.101, 1452.151, 1452.201, 1467.001, 1501.002, 1507.002, and 4201.002; and Occupations Code §162.001.

§11.1. Purpose.

§11.2. Definitions.

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

Filed with the Office of the Secretary of State on September 21, 2016.

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Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 676-6584

28 TAC §11.1, §11.2

STATUTORY AUTHORITY. The new sections are proposed under Health and Safety Code §62.054; Insurance Code §§36.001, 38.001, 401.056, 404.005, 423.004, 423.104, 441.005, 541.401, 823.002, 823.012, 843.002, 843.009(f), 843.051(g), 843.076, 843.080(a) and (b), 843.082, 843.102, 843.112, 843.151, 843.154, 843.2015, 843.251(b), 843.404, 843.406(b), 844.004, 1271.004(a) and (d), 1271.151, 1271.152, 1271.306(c), 1271.307(c), 1272.001, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, 1368.007, 1369.0543, 1369.057, 1451.254, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1467.001, 1467.003, 1501.002, 1501.010, 1507.002, 1507.009, 1507.059, §4201.002, 4201.003, and 4201.057(d), and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001. Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §823.012 provides, in relevant part, that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.009(f) provides that the commissioner adopt rules, consistent with the section, relating to applications under the section and consideration of those applications that the commissioner considers advisable.

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §1271.004(a) defines "Individual Health Care Plan."

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

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.057 provides that the commissioner may adopt rules necessary to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the

issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1467.001 provides definitions for use in Insurance Code Chapter 1467, including a definition of "facility-based physician."

Insurance Code §1467.003 provides that the commissioner, the Texas Medical Board, and the chief administrative law judge adopt rules necessary to implement their respective powers and duties under Chapter 1467.

Insurance Code §1501.002 provides definitions for terms used in Insurance Code Chapter 1501.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to: (1) implement Chapter 1501; and (2) meet the minimum requirements of federal law, including regulations.

Insurance Code §1507.002 provides definitions for terms used in Insurance Code Chapter 1507.

Insurance Code §1507.009 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter A.

Insurance Code §1507.059 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter B.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

Insurance Code §4201.057(d) provides that the commissioner adopt rules for appropriate verification and enforcement of compliance with §4201.057(c).

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE.

Section 11.1 implements Insurance Code §§36.001, 401.056, 404.005, 441.005, 541.401, 823.012, 843.009(f), 843.051(g) 843.076, 843.080(a), 843.082(1)(B) and (C), 843.102, 843.112, 843.151, 843.2015, 843.251, 843.404, 843.406, 844.004, 1271.004(d), 1271.151, 1271.152, 1271.306(c), 1271.307, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, 1369.0543, 1369.057, 1451.254, 1452.052, 1453.003, 1467.003, 1501.010, 1507.009, 1507.059, 4201.003, and 4201.057(d).

Section 11.2 implements Insurance Code §§823.002, 843.002, 1271.004(a), 1272.001, 1452.001, 1452.101, 1452.151, 1452.201, 1467.001, 1501.002, 1507.002, and 4201.002, and Occupations Code §162.001.

§11.1. General Provisions.

(a) Severability. If a court of competent jurisdiction holds that any provision of this chapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this chapter that can be given effect without the invalid provision or application. To this end, all provisions of this chapter are severable.

(b) Effect of rules. The sections in this chapter are prescribed to govern the performance of appropriate statutory and regulatory functions and are not to be construed as limitations on the exercise of statutory authority by the commissioner of insurance.

§11.2. Definitions.

(a) Except as otherwise provided, words and terms defined in Insurance Code Chapters 823 (concerning Insurance Holding Company Systems), 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), 1272 (concerning Delegation of Certain Functions of Health Maintenance Organizations), 1367 (concerning Coverage of Children), 1452 (concerning Physician and Provider Credentials), 1501 (concerning Health Insurance Portability and Availability Act), and 1507 (concerning Consumer Choice of Benefits Plans) have the same meanings when used in this subchapter.

(b) The following words and terms, when used in this chapter, have the meaning indicated below unless the context clearly indicates otherwise:

(1) Admitted assets--Assets as defined by statutory accounting principles, as permitted and valued under Chapter 11, Subchapter I, of this title (relating to Financial Requirements).

(2) Adverse determination--A determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(3) Affiliate--A person defined as an affiliate in §7.202 of this title (relating to Definitions).

(4) Agent--A person licensed under the Insurance Code to act as an agent for the sale of a health benefit plan.

(5) ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under Occupations Code §162.001 (concerning Certification by Board) and defined in Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

(6) Basic health care service--A health care service that an enrolled population might reasonably require to maintain good health, as prescribed in §11.508 and §11.509 of this title (relating to Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements; and relating to Additional Mandatory Benefit Standards: Individual and Group Agreements).

(7) Clinical director--A health professional who is:

(A) appropriately licensed and credentialed in compliance with §11.1606 of this title (relating to Organization of an HMO);

(B) an employee of, or party to a contract with, an HMO; and

(C) responsible for clinical oversight of the utilization review program, the credentialing of professional staff, and quality improvement functions.

(8) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Chapter 1507 and described in Chapter 21, Subchapter AA, of this title (relating to Consumer Choice Health Benefit Plans).

(9) Contract holder--An individual, association, employer, trust, or organization to which an individual or group contract for health care services has been issued.

(10) Control--As defined in §7.202 of this title.

(11) Copayment--A charge, which may be expressed in terms of a dollar amount or a percentage of the contracted rate, in addition to premium attributed to an enrollee for a service that is not fully prepaid.

(12) Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

(13) Dentist--An individual provider licensed to practice dentistry by the Texas State Board of Dental Examiners.

(14) Department--Texas Department of Insurance.

(15) Emergency care--As defined in Insurance Code §843.002 (concerning Definitions).

(16) Facility-based physician--A radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(17) Freestanding emergency medical care facility--A facility, licensed under Health and Safety Code Chapter 254 (concerning Freestanding Emergency Medical Care Facilities), structurally separate and distinct from a hospital, that receives an individual and provides emergency care as defined in Insurance Code §843.002.

(18) General hospital--An establishment, licensed under Health and Safety Code Chapter 241 (concerning Hospitals), that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

(19) HMO--A health maintenance organization as defined in Insurance Code §843.002.

(20) Health status-related factor--Any of the following in relation to an individual:

(A) health status;

(B) medical condition (including both physical and mental illnesses);

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability (including conditions arising out of acts of domestic violence, including family violence as defined by Insurance Code Chapter 544, Subchapter D (concerning Family Violence); or

(H) disability.

(21) Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. This includes, but is not limited to, licensed doctors of chiropractic, dentists, registered nurses, advanced practice nurses, physician assistants, pharmacists, optometrists, and acupuncturists.

(22) Insert page--A page used to replace an existing page of a previously approved or reviewed evidence of coverage or written plan description, including a member handbook.

(23) Institutional provider--A provider that is not an individual, such as any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage that may be provided by the HMO. This includes, but is not limited to:

(A) general hospitals;

(B) psychiatric hospitals;

(C) specialty hospitals;

(D) nursing homes;

(E) skilled nursing facilities;

(F) home health agencies;

(G) rehabilitation facilities;

(H) dialysis centers;

(I) free-standing surgical centers;

(J) diagnostic imaging centers;

(K) laboratories;

(L) hospice facilities;

(M) residential treatment centers;

(N) community mental health centers;

(O) pharmacies; and

(P) freestanding emergency medical care facilities.

(24) Insurance Code--The Texas Insurance Code.

(25) Limited provider network--A subnetwork within an HMO delivery network in which contractual relationships between physicians, certain providers, independent physician associations, physician groups, or any combination thereof, limit enrollees' access to only the physicians and providers in the subnetwork.

(26) Limited service HMO--An HMO that has been issued a certificate of authority to issue a limited health care service plan as defined in Insurance Code §843.002.

(27) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, which allows an HMO the flexibility to create multiple evidences of coverage by using combinations of approved individual provisions.

(28) NAIC--The National Association of Insurance Commissioners.

(29) NAIC UCAA--The National Association of Insurance Commissioners' Uniform Certificate of Authority Application.

(30) NCQA--The National Committee for Quality Assurance.

(31) Net worth--The amount by which total admitted assets exceed total liabilities, excluding liability for subordinated debt issued in compliance with Insurance Code Chapter 427 (concerning Subordinated Indebtedness).

(32) Out of area benefits or services--Benefits or services that an HMO covers when enrollees are outside the geographical limits of the HMO service area.

(33) Pharmaceutical services--Services, including dispensing prescription drugs, under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569 (concerning Pharmacy and Pharmacists), that are ordinarily and customarily rendered by a pharmacy or pharmacist.

(34) Pharmacist--An individual provider licensed to practice pharmacy under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569.

(35) Pharmacy--A facility licensed under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569.

(36) Preauthorization--As defined in Insurance Code §843.348(a) (concerning Preauthorization of Health Care Services).

(37) Premium--All amounts payable by a contract holder as a condition of receiving coverage from a carrier, including any fees or other contributions associated with a health benefit plan.

(38) Primary care physician or primary care provider--A physician or individual provider who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(39) Primary HMO--An HMO that contracts directly with, and issues an evidence of coverage to, individuals or organizations to arrange for or provide a basic, limited, or single health care service plan to enrollees on a prepaid basis.

(40) Provider HMO--An HMO that contracts directly with a primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within the primary HMO's defined service area.

(41) Psychiatric hospital--A licensed hospital that offers inpatient services, including treatment, facilities, and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment, psychiatric diagnostic services, psychiatric inpatient care, and treatment for mental illness. The services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults, children, or both.

(42) QI or quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(43) Recredentialing--The periodic process by which:

(A) qualifications of physicians and providers are reassessed;

(B) performance indicators, including utilization and quality indicators, are evaluated; and

(C) continued eligibility to provide services is determined.

(44) Schedule of charges--Specific rates or premiums to be charged for enrollee and dependent coverages.

(45) Service area--A geographic area within which direct service benefits are available and accessible to HMO enrollees who live, reside, or work within that geographic area and that complies with §11.1606 of this title.

(46) Single service HMO--An HMO that has been issued a certificate of authority to issue a single health care service plan as defined in Insurance Code §843.002.

(47) Specialty hospital--A licensed establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;

(B) has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;

(C) has a medical staff in regular attendance; and

(D) maintains records of the clinical work performed for each patient.

(48) Specialists--Physicians or individual providers who set themselves apart from the primary care physician or primary care provider through specialized training and education in a health care discipline.

(49) State-mandated health benefit plan--An accident or sickness insurance policy or evidence of coverage that provides state-mandated health benefits as defined in §21.3502 of this title (relating to Definitions).

(50) Subscriber--For conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO. For group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

(51) Subsidiary--As defined in §7.202 of this title.

(52) Telehealth service--As defined in Government Code §531.001 (concerning Definitions).

(53) Telemedicine medical service--As defined in Government Code §531.001.

(54) Urgent care--Health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable time would result in serious deterioration of the condition of his or her health.

(55) Utilization review--As defined in Insurance Code §4201.002 (concerning Definitions).

(56) Utilization review agent or URA--As defined in Insurance Code §4201.002.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 676-6584

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SUBCHAPTER B. NAME APPLICATION PROCEDURE

28 TAC §§11.101, 11.102, 11.104 - 11.109

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 541.401, 843.071, 843.076, 843.078, 843.080(a), 843.083, 843.151, and 843.154.

Insurance Code §32.041 provides that the department must furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §843.071 provides: (a) that a person may not organize or operate an HMO in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an HMO, without obtaining a certificate of authority under Chapter 843; and (b) that a person may not use "HMO" or "HMO" in the course of operation unless the person: (1) complies with Chapter 843 and: (A) §1367.053; (B) Chapter 1452, Subchapter A; (C) Chapter 1507, Subchapter B; (D) Chapters 222, 251, and 258, as applicable to an HMO; and (E) Chapters 1271 and 1272; and (2) holds a certificate of authority under Chapter 843.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

CROSS REFERENCE TO STATUTE.

Section 11.101 implements Insurance Code §32.041.

Section 11.102 implements Insurance Code §541.059 and §843.154.

Sections 11.104, 11.105 and 11.107 implement Insurance Code §843.071.

Section 11.106 implements Insurance Code §843.078.

Section 11.108 implements Insurance Code §843.080(a) and §843.083.

Section 11.109 implements Insurance Code §843.083.

§11.101. How To Obtain Forms.

§11.102. Information Required.

§11.104. Criteria.

§11.105. Use of the Term "HMO," Service Mark, Trademarks, d/b/a.

§11.106. Time Limits; Extension Requirements.

§11.107. Effect of Filing for or Receiving Certificate of Authority.

§11.108. Effect of Withdrawing Application for Certificate of Authority.

§11.109. Situations in Which Name Applications Will Cease.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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28 TAC §§11.101, 11.102, 11.104 - 11.109

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 541.401, 843.071, 843.076, 843.078, 843.078, 843.080(a), 843.083, 843.151, and 843.154.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §843.071 provides: (a) that a person may not organize or operate an HMO in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an HMO, without obtaining a certificate of authority under Chapter 843; and (b) that a person may not use "HMO" or "HMO" in the course of operation unless the person: (1) complies with Chapter 843 and: (A) §1367.053; (B) Chapter 1452, Subchapter A; (C) Chapter 1507, Subchapter B; (D) Chapters 222, 251, and 258, as applicable to an HMO; and (E) Chapters 1271 and 1272; and (2) holds a certificate of authority under Chapter 843.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

CROSS REFERENCE TO STATUTE.

Section 11.101 implements Insurance Code §32.041.

Section 11.102 implements Insurance Code §541.059 and §843.154.

Section 11.104, §11.105 and §11.107 implement Insurance Code §843.071.

Sections 11.106 implements Insurance Code §843.078.

Sections 11.108 implements Insurance Code §843.080(a) and §843.083.

Sections 11.109 implements Insurance Code §843.083.

§11.101. How to Obtain Forms.

A name application form and other HMO forms may be obtained by contacting the Company Licensing and Registration Office, Mail Code 103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or from the department's website at www.tdi.texas.gov.

§11.102. Information Required.

The name application form may be submitted with or at any time before submitting the application for certificate of authority, together with a $100 filing fee.

(1) The name, address, and title or relationship to the proposed HMO of each organizer must be shown on the name application form, along with the same information about any affiliated organization.

(2) An organization applying for a certificate of authority as an HMO or an existing HMO is prohibited from using the following words in its name, contracts, or literature: "insurance," "casualty," "surety," or "mutual."

(3) A name application form may be accepted by the commissioner before the proposed HMO's basic organizational document is filed with the Texas secretary of state. Applicants must use the same exact name when filing with the commissioner and the secretary of state.

(4) A certificate of authority will not be granted until the name has been accepted.

§11.104. Criteria.

The commissioner will review requests for reservation of names in the manner provided for the review of corporate names under Chapter 7, Subchapter G, of this title (relating to Review of Corporate Names).

§11.105. Use of the Term "HMO," Service Marks, Trademarks, and Assumed Name.

(a) While in the process of planning or development, the term "HMO" may be used as a part of the proposed HMO's name as long as the developmental status of the proposed HMO is made clear in all dealings with employers, individuals, prospective contract holders, news media, and others.

(b) A trademark, service mark, or assumed name must be filed with and approved by the commissioner before use.

(c) After the commissioner issues a certificate of authority, the HMO must use the name as it appears on the certificate of authority on all advertising and forms distributed to the public.

(d) After the commissioner issues a certificate of authority, the HMO must file any new trademark or service mark, or any changes to an existing trademark or service mark, with the commissioner.

§11.106. Time Limits; Extension Requirements.

Names reserved for use by a proposed HMO are subject to the following time limits and extension requirements:

(1) A requested name is reserved for 365 days from the date the name is accepted by the commissioner.

(2) Before the end of this 365-day period, a proposed HMO that has not submitted an application for a certificate of authority may request that the name reservation be extended for an additional 365 days by submitting the following:

(A) a letter of request for extension; and

(B) a statement explaining the current status of the proposed HMO and the estimated date on which an application for a certificate of authority will be filed.

(3) Extension requests may not be submitted more than 30 days before the end of the 365-day period for which the name is reserved.

(4) If the information detailed in paragraph (2) of this section is not received before the expiration of 365 days, then the name reservation expires and the proposed HMO must wait 30 days before filing a new name application form.

(5) If the extension request is received before the expiration of 365 days and if the statement of status sufficiently explains why the proposed HMO has not yet filed an application for a certificate of authority, then the name reservation may be extended for another 365 days.

(6) The requirements of paragraph (2) of this section must be met every 365 days until an application for certificate of authority is filed, or the extension expires and the proposed HMO must wait 30 days before filing a new name application form.

§11.107. Effect of Filing for or Receiving Certificate of Authority.

Once a proposed HMO has filed an application for a certificate of authority, the name application no longer must be extended. If the commissioner denies a certificate of authority, then the name application is canceled on the date the denial order becomes final. If a certificate of authority is granted, then the name is reserved for use by the HMO as long as the certificate of authority is in effect.

§11.108. Effect of Withdrawing Application for Certificate of Authority.

If an application is filed and then withdrawn or delayed at the request of a proposed HMO, then at the time of the withdrawal or request for delay, the proposed HMO must request that the name continue to be reserved and estimate the date on which the application will be refiled. If a 365-day name application period expires during the withdrawal period, then the requirements of §11.106(2) of this title (relating to Time Limits; Extension Requirements) must be met in order for the name application to be continued.

§11.109. Situations in Which Name Applications Will Cease.

A name will cease to be reserved when:

(1) a proposed HMO fails to request extension before the end of a 365-day name application period;

(2) the commissioner denies an application for a certificate of authority; or

(3) the commissioner revokes or cancels a certificate of authority.

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

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Norma Garcia
General Counsel
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SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

28 TAC §§11.201 - 11.207

STATUTORY AUTHORITY. The repeals are proposed under Health and Safety Code §62.054; Insurance Code §§32.041, 36.001, 38.001, 401.056, 801.056, 802.056, 803.003, 804.102, 843.002, 843.006, 843.076, 843.078, 843.079, 843.080(a) and (b), 843.082, 843.083, 843.102, 843.105, 843.151, 843.154, 843.201, 843.205, 843.251, 843.361, 843.402, 843.404,

1271.155, 1271.251, 1272.052, 4201.152 - 4201.154; and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.006 provides that, in general, each application, filing, and report required under Insurance Code Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapter 222, 251, or 258, as applicable to an HMO; or Chapter 1271 or 1272 is a public document.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable quality of care standards that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.402 provides for an HMO to maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least $100,000 or another amount prescribed by the commissioner, prescribes the form of the bond, and provides for the substitution of a cash deposit with the comptroller in lieu of a bond.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated; and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §4201.152 provides that a utilization review agent must conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Insurance Code §4201.153 provides that a utilization review agent must use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. The section provides requirements for utilization review determinations and screening criteria. The section further provides for the use of screening criteria and for the referral of a denial of requested treatment to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Insurance Code §4201.154 provides that a utilization review agent's written screening criteria and review procedures be made available for review and inspection to determine appropriateness and compliance as considered necessary by the commissioner and copying as necessary for the commissioner to accomplish the commissioner's duties under the Insurance Code.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE.

Section 11.201 implements Insurance Code §843.154.

Section 11.202 implements Insurance Code §843.006.

Section 11.203 implements Insurance Code §843.080.

Section 11.204 implements Health and Safety Code §62.054 and Insurance Code §§32.041, 801.056, 802.056, 804.102(b), 843.076, 843.078, 843.079, 843.082, 843.102, 843.105, 843.201, 843.205, 843.251, 843.361, 843.402, 1271.155, 1271.251, 1272.052, 4201.152, 4201.153, and 4201.154.

Section 11.205 implements Insurance Code §803.003.

Section 11.206 implements Insurance Code §843.082 and §843.083.

Section 11.207 implements Insurance Code §843.083.

§11.201. Filing Fee.

§11.202. Binding, Indexing, and Numbering Requirements.

§11.203. Revisions during Review Process.

§11.204. Contents.

§11.205. Documents To Be Available for Qualifying Examinations.

§11.206. Review of Application.

§11.207. Withdrawal of an Application.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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28 TAC §§11.201 - 11.207

STATUTORY AUTHORITY. The new sections are proposed under Health and Safety Code §62.054; Insurance Code §§32.041, 36.001, 38.001, 401.056, 801.056, 802.056, 803.003, 804.102, 823.002, 843.002, 843.006, 843.076, 843.078, 843.079, 843.080(a) and (b), 843.082, 843.083, 843.102, 843.105, 843.151, 843.154, 843.201, 843.205, 843.251, 843.361, 843.402, 843.404, 1271.155, 1271.251, 1272.052, 4201.152 - 4201.154, and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.006 provides that, in general, each application, filing, and report required under Insurance Code Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapter 222, 251, or 258, as applicable to an HMO; or Chapter 1271 or 1272 is a public document.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.402 provides for an HMO to maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least $100,000 or another amount prescribed by the commissioner, the form of the bond, and for the substitution of a cash deposit with the comptroller in lieu of a bond.

Insurance Code §843.404 provides that the commissioner may adopt rules, or by rule establish guidelines, requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMO's investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §4201.152 provides that a utilization review agent must conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Insurance Code §4201.153 provides that a utilization review agent must use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. The section provides requirements for utilization review determinations and screening criteria. The section further provides for the use of screening criteria and for the referral of a denial of requested treatment to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Insurance Code §4201.154 provides that a utilization review agent's written screening criteria and review procedures be made available for review and inspection to determine appropriateness and compliance as considered necessary by the commissioner and copying as necessary for the commissioner to accomplish the commissioner's duties under the Insurance Code.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE.

Section 11.201 implements Insurance Code §843.154.

Section 11.202 implements Insurance Code §843.006.

Section 11.203 implements Insurance Code §843.080.

Section 11.204 implements Health and Safety Code §62.054 and Insurance Code §§32.041, 801.056, 802.056, 804.102(b), 843.076, 843.078, 843.079, 843.082, 843.102, 843.105, 843.201, 843.205, 843.251, 843.361, 843.402, 1271.155, 1271.251, 1272.052, 4201.152, 4201.153, and 4201.154.

Section 11.205 implements Insurance Code §803.003.

Section 11.206 implements Insurance Code §843.082 and §843.083.

Section 11.207 implements Insurance Code §843.083.

§11.201. Filing Fee.

A filing fee required by Insurance Code §843.154 (concerning Fees), as determined by §7.1301 of this title (relating to Regulatory Fees), must accompany an application for a certificate of authority, unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees may not be attached to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System). The fee is nonrefundable.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) A proposed HMO may submit an application for a certificate of authority in electronic format, by electronic file transmission or in a data storage format acceptable to the department, or by paper.

(b) If an HMO submits an application in paper format, the applicant must submit three separate copies of the application in separate three-ring binders, so that pages may be easily replaced when necessary. Paper applications must include dividers with identifying subject tabs preceding each separate exhibit.

(c) Applications submitted in an electronic format must include separate file folders with names identifying each exhibit.

(d) Each application must contain a table of contents.

(e) All pages must be clearly legible and numbered.

(f) An HMO should not use identical items in more than one section of the application. Instead of using the same information in more than one place, an application must refer to the file or page on which the required form or list may be found.

(g) An original application becomes the charter file once the applicant submits all required revisions and the commissioner approves the application.

(h) The application is subject to Government Code Chapter 552 (concerning Public Information).

(i) Each item in the application must be identified by a unique number as more fully described in §11.301(2) of this title (relating to Filing Requirements).

§11.203. Revisions During Review Process.

(a) Revisions during the review of an application for a certificate of authority must be addressed to: Company Licensing and Registration Office, Mail Code 103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or submitted electronically as instructed by the department. The applicant must include a transmittal letter and any revision specified in this subchapter.

(b) Each revision to the basic organizational documents, bylaws, or officers and employees bond must be accompanied by a notarized certification of the corporate secretary or corporate president of the applicant that the revision submitted is true, accurate, and complete, and, if the item is a copy, by a notarized certification that the copy is a true, accurate, and complete copy of the original.

(c) If an electronic file or page is to be revised or replaced, the modified document must be submitted with the changed item or information clearly designated.

(d) Staff will conduct a review of the application and notify the applicant of the need for revisions necessary to meet the requirements of Insurance Code Chapter 843 (concerning Health Maintenance Organizations), this chapter, and other applicable insurance laws and regulations of this state. If the applicant does not make the necessary revisions, the department will deny the application.

(e) If the time required for the revisions will exceed the time limits set out in §1.809 of this title (relating to HMO Certificate of Authority), the applicant must request additional time within which to make the revisions. The applicant must specifically set out the length of time requested, which may not exceed 90 days. The commissioner may grant or deny the request for an extension of time at the commissioner's discretion under §1.809 of this title.

(f) The applicant may request additional extensions, but must set out in writing the need for the additional time for each requested extension. A request must provide sufficient detail for the commissioner to determine if good cause for the extension exists. The commissioner may grant or deny any additional request for an extension of time at the commissioner's discretion.

§11.204. Contents.

The application for a certificate of authority must contain the following, in this order:

(1) a completed name application form along with any certificate of reservation of corporate name issued by the secretary of state;

(2) a completed certificate of authority application form;

(3) the basic organizational documents and all amendments, complete with the original incorporation certificate with charter number and seal indicating certification by the secretary of state, if applicable;

(4) the bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant;

(5) information about officers, directors, and staff, including:

(A) a completed officers and directors page;

(B) NAIC UCAA biographical data forms for all persons who are to be responsible for the day-to-day conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee or other governing body or committee, the principal officers, and controlling shareholders of the applicant if the applicant is a corporation, or all partners or members if the applicant is a partnership or association; and

(C) a complete set of fingerprints for each director, officer, and executive of the applicant in compliance with Chapter 1, Subchapter D, of this title (relating to Effect of Criminal Conduct);

(6) organizational information, as follows:

(A) a chart or list clearly identifying the relationships between the applicant and any affiliates, and a list of any currently outstanding loans or contracts to provide services between the applicant and the affiliates;

(B) a chart showing the internal organizational structure of the applicant's management and administrative staff; and

(C) a chart showing contractual arrangements of the HMO's delivery network;

(7) a fidelity bond or deposit for officers and employees that must be:

(A) an original or copy of a bond complying with Insurance Code §843.402 (concerning Officers' and Employees' Bond), which must not contain a deductible; or

(B) a cash deposit held under Insurance Code §843.402 or as provided by Insurance Code §423.004 (concerning Statutory Deposits With Department) in the same amount and subject to the same conditions as the bond described in this paragraph;

(8) information relating to out-of-state licensure and service of legal process for all applicants must be submitted by using the attorney for service form; provided that:

(A) if the applicant is domiciled in another jurisdiction, an agent for service of legal process must be appointed in compliance with Insurance Code Chapter 804 (concerning Service of Process) using Form FIN 314 (rev. 04/00), and the applicant must furnish a copy of the certificate of authority from the domiciliary jurisdiction's licensing authority; and

(B) the applicant must furnish a statement acknowledging that all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this state is valid if served as provided in Insurance Code Chapter 804;

(9) the evidence of coverage to be issued to enrollees and any group agreement that is to be issued to employers, unions, trustees, or other organizations as described in Chapter 11, Subchapter F, of this title (relating to Evidence of Coverage);

(10) financial information, consisting of the following:

(A) a financial statement that includes a balance sheet reflecting the required net worth, assets, and any liabilities.

(B) if the applicant is newly formed, a balance sheet reflecting the HMO's proposed initial funding;

(C) projected financial statements using the NAIC UCAA ProForma Financial Statements for Health Companies, commencing with the proposed beginning of operations and containing at least two full calendar year projections, and including the identity and credentials of the person preparing the projections; and

(D) the most recent audited financial statements of the HMO's immediate parent company, the ultimate holding company parent, and any sponsoring organization;

(11) the schedule of charges, excluding any charges for Medicaid products, with an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title (relating to Actuarial Certification);

(12) if the applicant proposes to write Medicaid products, an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title, and noting whether the proposed rates are the maximum rates allowed by the contracting state agency, if rates less than the maximum rates allowed are being proposed or if the contracting state agency rates are not available;

(13) a description and a map of the applicant's proposed service area, with key and scale, which must identify the county or counties, or portions of counties, to be served; provided that all copies of the map must be in color, if the HMO submits a map on paper and in color;

(14) the form of any contract or monitoring plan between the applicant and:

(A) any person listed on the officers and directors page;

(B) any physician, medical group, association of physicians, or any other provider, and the form of any subcontract between those entities and any physician, medical group, association of physicians, or any other provider to provide health care services, provided that contracts, including subcontracts between physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees, must include a hold-harmless provision and comply with all other provisions of §11.901 of this title (relating to Required and Prohibited Provisions);

(C) any affiliated exclusive agent or agency;

(D) any affiliated person who will perform marketing, administrative, data processing services, or claims processing services;

(E) any affiliated person who will perform management services, together with a deposit or the original or a copy of a bond with no deductible meeting the requirements of Insurance Code §843.105 (concerning Management and Exclusive Agency Contracts);

(F) an ANHC that agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine, or a provider HMO that agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a primary HMO as part of the primary HMO delivery network; together with a monitoring plan, as required by §11.1604 of this title (relating to Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs);

(G) any insurer or group hospital service corporation to offer indemnity benefits under a point-of-service contract; and

(H) any delegated entity or delegated network, as those terms are described in Insurance Code Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization);

(15) a description of the quality improvement program and work plan that includes a process for medical peer review required by Insurance Code §843.082 (concerning Requirements for Approval of Application) and §843.102 (concerning Health Maintenance Organization Quality Assurance); provided that arrangements for sharing pertinent medical records between physicians, providers, or both, contracting or subcontracting under paragraph (14)(B) of this section with the HMO and ensuring the confidentiality of the records must be explained;

(16) insurance, guarantees, and other protection against insolvency:

(A) any affiliated reinsurance agreement and any other affiliated agreement described in Insurance Code §843.082(4)(C), covering excess of loss, stop-loss, catastrophes, or any combination thereof, which must provide that the commissioner and HMO will be notified no less than 60 days before termination or reduction of coverage by the insurer;

(B) any conversion policy or policies that will be offered by an insurer to an HMO enrollee in the event of the applicant's insolvency;

(C) any other arrangements offering protection against insolvency, including guarantees, as specified in §11.808 of this title (relating to Liabilities) and §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

(17) authorization for bank disclosure to the commissioner of the applicant's initial funding;

(18) the written description of health care plan terms and conditions made available by:

(A) an HMO other than an HMO offering a Children's Health Insurance Program (CHIP) plan to any current or prospective group contract holder and current or prospective enrollee of the applicant under Insurance Code §§843.201 (concerning Disclosure of Information About Health Care Plan Terms), 843.078 (concerning Contents of Application), and 843.079 (concerning Contents of Application; Limited Health Care Service Plan), and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees);

(B) an HMO offering a CHIP plan in the form of the member handbook, for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook;

(19) network configuration information for each of the HMO's physician or provider networks, including limited provider networks, along with:

(A) maps for each product type demonstrating the location and distribution of the physician, dentist, and provider network within the proposed service area by county, with each specialty represented in one map that includes the radii mileage requirements described in §11.1607 of this title (relating to Accessibility and Availability Requirements);

(B) lists for each product type of credentialed and contracted physicians, dentists, and individual providers, in an Excel-compatible format, specifying:

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) specialty;

(ix) name of the HMO contracted facility, including hospital(s), in which the physician or individual provider has privileges;

(x) date of last credentialing or recredentialing; and

(xi) an indication of whether they are accepting new patients;

(C) lists for each product type of credentialed and contracted facilities, including hospitals, in an Excel-compatible format, specifying:

(i) name of facility;

(ii) business address;

(iii) city;

(iv) state;

(v) county;

(vi) type of facility;

(vii) name of national accrediting body, if applicable; and

(viii) date of last credentialing or recredentialing;

(D) lists for each product type of hospital-based physicians that are contracted with the HMO, in an Excel-compatible format, specifying:

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) hospital-based specialty; and

(ix) name of each HMO contracted hospital in which the hospital-based physician practices;

(20) a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; provided that such compensation arrangements are confidential under Insurance Code §843.078(l) and not subject to Government Code Chapter 552 (concerning Public Information);

(21) documentation demonstrating that the applicant will pay for emergency care services performed by non-network physicians or providers as provided by Insurance Code §1271.155 (concerning Emergency Care);

(22) a description of the procedures by which:

(A) a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to enrollees in languages other than English, in compliance with Insurance Code §843.205 (concerning Member's Handbook; Information About Complaints and Appeals); and

(B) access to a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to an enrollee who has a disability affecting communication or reading, in compliance with Insurance Code §843.205;

(23) notification of the physical address in Texas of all books and records described in §11.205 of this title (relating to Additional Documents to be Available for Review);

(24) a description of the HMO's information systems, management structure, and personnel that demonstrates the applicant's capacity to meet the needs of enrollees and contracted physicians and

providers, and to meet the requirements of regulatory and contracting entities;

(25) a written description of the utilization management and utilization review program;

(26) the URA name and certificate or registration number if the applicant performs utilization review under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy), or the URA name and certificate number of the certified URA that will perform utilization review on behalf of the applicant if the applicant delegates utilization review;

(27) complaint and appeal procedures, templates of letters, and logs, including the complaint log, which must categorize each complaint using the following categories and noting all that are applicable to the complaint:

(A) quality of care or services;

(B) accessibility and availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous; and

(28) documentation of claim systems and procedures that demonstrates the HMO's ability to pay claims timely and comply with applicable claim payment statutes and rules.

§11.205. Additional Documents to be Available for Review.

(a) The following documents must be made available for review at the applicant's office in Texas or another location within Texas agreed to by the department and on request during the application process:

(1) administrative: policy and procedure manuals;

(2) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records complying with applicable law;

(3) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

(4) executed physician and provider contracts: a copy of the first page, including the form number, and signature page;

(5) executed subcontracts: a copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(6) manuals: current physician manual and current provider manual provided to each contracting physician or provider, which must contain details of the provisions that govern the physicians and providers;

(7) credentialing files: as specified in §11.1902(4) of this title (relating to Quality Improvement Program for Basic, Single Service, and Limited Service HMOs);

(8) reporting system: the statistical reporting system developed and maintained by the applicant that allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services;

(9) claims systems: policies and procedures that demonstrate the capacity to pay claims timely and to comply with all applicable statutes and rules;

(10) financial records: financial information, including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments, and debts; and

(11) any other records: demonstrating compliance with applicable statutes and rules, including audits or examination reports by other entities, including governmental authorities or accrediting agencies.

(b) After approval of the application, the following documents may be maintained outside Texas if the HMO has received prior approval by the commissioner in compliance with Insurance Code §803.003 (concerning Authority to Locate Out of State):

(1) the financial records listed in subsection (a)(10) of this section;

(2) minutes of HMO organizational meetings, which indicate the type and date of each meeting and the officer or officers who are responsible for the handling of the funds of the applicant;

(3) minutes of meetings of the HMO board of directors; and

(4) management committee meeting minutes.

§11.206. Review of Application; Examination.

(a) An application for a certificate of authority will be processed in compliance with §1.809 of this title (relating to HMO Certificate of Authority).

(b) After completion of the department's review of documents, the department may perform quality of care and financial examinations. If a hearing is held in compliance with §1.809 of this title, then the examinations must occur before the date of the hearing. The commissioner may request a copy of the most recent financial examination report issued by the domiciliary regulator of an applicant that is a foreign HMO, instead of conducting a financial examination.

§11.207. Withdrawal of an Application.

(a) On written notice to the department, an applicant may request withdrawal of an application for a certificate of authority from consideration by the department.

(b) The department may close an application if the department determines that the applicant has failed to respond in a timely manner to requests made by the department for additional information or if the application is incomplete.

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

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SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO SUBSEQUENT TO ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §§11.301 - 11.303

STATUTORY AUTHORITY. The repeals are proposed under Health and Safety Code §62.054; Insurance Code Chapter 843, Subchapter J; and Insurance Code §§32.041, 36.001, 38.001, 401.051, 401.052, 401.054, 401.056, 404.005, 423.004, 802.056, 803.003, 804.102, 843.076, 843.078, 843.079, 843.080(a) and (b), 843.082, 843.101 - 843.103, 843.105, 843.151, 843.154, 843.156, 843.201, 843.205, 843.251, 1271.102, 1271.155, 1271.251, 1271.306(c), 1271.307(c), 1272.052, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, and 1369.0541.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 843, Subchapter J, provides for various matters relating to the payment of claims by HMOs to physicians and providers, including clean claims, the timing of claims and submission of claims, deadlines for action on claims, claim auditing, verification, coordination of payment, and payment for emergency care payments, and provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §32.041 provides that the department must furnish to the companies required to report to the department the necessary forms for the required statements provides.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.052 provides, in relevant part, for the department to visit and examine a carrier as frequently as the department considers necessary.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.101 provides, in relevant part, that an HMO may provide or arrange for medical care services only through: (1) other HMOs; or (2) physicians or groups of physicians who have independent contracts with the HMOs. The section also provides that HMOs may provide or arrange for health care services only through: (1) other HMOs; (2) providers or groups of providers who are under contract with or are employed by the HMO; or (3) additional HMOs or physicians or providers who have contracted for health care services with: (A) the other HMOs; (B) physicians with whom the HMO has contracted; or (C) providers who are under contract with or are employed by the HMO. The section also provides that an HMO may provide or authorize the following in a manner approved by the commissioner: (1) emergency care; (2) services by referral; and (3) services provided outside the service area.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.103 provides, in relevant part, that an HMO may: (1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the HMO or for another purpose necessary in engaging in the business of the HMO; and (2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees. The section provides that if the exercise of a power granted under subsection (a) involves an affiliate, as described by §823.003, the HMO must file notice and adequate supporting information with the commissioner for approval before exercising that power. The section provides that the commissioner disapprove the exercise of a power described by subsection (a) that would in the commissioner's opinion: (1) substantially and adversely affect the financial soundness of the HMO and endanger its ability to meet its obligations; or (2) impair the interests of the public or the HMO's enrollees or creditors in this state. The section provides for the commissioner to disapprove the exercise of a power within 31 days after notice is filed, with a 30 day extension.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

CROSS REFERENCE TO STATUTE.

Section 11.301 implements Health and Safety Code §62.054 and Insurance Code §§803.003, 843.079, 843.080, 843.082, 843.101 - 843.103, 843.105, 843.201, 843.205, 843.251, 1271.102, 1271.155, 1271.251, 1272.052, and 1369.0541.

Section 11.302 implements Insurance Code §802.056, 843.078, and 843.080.

Section 11.303 implements Insurance Code Chapter 843, Subchapter J, and Insurance Code §§401.051, 401.052, 401.054, 802.056, 803.003, 843.102, 843.156, and 843.251.

§11.301. Filing Requirements.

§11.302. Service Area Expansion or Reduction Applications.

§11.303. Examination.

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

Filed with the Office of the Secretary of State on September 21, 2016.

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Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 676-6584

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SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO AFTER ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §§11.301 - 11.303

STATUTORY AUTHORITY. The new sections are proposed under Health and Safety Code §62.054; Insurance Code Chapter 843, Subchapter J; Insurance Code §§32.041, 36.001, 38.001, 401.051, 401.052, 401.054, 401.056, 404.005, 423.004, 802.056, 803.003, 804.102, 843.076, 843.078, 843.079, 843.080(a) and (b), 843.082, 843.101 - 843.103, 843.105, 843.151, 843.154, 843.156, 843.201, 843.205, 843.251, 1271.102, 1271.155, 1271.251, 1271.306(c), 1271.307(c), 1272.052, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, and 1369.0541.

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Insurance Code Chapter 843, Subchapter J, provides for various matters relating to the payment of claims by HMOs to physicians and providers, including clean claims, the timing of claims and submission of claims, deadlines for action on claims, claim auditing, verification, coordination of payment, and payment for emergency care payments, and provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

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Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

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Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents

described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.101 provides, in relevant part, that an HMO may provide or arrange for medical care services only through: (1) other HMOs; or (2) physicians or groups of physicians who have independent contracts with the HMOs. The section also provides that HMOs may provide or arrange for health care services only through: (1) other HMOs; (2) providers or groups of providers who are under contract with or are employed by the HMO; or (3) additional HMOs or physicians or providers who have contracted for health care services with: (A) the other HMOs; (B) physicians with whom the HMO has contracted; or (C) providers who are under contract with or are employed by the HMO. The section also provides that an HMO may provide or authorize the following in a manner approved by the commissioner: (1) emergency care; (2) services by referral; and (3) services provided outside the service area.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.103 provides, in relevant part, that an HMO may: (1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the HMO or for another purpose necessary in engaging in the business of the HMO; and (2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees. The section provides that if the exercise of a power granted under subsection (a) involves an affiliate, as described by §823.003, the HMO must file notice and adequate supporting information with the commissioner for approval before exercising that power. The section provides that the commissioner disapprove the exercise of a power described by subsection (a) that would in the commissioner's opinion: (1) substantially and adversely affect the financial soundness of the HMO and endanger its ability to meet its obligations; or (2) impair the interests of the public or the HMO's enrollees or creditors in this state. The section provides for the commissioner to disapprove the exercise of a power within 31 days after the HMO files its notice, with a 30-day extension.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that If the commissioner does not disapprove a form

before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

CROSS REFERENCE TO STATUTE.

Section 11.301 implements Health and Safety Code §62.05 and Insurance Code §§803.003, 843.079, 843.080, 843.082, 843.101 - 843.103, 843.105, 843.201, 843.205, 843.251, 1271.102, 1271.155, 1271.251, 1272.052, and 1369.0541.

Section 11.302 implements Insurance Code §802.056, 843.078, and 843.080.

Section 11.303 implements Insurance Code Chapter 843, Subchapter J, and Insurance Code §§401.051, 401.052, 401.054, 802.056, 803.003, 843.102, 843.156, and 843.251.

§11.301. Filing Requirements.

After the commissioner issues an HMO's certificate of authority, the HMO is required to file with the commissioner, either for approval before effect or for information only, any items specified in §11.204 of this title (relating to Contents) that the HMO has deleted, amended, or revised as outlined in paragraphs (4) and (5) of this section and any items specified in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes made necessary by federal or state law or regulations. All requirements in this section apply to both electronic and paper filings unless stated otherwise.

(1) Completeness and format of filings.

(A) The department will not accept a filing for review until the filing is complete. An application to modify an approved application for a certificate of authority that requires the commissioner's approval under Insurance Code §843.080 (concerning Modification or Amendment of Application Information) or Insurance Code Chapter 1271, Subchapter C, (concerning Commissioner Approval) is considered complete when all information required by this section; §11.302; and Chapter 11, Subchapter T, of this title (relating to Quality of Care) that is applicable and reasonably necessary for the department to make a final determination has been filed.

(B) Unless otherwise required by this chapter or the Insurance Code, an HMO may submit a filing electronically through the NAIC's System for Electronic Rate and Form Filing or through any other method acceptable to the department.

(C) Unless otherwise required by this chapter or the Insurance Code, paper filings must:

(i) be submitted on 8-1/2- by 11-inch paper;

(ii) not be submitted in bound booklets;

(iii) be legible;

(iv) be in typewritten, computer generated, or printer's proof format; and

(v) except for maps, not contain any color highlighting unless accompanied by a clean copy without highlighting.

(D) As provided in this section, an HMO may submit some filings as provided in §7.201 of this title (relating to Forms Filings).

(E) As provided in this section, an HMO may submit some filings as provided in §11.203(a) of this title (relating to Revisions during Review Process).

(2) Identifying form numbers required. Each item required to be filed by paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. The identifying form numbers must be composed of a total of no more than 40 letters, numbers, symbols, or spaces.

(A) The identifying form number must appear in the lower left-hand corner of the page. In the case of a multiple-page document, the identifying form number must only appear on the lower left-hand corner of the first page, and page numbers should appear on subsequent pages.

(B) If an item is to be replaced or revised after issuance of a certificate of authority, a new identifying form number must be assigned.

(i) A change in address or phone number on a form will not require a new identifying form number.

(ii) A new edition date added to the original identifying form number is an acceptable way of revising the number so that it is identifiable from any previously approved item; for example, if "G-100" was the originally approved number, then the revision may be numbered "G-100 12/79."

(iii) Changing the case of the suffix is not considered to be a change in the number; for example, "ED" and "ed," or "REV" and "rev" are the same for form numbering purposes.

(3) Attachments for filings. Filings required by paragraphs (4)(A) and (B) and (5)(A) and (B) of this section must be accompanied by the following:

(A) an HMO certification and transmittal form for each new, revised, or replaced item;

(B) the supporting documentation considered necessary by the commissioner to review the filing and, for filings submitted on paper, a cover letter which includes the following:

(i) company name;

(ii) form numbers that are being submitted; and

(iii) a paragraph that describes the type of filing being submitted, along with any additional information that would aid in processing the filing, including the reasons for submitting the filing; and

(C) the applicable filing fee as determined by §7.1301 of this title (relating to Regulatory Fees), unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees should not be attached to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System).

(4) Filings requiring approval. After issuance of a certificate of authority, each HMO must file for approval with the commissioner information required by any amendment to items specified in §11.204 of this title if the information has not previously been filed with and approved by the commissioner. In addition, an HMO must file with the commissioner, using the method specified below, a written request to implement or modify the following operations or documents and receive the commissioner's approval before putting the modifications into effect:

(A) electronically through the NAIC's System for Electronic Rate and Form Filing:

(i) evidence of coverage filings, as described in §11.501 of this title (relating to Contents of the Evidence of Coverage);

(ii) a description and a map of the service area, with key and scale, which must identify the county or counties or portions of counties to be served;

(iii) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the member handbook for all plans other than Children's Health Insurance Program (CHIP) plans in compliance with the requirements of Insurance Code §843.201 (concerning Disclosure of Information About Health Care Plan Terms) and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(iv) any material change in the HMO's emergency care procedures;

(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department:

(i) any material change in network configuration; and,

(ii) if a material change in the network configuration results in the HMO's inability to comply with the network adequacy standards described in §11.1607 of this title (relating to Accessibility and Availability Requirements), an access plan that complies with that section;

(C) as provided in §7.201 of this title:

(i) the form of all contracts described in §11.204(14)(A), (C), (D), and (E) of this title, including any amendments to those contracts and prior notification of the cancellation of any management contracts in §11.204(14)(E) of this title;

(ii) the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B) of this title, including any amendments to those contracts;

(iii) any new or revised loan agreements or amendments documenting loans made by the HMO to any affiliated person or to any medical or other health care physician or provider, whether providing services currently, previously, or potentially in the future; and any guarantees of any affiliated person's, physician's, or provider's obligations to any third party;

(iv) any agreement by which an affiliate agrees to handle an HMO's investments under §11.806 of this title (relating to Investment Management by Affiliate Corporation);

(v) any change in the physical address of the books and records described in §11.205 of this title (relating to Additional Documents to be Available for Review);

(vi) any change to any of the requirements for guarantees under §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

(vii) any insurance contracts or amendments, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, between the HMO and affiliates, as described in §11.204(16) of this title; and

(viii) modifications to any type of affiliate compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to, enrollees, including any financial incentives for physicians and providers;

(D) as provided in §11.203(a) of this title, a copy of any proposed amendment to basic organizational documents, bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant and, if the approved amendment must be filed with the secretary of state, a certified copy of the amendment with the file mark of the secretary of state; and

(E) as provided in Chapter 11, Subchapter B, of this title (relating to Name Application Procedure), any name or assumed name on a form, as specified in §11.105 of this title (relating to Use of the Term "HMO," Service Marks, Trademarks, Assumed Name).

(5) Filings for information. Material filed under this paragraph is not to be considered approved, but may be subject to review for compliance with Texas law and consistency with other HMO documents. Each item filed under this paragraph must be accompanied by a completed HMO certification and transmittal form in addition to those attachments required under paragraph (3) of this section. Within 30 days of the effective date, an HMO must file with the commissioner, for information, deletions and modifications to the following previously approved or filed operations and documents:

(A) electronically through the NAIC's System for Electronic Rate and Form Filing:

(i) the formula or method for calculating the schedule of charges as specified in Chapter 11, Subchapter H, of this title (relating to Schedule of Charges);

(ii) any modification of drug coverage under Insurance Code §1369.0541 (concerning Modification of Drug Coverage Under Plan); and

(iii) the member handbook for CHIP plans, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook;

(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department:

(i) a copy of the form of any new contract or subcontract or any substantive change to previously filed copies of forms of all contracts between the HMO and any physician or provider described in §11.204(14)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether used with all contracts or on an individual basis. All copies of amended contracts must be marked to indicate revisions. In addition, the HMO must answer all questions listed on the HMO certification and transmittal form;

(ii) a copy of the executed agreement between the HMO and any delegated entities and delegated networks as defined in §11.2602 of this title (relating to Definitions); and

(iii) any change in the quality assurance program, including the peer review program, as required by Insurance Code §843.082(1) (concerning Requirements for Approval of Application) or §843.102 (concerning Health Maintenance Organization Quality Assurance), with descriptions of arrangements for sharing pertinent medical records between physicians and providers contracting or subcontracting under §11.204(14)(B) of this title with the HMO and ensuring the records' confidentiality;

(C) as provided in §7.201 of this title, a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds, for officers and employees, including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (14)(D) of this title;

(D) as provided in §11.203(a) of this title:

(i) a list of officers and directors and a biographical data sheet for each person listed on the officers and directors page under Insurance Code §843.078(b) (concerning Contents of Application) and biographical data forms in §11.204(5)(A), (B), and (C) of this title; and

(ii) any change of the certificate of authority for a domestic or foreign HMO, and, if a foreign HMO, a certified copy of the certificate of authority and power of attorney.

(6) Approval period. Any modification for which the commissioner's approval is required may be considered approved, unless it is disapproved within 30 days from the date the filing is determined by the department to be complete. The commissioner may postpone the action for a period not to exceed 30 days, as necessary for proper consideration. The department will notify the HMO in writing if it postpones a decision on a modification.

(7) Approval, disapproval, and pending.

(A) Filings requiring approval under paragraph (4)(A)(i) - (iii) of this section will be approved or disapproved in writing within the period set forth in paragraph (6) of this section unless, before the department's issuance of notice of proposed negative action under §1.704(a) of this title (relating to Summary Procedure; Notice), the HMO has been contacted by the department regarding corrections or additional information necessary for commissioner's approval, and files a written consent to waive the approval period with the department.

(B) The department may waive the approval period on its receipt of the HMO's written consent.

(C) The department may hold the filing in a pending status for a reasonable period, but not more than 15 calendar days after the date of the department's request.

(D) If the HMO has not addressed the department's request for corrections or additional information within 15 calendar days, then the HMO may withdraw the filing before the end of the applicable review period, which is either the 30th day after filing or the 60th day after filing for an extended review period.

§11.302. Service Area Expansion or Reduction Applications.

(a) An HMO must file an application with the department for approval before the HMO may expand an existing service area, reduce an existing service area, or add a new service area.

(b) For the purposes of an application to expand an existing service area, reduce an existing service area, or add a new service area, an HMO must file the following items:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area as required by §11.204(13) of this title (relating to Contents);

(2) network configuration information, as required by §11.204(19) of this title;

(3) combined financial projections as described in §11.204(10)(B) of this title, including a breakdown of the income statement for existing business, and the effect of the proposed service area expansion or reduction; and

(4) if any of the items specified in §11.301 of this title (relating to Filing Requirements) are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be filed for approval or filed for information, as outlined in §11.301(4) and (5) of this title.

(c) The department will not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval under Insurance Code §843.080 (concerning Modification or Amendment of Application Information) or Chapter 1271 Subchapter C, (concerning Commissioner Approval) is considered complete when all information required by §11.301 of this title; this section; and Chapter 11, Subchapter T, of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department has been filed with the department.

(d) Before consideration of a service area expansion or reduction application, an HMO must comply with the requirements of Chapter 11, Subchapter T, of this title, in the existing service areas and in the proposed service areas.

§11.303. Examination.

(a) The department has authority to conduct examinations of HMOs under Insurance Code Chapters 401 (concerning Audits and Examinations) and 751 (concerning Market Conduct Surveillance), and Insurance Code §843.156 (concerning Examinations) and §843.251 (concerning Complaint System Required; Commissioner Rules and Examination). The department will conduct examinations to determine the financial condition (financial exams), quality of health care services (quality of care exams), or compliance with laws affecting the conduct of business (market conduct exams).

(b) The following documents must be available for review at the HMO's office located within Texas or at a location approved by the department under Insurance Code §803.003 (concerning Authority to Locate Out of State):

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, for example, resumes and job descriptions; and other items as requested;

(2) quality improvement: program description, work plans, program evaluations, and committee and subcommittee meeting minutes;

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(4) complaints and appeals: policies and procedures and templates of letters; complaint and appeal logs, including documentation and details of actions taken; and complaint and appeal files;

(5) satisfaction surveys: enrollee, physician, and provider satisfaction surveys, and enrollee disenrollment and termination logs;

(6) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records;

(7) network configuration information: as required by §11.204(19) of this title (relating to Contents) demonstrating adequacy of the physician, dentist, and provider network;

(8) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

(9) executed physician and provider contracts: copy of the first page, including form number, and signature page;

(10) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(11) credentialing: credentialing policies and procedures and credentialing files;

(12) reports: any reports submitted by the HMO to a governmental entity;

(13) claims systems: policies and procedures and systems or processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and enrollees;

(14) financial records: financial information, including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(15) other: any other records requested by the department to demonstrate compliance with applicable statutes and rules.

(c) The department will conduct quality of care exams as follows:

(1) Entrance conference. The examination team or assigned examiner may hold an entrance conference with the HMO's key management staff or their designee before beginning the examination.

(2) Interviews. Examination team members or the examiner may conduct interviews with key management staff or their designated personnel.

(3) Exit conference. On completion of the examination, the examination team or examiner may hold an exit conference with the HMO's key management staff or their designee.

(4) Written report of examination. The examination team or examiner will prepare a written report of the examination. The department will provide the HMO with the written report, and if any significant deficiencies are cited, the department will issue a letter outlining the time frames for a corrective action plan and corrective actions.

(5) Corrective action plan. If the examination team or examiner cites significant deficiencies, the HMO must provide a signed corrective action plan to the department no later than 30 days from receipt of the written examination report. The HMO's plan must provide

for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

(6) Verification of correction. The department will verify the correction of deficiencies by submitted documentation or by on-site examination.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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For further information, please call: (512) 676-6584

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SUBCHAPTER F. EVIDENCE OF COVERAGE

28 TAC §§11.501 - 11.513

STATUTORY AUTHORITY. The repeals are proposed under Civil Practice and Remedies Code Chapters 140 and 171; Insurance Code Title 8, Subtitle E; Insurance Code Chapter 4201, Subchapters H and I; and Insurance Code §§32.041, 36.001, 521.102, 541.059, 541.401, 542.057, 843.151, 843.154, 843.201, 843.2071, 1201.062, 1203.002, 1203.003, 1203.052, 1203.053, 1203.054, 1271.005, 1271.006, 1271.051, 1271.101 - 1271.104, 1271.151 - 1271.155, 1271.201, 1271.251, 1271.253,1271.304, 1271.306, 1271.307, 1354.002, 1356.005, 1358.054 - 1358.057, 1359.003, 1362.003 - 1362.005, 1363.003 - 1363.005, 1364.004, 1367.053 - 1367.055, 1367.105, 1367.153, 1367.154, 1367.207, 1369.054, 1369.0541 - 1369.0544; 1369.055 - 1369.057, 1451.254 - 1451.258, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1503.003, 4201.002, and 4201.003.

Civil Practice and Remedies Code Chapter 140 provides for subrogation rights for the issuer of a plan that provides benefits under which the policy or plan issuer may be obligated to make payments or provide medical or surgical benefits to or on behalf of a covered individual as a result of a personal injury to the individual caused by the tortious conduct of a third party.

Civil Practice and Remedies Code Chapter 171 provides for arbitration agreements.

Insurance Code Title 8, Subtitle E, provides for benefits payable under health coverages.

Insurance Code Chapter 4201, Subchapter H, provides for the appeal of adverse determinations.

Insurance Code Chapter 4201, Subchapter I, provides for the independent review of adverse determinations.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.057 provides deadlines for the payment of claims.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §1201.062 provides that an individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide certain coverage for children and grandchildren.

Insurance Code §1203.002 places restrictions on coordination of benefits provisions in evidences of coverage.

Insurance Code §1203.003 provides that a provision of an insurance policy that violates §1203.003 is void.

Insurance Code §1203.052 allows the coordination of dental benefits between primary and secondary insurers.

Insurance Code §1203.053 prohibits certain dental coordination of benefits provisions.

Insurance Code §1203.054 provides that a provision of an insurance policy that violates §1203.053 is void.

Insurance Code §1271.005 provides that: (a) Chapters 1368 and 1652 apply to an HMO other than an HMO that offers only a single health care service plan; (b) Chapter 1355, Subchapter B, applies to an HMO providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that: (1) Chapter 1355, Subchapter B, does not conflict with Chapter 1271, Chapter 843, Subchapter A; Chapter 1452, or Chapter 1507, Subchapter B; and (2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the HMO and is subject to inspection and review as required by Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; or rules adopted under Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; (c) an HMO must comply with Chapter 542, Subchapter B, with respect to prompt payment to an enrollee; (d) notwithstanding any other law, Chapter 1355, Subchapter C, applies to a group contract issued by an HMO; and (e) notwithstanding any other law, §1201.062 applies to an evidence of coverage issued by an HMO.

Insurance Code §1271.006 provides for a limiting age of 25 for children and grandchildren and for benefits to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Insurance Code §1271.051 provides that: (a) an evidence of coverage that is a contract must contain a clear and complete statement of the information required by §§1271.052 - 1271.054; and (b) an evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by §§1271.052 - 1271.054.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and the commissioner does not disapprove the form before the 31st day after the date the form is filed, the form is considered approved. §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.103 provides that: (a) after notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the commissioner; and (b) if the commissioner withdraws approval of a form under the section, the form may not be issued until it is approved.

Insurance Code §1271.104 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 Chapter 1271, Subchapter C.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.153 provides basic health care services provided under an evidence of coverage include periodic health evaluations for each adult enrollee, and that the section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Insurance Code §1271.154 provides, in relevant part, that an HMO must ensure that each health care plan provided by the HMO includes well-child care from birth.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

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, Subchapter F.

Insurance Code §1271.304 provides constraints on the termination of group continued coverage.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

Insurance Code §1271.307 provides that an individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee, that an HMO may decline to renew an individual health care plan or conversion contract only under specified conditions, and that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1354.002 provides that if a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Insurance Code §1356.005 provides that a health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer, and contains conditions regarding that coverage.

Insurance Code §1358.054 provides that: (a) a health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for: (1) diabetes equipment; (2) diabetes supplies; and (3) diabetes self-management training in accordance with the requirements of §1358.055; and (b) a health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under §1358.054. The section also provides that the amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Insurance Code §1358.055 contains conditions governing the provision of diabetes self-management training.

Insurance Code §1358.056 provides that a health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1359.003 provides that: (a) a group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease; and (b) the group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Insurance Code §1362.003 provides that: (a) a health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer, and that (b) that coverage required under the section includes at a minimum: (1) a physical examination for the detection of prostate cancer and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male who: (A) is at least 50 years of age and is asymptomatic or (B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Insurance Code §1362.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1362 and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to administer Chapter 1362.

Insurance Code §1363.003 provides that: (a) a health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer and (b) provide for minimum coverage required under the section.

Insurance Code §1363.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1363 and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to administer Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to administer Chapter 1364.

Insurance Code §1367.053 provides that a health benefit plan that provides coverage for a family member of an insured or enrollee must provide for each covered child from birth through the date of the child's sixth birthday coverage for certain immunizations, and defines "covered child" for the purposes of the section.

Insurance Code §1367.054 provides that coverage required under §1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement, and that this does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

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Insurance Code §1367.153 provides that a health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.054 provides for notice and disclosure of certain information to enrollees and other individuals by an issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

Insurance Code §1369.0542 provides that a health benefit plan issuer must display on a public Internet website maintained by the issuer formulary information as required by the commissioner by rule, requires a direct electronic link to the formulary information to be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website, and provides that the information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.0544 provides that a health benefit plan issuer may make the information described by 1369.0543(d)(1) available to enrollees, prospective enrollees, and others through a toll-free telephone number that operates at least during normal business hours.

Insurance Code §1369.055 provides that an issuer of a health benefit plan that covers prescription drugs must offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. The section also provides that this does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is: (1) covered under the health benefit plan; and (2) medically appropriate for the enrollee.

Insurance Code §1369.056 provides that the refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of §4201.002 if: (1) the drug is not included in a drug formulary used by the health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary. The section also provides that the enrollee may appeal the adverse determination under Chapter 4201, Subchapters H and I.

Insurance Code §1369.057 provides that the commissioner may adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1451.255 provides that a health benefit plan must permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist The section provides that a health benefit plan may limit an enrollee's self-referral to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee, and makes other provisions concerning the selection of a physician to provide such care.

Insurance Code §1451.256 provides, in relevant part, that a health benefit plan must permit an enrollee who selects an obstetrician or gynecologist under §1451.255 to have direct access to the health care services of that selected physician without a referral from the enrollee's primary care physician or prior authorization or precertification from the plan issuer. The section provides that a health benefit plan may not impose a copayment or deductible for direct access to health care services as required by the section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

Insurance Code §1451.257 provides that a health benefit plan must include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

Insurance Code §1451.258 provides that a health benefit plan issuer must provide in clear and accurate language to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under Chapter 1451, Subchapter F.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1503.003 provides for coverage of certain students by a health benefit plan.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

CROSS REFERENCE TO STATUTE.

Section 11.501 implements Insurance Code §§541.059, 843.154, 1271.051 - 1271.054, and 1271.101.

Sections 11.502, 11.503 and 11.504 implement Insurance Code §§1271.102 - 1271.104.

Section 11.505 implements Insurance Code §1271.104.

Section 11.506 implements Insurance Code Chapter 542, Subchapter A; Insurance Code Chapter 4201, Subchapter H; Insurance Code Chapter 4201, Subchapter I; and Insurance Code §§521.102, 843.201, 843.2071, 1201.062, 1203.002, 1203.003, 1271.005, 1271.006, 1271.051, 1271.201, 1271.304, 1271.307, 1354.002, 1367.053, 1367.054, 1369.054 - 1369.056, 1451.255 - 1451.257, 1456.003, and 1503.003.

Section 11.507 implements Insurance Code §1271.306.

Section 11.508 implements Insurance Code §§1271.151, 1271.153 - 1271.155, 1356.005, 1358.054 - 1358.056, 1362.003, 1362.004, 1363.003, 1363.004, and 1367.053.

Sections 11.509 and 11.510 implement Insurance Code Title 8, Subtitle E and Insurance Code §1367.153 and §1359.003.

Section 11.511 implements Civil Practice and Remedies Code Chapters 140 and 171, Insurance Code §§1203.003, 1203.052 - 1203.054, and 1271.306.

Section 11.512 implements Insurance Code §1701.061 and §4201.002.

§11.501. Forms Which Must Be Approved Prior to Use.
§11.502. Filing Requirements for Evidence of Coverage.
§11.503. Filing Requirements for Evidence of Coverage Subsequent to Receipt of Certificate of Authority.
§11.504. Disapproval of an Evidence of Coverage.
§11.505. Specifications for the Evidence of Coverage and Matrix Filings.
§11.506. Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate.
§11.507. Additional Mandatory Contractual Provisions: Conversion and Individual Agreements.
§11.508. Mandatory Benefit Standards: Group, Individual and Conversion Agreements.
§11.509. Additional Mandatory Benefit Standards: Group Agreement Only.
§11.510. Mandatory Offers.
§11.511. Optional Provisions.
§11.512. Optional Benefits.
§11.513. Additional Information May Be Required.

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

Filed with the Office of the Secretary of State on September 21, 2016.

TRD-201604911
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 676-6584

♦ ♦ ♦

28 TAC §§11.501 - 11.509, 11.511, 11.512

STATUTORY AUTHORITY. The new sections are proposed under Civil Practice and Remedies Code Chapter 140; Civil Practice and Remedies Code Chapter 171; Insurance Code Title 8, Subtitle E; Insurance Code Chapter 4201, Subchapters H and I; Insurance Code §§32.041, 36.001, 521.102, 541.059, 541.401, 542.057, 843.151, 843.154, 843.201, 843.2071, 1201.062, 1203.003, 1203.052, 1203.053, 1203.054, 1271.005, 1271.006, 1271.051, 1271.101 - 1271.104, 1271.151 - 1271.155, 1271.201, 1271.251, 1271.253,1271.304, 1271.306, 1271.307, 1354.002, 1356.005, 1358.054 - 1358.057, 1359.003, 1362.003 - 1362.005, 1363.003 - 1363.005, 1364.004, 1367.053 - 1367.055, 1367.105, 1367.153, 1367.154, 1367.207, 1369.054, 1369.0541 - 1369.0544, 1369.055 - 1369.057, 1451.254 - 1451.258, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1503.003, 4201.002, and 4201.003.

Civil Practice and Remedies Code Chapter 140 provides for subrogation rights for the issuer of a plan that provides benefits under which the policy or plan issuer may be obligated to make payments or provide medical or surgical benefits to or on behalf of a covered individual as a result of a personal injury to the individual caused by the tortious conduct of a third party.

Civil Practice and Remedies Code Chapter 171 provides for arbitration agreements.

Insurance Code Title 8, Subtitle E, provides for benefits payable under health coverages.

Insurance Code Chapter 4201, Subchapter H, provides for the appeal of adverse determinations.

Insurance Code Chapter 4201, Subchapter I, provides for the independent review of adverse determinations.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.057 provides deadlines for the payment of claims.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §1201.062 provides that an individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide certain coverage for children and grandchildren.

Insurance Code §1203.002 places restrictions on coordination of benefits provisions in evidences of coverage.

Insurance Code §1203.003 provides that a provision of an insurance policy that violates §1203.003 is void.

Insurance Code §1203.052 allows the coordination of dental benefits between primary and secondary insurers.

Insurance Code §1203.053 prohibits certain dental coordination of benefits provisions.

Insurance Code §1203.054 provides that a provision of an insurance policy that violates §1203.053 is void.

Insurance Code §1271.005 provides that: (a) Chapters 1368 and 1652 apply to an HMO other than an HMO that offers only a single health care service plan; (b) Chapter 1355, Subchapter B, applies to an HMO providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that: (1) Chapter 1355, Subchapter B, does not conflict with Chapter 1271, Chapter 843, Subchapter A; Chapter 1452, or Chapter 1507, Subchapter B; and (2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the HMO and is subject to inspection and review as required by Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; or rules adopted under Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; (c) an HMO must comply with Chapter 542, Subchapter B, with respect to prompt payment to an enrollee; (d) notwithstanding any other law, Chapter 1355, Subchapter C, applies to a group contract issued by an HMO; and (e) notwithstanding any other law, §1201.062 applies to an evidence of coverage issued by an HMO.

Insurance Code §1271.006 provides for a limiting age of 25 for children and grandchildren and for benefits to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Insurance Code §1271.051 provides that: (a) an evidence of coverage that is a contract must contain a clear and complete statement of the information required by §§1271.052, 1271.053, and 1271.054; and (b) an evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by §§1271.052, 1271.053, and 1271.054.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.103 provides that: (a) after notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the commissioner; and (b) if the commissioner withdraws approval of a form under the section, the form may not be issued until it is approved.

Insurance Code §1271.104 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 Chapter 1271, Subchapter C.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.153 provides basic health care services provided under an evidence of coverage include periodic health evaluations for each adult enrollee, and that the section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Insurance Code §1271.154 provides, in relevant part, that an HMO must ensure that each health care plan provided by the HMO includes well-child care from birth.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

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, Subchapter F.

Insurance Code §1271.304 provides constraints on the termination of group continued coverage.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

Insurance Code §1271.307 provides that an individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee, that an HMO may decline to renew an individual health care plan or conversion contract only under specified conditions, and that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1354.002 provides that If a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Insurance Code §1356.005 provides that a health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer, and contains conditions regarding that coverage.

Insurance Code §1358.054 provides that: (a) a health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for: (1) diabetes equipment; (2) diabetes supplies; and (3) diabetes self-management training in accordance with the requirements of §1358.055; and (b) a health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under §1358.054. The section also provides that the amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Insurance Code §1358.055 contains conditions governing the provision of diabetes self-management training.

Insurance Code §1358.056 provides that a health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1359.003 provides that: (a) a group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease; and (b) the group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Insurance Code §1362.003 provides that: (a) a health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer; (b) that coverage required under the section includes at a minimum: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male who: (A) is at least 50 years of age and is asymptomatic; or (B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Insurance Code §1362.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1362 and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to administer Chapter 1362.

Insurance Code §1363.003 provides that: (a) a health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal

cancer; and (b) provides for minimum coverage required under the section.

Insurance Code §1363.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1363 and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to administer Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to administer Chapter 1364.

Insurance Code §1367.053 provides that a health benefit plan that provides coverage for a family member of an insured or enrollee must provide for each covered child from birth through the date of the child's sixth birthday coverage for certain immunizations, and defines "covered child" for the purposes of the section.

Insurance Code §1367.054 provides that coverage required under §1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement, and that this does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

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Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.153 provides that a health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

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Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

Insurance Code §1369.0542 provides that a health benefit plan issuer must display on a public Internet website maintained by the issuer formulary information as required by the commissioner by rule, requires a direct electronic link to the formulary information to be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website, and provides that the information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.0544 provides that a health benefit plan issuer may make the information described by 1369.0543(d)(1) available to enrollees, prospective enrollees, and others through a toll-free telephone number that operates at least during normal business hours.

Insurance Code §1369.055 provides that an issuer of a health benefit plan that covers prescription drugs must offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. The section also provides that this does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is: (1) covered under the health benefit plan; and (2) medically appropriate for the enrollee.

Insurance Code §1369.056 provides that the refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of §4201.002 if: (1) the drug is not included in a drug formulary used by the health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary. The section also provides that the enrollee may appeal the adverse determination under Chapter 4201, Subchapters H and I.

Insurance Code §1369.057 provides that the commissioner may adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1451.255 provides that a health benefit plan must permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist The section provides that a health benefit plan may limit an enrollee's self-referral to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee, and makes other provisions concerning the selection of a physician to provide such care.

Insurance Code §1451.256 provides, in relevant part, that a health benefit plan must permit an enrollee who selects an obstetrician or gynecologist under §1451.255 to have direct access to the health care services of that selected physician without a referral from the enrollee's primary care physician or prior authorization or precertification from the plan issuer. The section provides that a health benefit plan may not impose a copayment or deductible for direct access to health care

services as required by the section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

Insurance Code §1451.257 provides that a health benefit plan must include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

Insurance Code §1451.258 provides that a health benefit plan issuer must provide in clear and accurate language to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under Chapter 1451, Subchapter F.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1503.003 provides for coverage of certain students by a health benefit plan.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

CROSS REFERENCE TO STATUTE.

Section 11.501 implements Insurance Code §§541.059, 843.154, 1271.051, 1271.052, 1271.053, 1271.054, and 1271.101.

Sections 11.502- 11.504 implement Insurance Code §§1271.102, 1271.103, and 1271.104.

Section 11.505 implements Insurance Code §1271.104.

Section 11.506 implements Insurance Code Chapter 542, Subchapter A; Insurance Code Chapter 4201, Subchapter H; Insurance Code Chapter 4201, Subchapter I; and Insurance Code §§521.102, 843.201, 843.2071, 1201.062, 1203.002, 1203.003, 1271.005, 1271.006, 1271.051, 1271.201, 1271.304, 1271.307, 1354.002, 1367.053, 1367.054, 1369.054- 1369.056, 1451.255, 1451.256, 1451.257, 1456.003, and 1503.003.

Section 11.507 implements Insurance Code §1271.306.

Section 11.508 implements Insurance Code §§1271.151, 1271.153, 1271.154, 1271.155, 1356.005, 1358.054, 1358.055, 1358.056, 1362.003, 1362.004, 1363.003, 1363.004, and 1367.053.

Section 11.509 implements Insurance Code Title 8, Subtitle E and Insurance Code §1367.153 and §1359.003.

Section 11.510. The proposed rule eliminates §11.510 from the existing rule, for the reason given above.

Section 11.511 implements Civil Practice and Remedies Code Chapters 140 and 171, Insurance Code §1203.003, 1203.052 - 1203.054, 1271.306.

Section 11.512 implements Insurance Code §1701.061, 4201.002.

§11.501. Contents of the Evidence of Coverage.

(a) An evidence of coverage or an amendment to an evidence of coverage may not be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

(1) group agreement;

(2) certificate issued to each subscriber who is enrolled through a group (the same form may be used as both the group agreement and the group certificate);

(3) conversion and individual agreements;

(4) group, conversion, and individual applications for coverage;

(5) group subscriber enrollment form;

(6) riders, endorsements, amendments, and letters of agreement;

(7) matrix filings;

(8) schedule of benefits; and

(9) any other form attached to or made a part of the evidence of coverage.

(b) Each of the forms described in subsection (a) of this section must be identified with a unique form number and individually approved by the commissioner before being issued, delivered, or used in Texas. Each form described in subsection (a) of this section will be considered a separate evidence of coverage filing and, except as provided in subsection (c) of this section, is subject to the filing fee prescribed in §7.1301(g)(4) of this title (relating to Regulatory Fees) for initial submissions.

(c) The filing fee for matrix filings is $100 per individual evidence of coverage provision, with a maximum fee of $500, whether the filing is an initial submission or a resubmission.

§11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority.

(a) The filing and formatting requirements of §11.301(1)(B) and (2)(A) of this title (relating to Filing Requirements) apply to an evidence of coverage, when filed as part of the application for a certificate of authority.

(b) During the review period, an applicant must submit each new page or form reflecting any revisions.

(c) No later than the 10th calendar day after approval or issuance of a certificate of authority, an HMO must file a clean, final version of the evidence of coverage with revisions and a copy of the

original version of the evidence of coverage showing the new or revised text as redlined. The submission must include:

(1) an explanation that the evidence of coverage was submitted as part of the application for a certificate of authority and is being submitted in compliance with this subsection;

(2) a certification that the forms are without deviation and are the exact final evidence of coverage versions that resulted in approval of the certificate of authority application; and

(3) the final version of an approved service area description and map as attached to the evidence of coverage, with key and scale, which must identify the county or counties or portions of counties to be served.

(d) Any discrepancy in content between the final document to be issued and the approved version is grounds for revocation of a certificate of authority.

§11.503. Filing Requirements for Evidence of Coverage after Receipt of Certificate of Authority.

(a) After receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the approval of the commissioner. The evidence of coverage must be filed as provided in §11.301 of this title (relating to Filing Requirements).

(b) The department will notify the HMO of the department's action in compliance with §1.704 of this title (relating to Summary Procedure; Notice).

(c) The department will base its approval or disapproval on the content of drafts submitted to the department. Filings must comply with the specifications described in §11.505 of this title (relating to Specifications for the Evidence of Coverage and Matrix Filings). Any discrepancy in content between the final document to be issued and the approved draft is grounds for revocation of the certificate of authority.

(d) The review period for an evidence of coverage filing begins on the date an acceptable, typed draft of the form is received.

(e) The review period may be extended on 30-days written notice of extension to the HMO before the expiration of the initial review period.

(f) At the end of the review period, the evidence of coverage filing is considered approved unless it has already been withdrawn, affirmatively approved, or disapproved by the commissioner.

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of an evidence of coverage, the department will specify the reason for the disapproval. The department may disapprove any form or withdraw any previous approval if a form:

(1) fails to meet the requirements of Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, or other applicable statutes and regulations;

(2) does not properly describe the services and benefits;

(3) contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate Insurance Code Chapters 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), 543 (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544 (concerning Prohibited Discrimination), or 547 (concerning False Advertising by Unauthorized Insurers), or any other applicable law or regulations;

(4) provides services or benefits that are too restrictive to achieve the purpose for which the form was designed;

(5) fails to attain a reasonable degree of readability, simplicity, and conciseness;

(6) provides services or benefits or contains other provisions that would endanger the solvency of the issuing HMO; or

(7) is contrary to the law or policy of this state.

(b) If the department disapproves a form, the HMO may file a written request for a hearing on the matter under Insurance Code §1271.102 (concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval).

§11.505. Specifications for Evidence of Coverage Including Insert Pages and Matrix Filings.

(a) The filing and formatting requirements of §11.301 of this title (relating to Filing Requirements) apply to an evidence of coverage.

(b) The style, arrangement, and overall appearance of documents must give no undue prominence to any portion of the text. The text of the group, individual, and conversion agreements, the certificate, and all amendments include all printed matter except:

(1) the HMO's name, address, website address, and phone number;

(2) the name or title of the form;

(3) the captions and subcaptions; and

(4) any brief introduction to or description of the evidence of coverage.

(c) Each evidence of coverage must indicate by example information that will appear in any blanks with the exception of single-case forms, which must be filed complete and ready for use.

(d) An HMO must identify each form by a unique form number in compliance with §11.301(2) of this title. Any change in form number is considered a change in the form and requires approval as a new form.

(e) Certain language must not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets, include the range of variable information or amounts, and include an explanation of how and under what circumstances the information will vary.

(f) Each evidence of coverage must meet the readability standards of §3.601 of this title (relating to Purpose and Scope, Applicability, and Definitions Used in This Subchapter) and §3.602 of this title (relating to Plain Language Requirements).

(g) A matrix filing must comply with the filing requirements in this section and §11.301 of this title. In addition, an HMO submitting a matrix filing:

(1) must identify each provision with a unique form number that is sufficient to distinguish it as a matrix filing; and

(2) may use the same provision filed under one form number for all HMO products, provided that the language is applicable to each HMO product; however, any changes in the language to comply with the requirements for each HMO product will require a unique form number.

(h) Evidences of coverage, agreements, and contracts may be submitted with insert pages, or an insert page may be filed subsequent to the approval of an evidence of coverage, agreement, or contract.

(i) Any HMO submitting an insert page filing:

(1) must identify each insert page with a unique form number located on the lower left hand corner of the page;

(2) may use the same insert page filed under one form number for all plans, provided the language is applicable to each plan type; however, any changes in the language to comply with the requirements for each plan type will require a unique form number;

(3) may use the same insert page to replace an existing page of a previously approved or reviewed evidence of coverage, agreement, or contract. However, if used in this manner, the replaced page, as originally filed, must reflect a unique form number that distinguishes it from the other pages of the form or contract; and

(4) must list the form number for each insert page on the transmittal checklist and provide a statement indicating how the insert page will be used and the type of plan for which the insert page will be used.

(j) In addition to providing the appropriate certification on the transmittal checklist, an HMO submitting a filing as a matrix filing or as an insert page must provide certifications certifying that, when issued, the evidences of coverage, certificates, contracts, riders, or applications created from the forms comply in all respects with all applicable statutes and regulations with regard to the final plan document that will be issued.

§11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate.

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions:

(1) Face page. Where applicable, the name, address, website address, and phone number of the HMO must appear. The toll-free number referred to in Insurance Code §521.102 (concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints) must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form, the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Insurance Code Chapter 521, Subchapter C, (concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints), in compliance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(D) The HMO must provide the notices specified by §11.1610 of this title (relating to Annual Network Adequacy Report) and §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers).

(2) Benefits. A schedule of all health care services that are available to enrollees under the basic, limited, or single service plan must be included, together with any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services.

(i) Each basic health care service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50 percent of the total cost of services provided.

(ii) A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

(iii) The HMO must state the copayment, the limit on enrollee copayments, and the enrollee reporting responsibility in the group, individual, or conversion agreement and group certificate.

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. Except in cases involving emergency care and services that are not available in the HMO's delivery network, an HMO may charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network. This subparagraph does not apply to a consumer choice benefit plan authorized by Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans), and as described in Chapter 21, Subchapter AA, of this title (relating to Consumer Choice Health Benefit Plans).

(C) Facility-based Physicians. In compliance with Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), a statement that:

(i) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network;

(ii) the non-network facility-based physician or other health care practitioner may balance bill the enrollee for amounts not paid by the health benefit plan; and

(iii) if the enrollee receives a balance bill, the enrollee should contact the HMO.

(D) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B, (concerning Childhood Immunizations) for a child from birth through the date the child is six years of age, except that a small employer health benefit plan as defined by Insurance Code §1501.002 (concerning Definitions) that covers the immunizations may charge a copayment, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

(3) Cancellation and nonrenewal. A statement specifying the following grounds for cancellation and nonrenewal of coverage and the minimum notice period that will apply.

(A) An HMO may cancel coverage of a subscriber in a group and the subscriber's enrolled dependents under circumstances described in this subparagraph, so long as the circumstances do not include health status-related factors, unless otherwise prohibited by law:

(i) for nonpayment of amounts due under the contract, after not less than 30-days written notice, except no additional written notice will be required for failure to pay premium;

(ii) after not less than 15-days written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (13) of this subsection;

(iii) after not less than 15-days written notice, in the case of fraud in the use of services or facilities;

(iv) immediately, subject to continuation of coverage and conversion privilege provisions, if applicable, for failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area; and

(v) after not less than 30-days written notice, where the subscriber does not reside, live, or work in the service area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premium, at the end of the grace period as described in paragraph (12) of this subsection;

(ii) in the case of fraud on the part of the group, after 15-days written notice;

(iii) for employer groups, for violation of participation or contribution rules, under §26.8(h) of this title (relating to Guaranteed Issue; Contribution and Participation Requirements) and §26.303(j) of this title (relating to Coverage Requirements);

(iv) for employer groups, under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) on discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage;

(v) where no enrollee resides, lives, or works in the service area of the HMO or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees after 30-days written notice; and

(vi) if membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, after 30-days written notice.

(C) A group or individual contract holder may cancel a contract in the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees under this chapter or other law after not less than 30-days written notice to the HMO.

(D) An HMO may cancel an individual contract under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premiums under the terms of the contract, including any timeliness provisions, without written notice, subject to paragraph (12) of this subsection;

(ii) in the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this subsection, after not less than 15-days written notice;

(iii) in the case of fraud in the use of services or facilities, after not less than 15-days written notice;

(iv) after not less than 30-days written notice where the subscriber does not reside, live, or work in the service area of the HMO or area in which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area;

(v) in case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 90-days written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area; and

(vi) in case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 180-days written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B, (concerning Prompt Payment of Claims); Insurance Code §1271.005 (concerning Applicability of Other Law); and rules adopted under these Insurance Code provisions.

(5) Complaint and appeal procedures. A description of the HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy).

(6) Definitions. A provision defining any words in the evidence of coverage that have other than the usual meaning. Definitions must be in alphabetical order.

(7) Effective date. A statement of the effective date requirements of various kinds of enrollees.

(8) Eligibility. A statement of the eligibility requirements for membership.

(A) The statement must provide that the subscriber must reside, live, or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;

(iii) in the service area with the subscriber's spouse; or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) The statement must provide the conditions under which dependent enrollees may be added to those originally covered.

(C) The statement must describe any limiting age for subscriber and dependents.

(D) The statement must provide a clear statement regarding the coverage of newborn children.

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury for which coverage is provided.

(iii) The HMO may require that the subscriber notify the HMO during the initial 31 days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) The HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency or born in a non-network facility to a mother who does not have HMO coverage, but may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO must allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren that complies with Insurance Code §1201.062 (concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program) and §1271.006 (concerning Benefits to Dependent Child and Grandchild).

(9) Emergency services. A description of how to obtain services in emergency situations including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition;

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or in a comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that:

(i) the HMO must approve or deny coverage of post-stabilization care as requested by a treating physician or provider; and

(ii) the HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request; and

(F) for purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002 (concerning Definitions);

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment);

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

(10) Entire contract, amendments. A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

(11) Exclusions and limitations. A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(12) Grace period. A provision for a grace period of at least 30 days for the payment of any premium due after the first premium payment during which the coverage remains in effect. An HMO may add a charge to the premium for late payments received within the grace period.

(A) If payment is not received within the 30 days, coverage may be canceled after the 30th day and the terminated members may be held liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(B) Despite subparagraph A of this paragraph, provisions regarding the liability of group contract holder for an enrollee's premiums must comply with Insurance Code §843.210 (concerning Terms of Enrollee Eligibility) and §21.4003 of this title (relating to

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

(13) Incontestability:

(A) All statements made by the subscriber on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or nonrenew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract or group certificate may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application. For small employer coverage, the misrepresentation must be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31-days prior written notice of any premium rate change.

(14) Out-of-network services. Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO must offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO may not require the enrollee to change primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(15) Schedule of charges. A statement that discloses the HMO's right to change the rate charged with 60-days written notice under Insurance Code §843.2071 (concerning Notice of Increase in Charge for Coverage) and Insurance Code Chapter 1254 (concerning Notice of Rate Increase for Group Health and Accident Coverage).

(16) Service area. A description and a map of the service area, with key and scale, that identifies the county, or counties, or portions of counties to be served, and indicating primary care physicians, hospitals, and emergency care sites. A ZIP code map and a physician and provider list may be used to meet the requirement.

(17) Termination due to attaining limiting age. A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of the limiting age.

(18) Termination due to student dependent's change in status. A provision regarding coverage of student dependents that complies with Insurance Code Chapter 1503 (concerning Coverage of Certain Students), if applicable.

(19) Conformity with state law. A provision that if the agreement or certificate contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges) or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, 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), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement, the long-term care rules, and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician. A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201 (concerning Designation of Specialist as Primary Care Physician).

(22) Selected obstetrician or gynecologist. Group, individual, and conversion agreements, and group certificates, except small employer health benefit plans as defined by Insurance Code §1501.002 (concerning Definitions), must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Chapter 1451, Subchapter F,(concerning Access to Obstetrical or Gynecological Care). An HMO may not prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO must permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) Access to the health care services of an obstetrician or gynecologist includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO may not impose any penalty, financial or otherwise, on the obstetrician or gynecologist for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good-faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. The limitation must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from the enrollee's primary care physician or primary care provider. The enrollee must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee who elects to receive obstetrical or gynecological services from a primary care physician (a family physician, internal medicine physician, or other qualified physician) must adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

(23) Diagnosis of Alzheimer's disease. An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354 (concerning Eligibility for Benefits for Alzheimer's Disease) by a physician licensed in this state satisfies any requirement for demonstrable proof of organic disease.

(24) Drug Formulary. An agreement that covers prescription drugs and uses one or more formularies must comply with Insurance Code Chapter 1369, Subchapter B, (concerning Coverage of Prescription Drugs Specified by Drug Formulary) and Chapter 21, Subchapter V, of this title (relating to Pharmacy Benefits).

(25) Inpatient care by nonprimary care physician. If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility, for example, hospital or skilled nursing facility, a provision that on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

§11.507. Additional Mandatory Contractual Provisions: Conversion and Individual Agreements.

Conversion and individual agreements must contain the following additional mandatory provisions:

(1) Reinstatement. A provision clearly setting forth the requirements for reinstatement and disclosing how reinstatement changes or affects the rights and coverages originally provided. New evidence of insurability may be required.

(2) Ten days to examine agreement. A provision stating that the contract holder may return the contract within 10 days of receiving it and have the premium paid refunded if, after examination of the contract, the contract holder is not satisfied with it for any reason. If the contract holder returns the contract to the issuing HMO or to the agent through whom it was purchased, then the contract is considered void from the beginning and the parties are in the same position as if no contract had been issued. If services are rendered or claims paid by the HMO during the 10 days, the subscriber is responsible for repaying the HMO for the services or claims.

(3) Consideration. The original consideration, including premiums, application fee, and any other amounts to be paid for coverage, must be expressed in the agreement or in the application.

(4) Continuance of coverage due to change in marital status. A provision stating that if a person loses coverage due to a change in marital status, that person will be issued coverage in compliance with §21.407 of this title (relating to Continuance of Coverage).

§11.508. Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements.

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9) or (14) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):

(1) outpatient services, including the following:

(A) primary care and specialist physician services;

(B) outpatient services by other providers;

(C) diagnostic services, including laboratory, imaging, and radiologic services;

(D) therapeutic radiology services;

(E) prenatal services, if maternity benefits are covered;

(F) outpatient rehabilitation therapies including physical therapy, speech therapy, and occupational therapy;

(G) home health services, as prescribed or directed by the responsible physician or other authority designated by the HMO;

(H) preventive services, including:

(i) periodic health examinations for adults as required by Insurance Code §1271.153 (concerning Periodic Health Evaluations);

(ii) immunizations for children as required by Insurance Code §1367.053 (concerning Coverage Required);

(iii) well-child care from birth as required by Insurance Code §1271.154 (concerning Well-Child Care From Birth);

(iv) cancer screenings as required by Insurance Code Chapters 1356 (concerning Low-Dose Mammography), 1362

(concerning Certain Tests for Detection of Prostate Cancer), and 1363 (concerning Certain Tests for Detection of Colorectal Cancer);

(v) eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines; and

(vi) immunizations for adults under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor;

(I) coverage for outpatient mental health services complying with the mental health parity requirements in Chapter 21, Subchapter P, of this title (relating to Mental Health Parity); and

(J) emergency services as required by Insurance Code §1271.155 (concerning Emergency Care), including emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus;

(2) inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary; use of operating room and related facilities; use of intensive care unit and services; X-ray services; laboratory and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; special duty nursing when medically necessary; radiation therapy; inhalation therapy; whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for the enrollee; administration of whole blood and blood plasma; and short-term rehabilitation therapy services in the acute hospital setting;

(3) inpatient physician care services, including services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services; and

(4) outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.

(b) Each evidence of coverage must also include coverage for services as follows:

(1) breast reconstruction as required by federal law if the plan provides coverage for mastectomy, which is subject to the same deductible or copayment applicable to mastectomy, and which may not be denied because the mastectomy occurred before the effective date of coverage;

(2) prenatal services, delivery, and postdelivery care for an enrollee and her newborn child as required by federal law, if the plan provides maternity benefits; and

(3) diabetes self-management training, equipment, and supplies as required by Insurance Code Chapter 1358, Subchapter B, (concerning Diabetes).

(c) Benefits described in this section that do not apply to small employer plans are not required to be included in those plans.

(d) A state-mandated health benefit plan must provide coverage for basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in §§21.3515 - 21.3518 of this title (concerning State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Group HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-Mandated Health Benefits in Large Employer HMO Plans), and must provide the services without limitation as to time and cost, other than limitations specifically prescribed in this subchapter.

(e) Nothing in this title requires an to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the HMO's, physician's, or provider's religious convictions. An HMO that limits or denies health care services under this subsection must set out the limitations in its evidence of coverage.

§11.509. Additional Mandatory Benefit Standards: Individual and Group Agreements.

Individual and group agreements must contain the following additional mandatory provisions as applicable:

(1) Certificate. Group agreements must include provisions that the contract holder must be provided with subscriber certificates to be delivered to each subscriber, the certificate is a part of the group contract as if fully incorporated, and any direct conflict between the group agreement and the certificate will be resolved according to the terms most favorable to the subscriber. If the same form is used as both the group contract and the certificate, a copy of the group contract must be delivered to each subscriber.

(2) New enrollees. Group agreements must include a provision specifying the conditions under which new enrollees may be added to those originally covered, including effective date requirements. For coverage issued to employers, group agreements must include a provision for special enrollment under 45 C.F.R. §146.117 (concerning Special Enrollment Periods).

(3) Agreements must comply with the benefit, offer, and notice requirements contained in Insurance Code Title 8, Subtitle E, (concerning Benefits Payable Under Health Coverages), as applicable.

(4) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans, may not exclude from coverage under the plan an enrollee who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing the dental care. This benefit does not require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

(5) Agreements, including consumer choice health benefit plan agreements, providing coverage for children under 18 must define reconstructive surgery for craniofacial abnormalities as provided by Insurance Code §1367.153 (concerning Reconstructive Surgery for Craniofacial Abnormalities; Definition Required).

(6) Group agreements, including consumer choice health benefit plan agreements, must cover formulas necessary to treat phenylketonuria or a heritable disease to the same extent that the agreement provides coverage for drugs that are available only on the orders of a physician, as required by Insurance Code Chapter 1359 (concerning Formulas for Individuals With Phenylketonuria or Other Heritable Diseases).

§11.511. Optional Provisions.

Evidences of coverage may contain optional provisions, including, but not limited to, the following:

(1) Coordination of benefits. Plans may contain a provision that the value of any benefits or services provided by the HMO may be coordinated with any other type of insurance plan or coverage under governmental programs so no more than 100 percent of eligible expenses incurred is paid. The coordination of benefits provision applies to the plan when an enrollee has health care coverage under more than one plan. This provision will only apply for the duration of the enrollee's coverage in a plan.

(A) If benefits are covered by more than one plan, any plan or plans that do not have a coordination of benefits provision are primary.

(B) Group plans issued or renewed on or before March 25, 2014, may not coordinate benefits with any type of individual or conversion plan.

(C) Group plans issued or renewed on or after March 25, 2014, may coordinate benefits with other plans subject to the requirements of Insurance Code Chapter 1203 (concerning Coordination of Benefits Provisions) and Chapter 3, Subchapter V, of this title (relating to Coordination of Benefits).

(2) Subrogation. Plans may contain a provision that the HMO is subrogated to and has a right to reimbursement from an individual's recovery for a personal injury for payments made or costs of benefits provided by the HMO as a result of that injury, subject to and limited by the provisions of Civil Practice and Remedies Code Chapter 140 (concerning Contractual Subrogation Rights of Payors of Certain Benefits), as added by Acts 2013, 83rd Leg., R.S., Ch. 180, §1 (HB 1869).

(3) Sale of substitutes to workers' compensation insurance. If the HMO chooses to market a product that provides coverage for on-the-job injuries or illness, it must comply with §5.6302 of this title (relating to Sale of Substitutes to Workers' Compensation Insurance).

(4) Conversion privilege. Group agreements and certificates for an HMO may, at the HMO's option, contain a conversion privilege. If an HMO elects to offer a conversion privilege, it must provide that, on termination of coverage, each enrollee who resides, lives, or works in the service area who has been covered under the group contract for a period of at least three months, or in the case of a court-ordered dependent, lives outside the service area but within the United States, has the right to convert within 31 days to a conversion agreement without presenting evidence of insurability. A single service or limited service HMO must offer a conversion contract without requiring evidence of insurability. Charges must comply with §11.704 of this title (relating to Conversion Rates).

(5) Arbitration. Plans may contain a statement of any arbitration procedure. If enrollee complaints and grievances are resolved through a specified arbitration agreement, the arbitration must be conducted under Texas Civil Practice and Remedies Code Chapter 171 (concerning General Arbitration).

§11.512. Optional Benefits.

An HMO may provide health services to its enrollees in addition to the services required in §11.508 of this title (relating to Basic Health Care Services and Mandatory Benefit Standards: Group, Individual and Conversion Agreements). An HMO may limit these optional health services as to time and cost. Evidences of coverage may contain optional benefits, including:

(1) corrective appliances and artificial aids;

(2) cosmetic surgery;

(3) care for military service-connected disabilities for which the enrollee is legally entitled to services and for which facilities are reasonably available to the enrollee;

(4) care for conditions that state or local law requires be treated in a public facility;

(5) dental services, except as otherwise required;

(6) vision care;

(7) custodial or domiciliary care;

(8) experimental and investigational medical, surgical, or other experimental or investigational health care procedures, unless approved as a basic health care service by the policymaking body of the HMO, provided that:

(A) a denial of a request for experimental or investigational services is an adverse determination; and

(B) an HMO must comply with Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy) if the HMO denies requested services because the HMO determines that the requested services are experimental and investigational;

(9) personal or comfort items and private rooms, unless medically necessary during inpatient hospitalization;

(10) durable medical equipment for home use (such as wheelchairs, surgical beds, respirators, or dialysis machines);

(11) infertility medical services, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and outpatient infertility drugs;

(12) reversal of voluntary sterilization;

(13) prescribed drugs and medicines incident to outpatient care; and

(14) noninsurance benefits, provided that the HMO complies with Chapter 21, Subchapter NN, of this title (relating to Noninsurance Benefits and Features).

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

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SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

28 TAC §11.602, §11.603

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code Chapter 541, Subchapters B and B-1; Insurance

Code §§36.001, 541.058, 542.003 - 542.006, 542.055 - 542.061, and 547.051.

Insurance Code Chapter 541, Subchapter B, provides the definition of unfair methods of competition and unfair or deceptive acts or practices.

Insurance Code Chapter 541, Subchapter B-1, provides requirements for advertising.

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

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in the listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receive during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer's acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

CROSS REFERENCE TO STATUTE.

Section 11.602 implements Insurance Code Chapter 541, Subchapters B and B-1; and Insurance Code §§542.003 - 542.006, 542.055, 542.056 - 542.061, and 547.051.

Section 11.603 implements Insurance Code Chapter 541, Subchapter B-1, and Insurance Code §541.058.

§11.602. Health Maintenance Organizations Subject to the Insurance Code Chapters 541, 542, and 547 and Related Rules.

§11.603. Filings.

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

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28 TAC §11.602, §11.603

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 541, Subchapters B and B-1; and Insurance Code §§36.001, 541.058, 542.003 - 542.006, 542.055 - 542.061, and 547.051.

Insurance Code Chapter 541, Subchapter B, provides the definition of unfair methods of competition and unfair or deceptive acts or practices.

Insurance Code Chapter 541, Subchapter B-1, provides requirements for advertising.

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

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in certain listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receives during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer's acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

CROSS REFERENCE TO STATUTE.

Sections 11.602 implements Insurance Code Chapter 541, Subchapters B and B-1; and Insurance Code §§542.003 - 542.006, 542.055 - 542.061, and 547.051.

Sections 11.603 implements Insurance Code Chapter 541, Subchapter B-1; and Insurance Code §541.058.

§11.602. HMOs Subject to Insurance Code Chapters 541, 542, and 547, and Related Rules.

HMOs must comply with Insurance Code Chapters 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), and 547 (concerning False Advertising by Unauthorized Insurers) and related rules, to the extent these rules may be applied to HMOs in the same manner as insurance companies.

§11.603. Filings.

Any HMO licensed to do business in Texas that offers coverage to Medicare beneficiaries under the provisions of Subchapter XVIII of 42 United States Code, Health Insurance for the Aged and Disabled, must file with the department a copy of each advertisement related to the coverage that is produced by the HMO or its agents and is an invitation to inquire or invitation to contract as defined in §21.113 of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising) no later than 45 days before its use. Material must be filed in compliance with §21.120 of this title (relating to Filing for Review). Material filed under this paragraph is not to be considered approved but may be subject to review for compliance with Texas law and consistency with other documents.

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

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SUBCHAPTER H. SCHEDULE OF CHARGES

28 TAC §§11.701 - 11.707

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §§36.001, 843.151, 1271.251 - 1271.253, and 1271.306.

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

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 §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

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, Subchapter F.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

CROSS REFERENCE TO STATUTE.

Sections 11.701 - 11.703 and §§11.705 - 11.707 implement Insurance Code §1271.251 and §1271.253.

Section 11.704 implements Insurance Code §1271.252 and §1271.306.

§11.701. Must Be Filed Prior to Use.

§11.702. Actuarial Certification.

§11.703. Supporting Documentation.

§11.704. Charges for Individuals.

§11.705. Enrollment Fees.

§11.706. Determination of Reasonability of Rates.

§11.707. Subsequent Review of the Formula or Method for Calculating the Schedule of Charges.

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

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28 TAC §§11.701 - 11.704

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§36.001, 843.151, 1271.251 - 271.253, and 1271.306.

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

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 §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

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, Subchapter F.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

CROSS REFERENCE TO STATUTE.

Sections 11.701 - 11.703 implement Insurance Code §1271.251 and §1271.253.

Section 11.704 implements Insurance Code §1271.252 and §1271.306.

§11.701. Schedule of Charges Must be Filed Before Use.

(a) No schedule of charges, formula, or method for calculating the schedule of charges may be used until a copy of the formula or method for calculating the schedule of charges with supporting documentation has been filed with the commissioner, as required by §11.703 of this title (relating to Filings and Supporting Documentation).

(b) The schedule of charges must include all charges made for group, conversion, or individual coverage.

§11.702. Actuarial Certification.

Each formula or method for calculating the schedule of charges must be accompanied by the certification of a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate, or unfairly discriminatory. An actuary is considered qualified if he or she is a member in good standing of both the American Academy of Actuaries and the Society of Actuaries.

§11.703. Filings and Supporting Documentation.

An HMO must submit schedule of charges information with the certificate of authority application in compliance with §11.204(11) and (12) of this title (relating to Contents). After the commissioner issues a certificate of authority, the HMO must file rates and supporting documentation before use as follows:

(1) rates for a new product:

(A) evidences of coverage to which the rates apply;

(B) for individual and small group plans, a new rate sheet including rates for each plan and each combination of rating factors used by the HMO; and

(C) actuarial memorandum:

(i) a brief description of benefits and general marketing method;

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

(iii) a list of retention components, including, but not limited to, expenses, taxes, fees, and profit expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

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

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

(vi) the assumptions and support used in developing rates, including, but not limited to, adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits;

(vii) any other data used to support the proposed rate; and

(viii) an actuarial certification required by §11.702 of this title (relating to Actuarial Certification);

(2) rate adjustments for an existing product:

(A) evidences of coverage to which the rates adjustments apply;

(B) for individual and small group plans, a new rate sheet that includes rates for each plan and each combination of rating factors used by the HMO; and

(C) actuarial memorandum:

(i) a brief description of benefits and general marketing method;

(ii) the scope and reason for the rate revision;

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

(iv) a brief description of how revised rates were determined, including a general description and source of each assumption used, which must also include a list of expenses, taxes, fees, and profit, expressed as a percent of premium, dollars per policy or dollars per unit of benefit, or both;

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

(vi) the assumptions and support used in developing rates, including, but not limited to, adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits;

(vii) any other data used to support the proposed rate increase; and

(viii) an actuarial certification required by §11.702 of this title.

§11.704. Conversion Rates.

(a) Charges for any individual's coverage may not be based on the individual's health status.

(b) The charge by an HMO for individual coverage that has been converted from group coverage may not exceed 200 percent of the rate that the individual would be charged for comparable group coverage.

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

Filed with the Office of the Secretary of State on September 22, 2016.

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Norma Garcia
General Counsel
Texas Department of Insurance
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For further information, please call: (512) 676-6584

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SUBCHAPTER I. FINANCIAL REQUIREMENTS

28 TAC §§11.801 - 11.808, 11.810

STATUTORY AUTHORITY.

The repeals are proposed under Insurance Code Chapter 823; and Insurance Code §§32.041, 36.001, 401.051, 401.054, 401.056, 404.003, 404.005, 421.001(c), 423.104, 441.005, 521.102, 541.058, 541.059, 541.401, 542.003 - 542.006, 542.055 - 542.061, 547.051, 801.056, 802.001, 823.012, 842.002(28), 843.151, 843.155, 843.156, 843.157, 843.201, 843.2015, 843.205, 843.207, 843.2071, 843.251, 843.361, 843.401, 843.403 - 843.406, and 843.461.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.003(a) provides that if the financial condition of an insurer, when reviewed as provided by Insurance Code §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

Insurance Code §404.003(c) provides that, in an order issued under Insurance Code §404.003(a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by Insurance Code §404.003(a).

Insurance Code §404.003(d) provides that the commissioner may use the remedies available under Insurance Code §404.003(c) in conjunction with the provisions of Insurance Code Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §421.001(c) provides that the commissioner adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under the subsection applies must establish reserves in compliance with that formula.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in the listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it received during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer's acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

Insurance Code §802.001 provides that the commissioner may change the form of any annual statement an insurance company is required to file and that the form may require only information that relates to the business of the insurance company.

Insurance Code §823.012 provides that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823, including the conducting of business and proceedings under Chapter 823. The section further provides that the commissioner by rule establish procedures to: (1) promptly consider the prepayment notices reported under §823.053(b); (2) annually review each reported ordinary dividend paid within the 12 months preceding the date of the report; and (3) take appropriate actions authorized by the Insurance Code.

Insurance Code §843.002(28) provides that the term "Uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment

for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

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 §843.155 provides the form and contents of annual reports HMOs must file with the commissioner.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.157 provides for the rehabilitation, liquidation, supervision, or conservation of health maintenance organizations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.401 provides that a director, officer, member, employee, or partner of an HMO who receives, collects, disburses, or invests funds in connection with the activities of the HMO is responsible for the funds in a fiduciary relationship to the enrollees.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §843.406(a) provides that if the financial condition of an HMO indicates that the continued operation of the HMO could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing: (1) suspend or revoke the HMO's certificate of authority; or (2) order

the HMO to take action reasonably necessary to correct the condition, including: (A) reducing by reinsurance the total amount of present and potential liability for benefits; (B) reducing the volume of new business being accepted; (C) reducing expenses by specified methods; (D) suspending or limiting for a period the writing of new business; or (E) increasing the HMO's capital and surplus by contribution.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §843.461 provides for the commissioner's power to maintain enforcement actions against HMOs.

CROSS REFERENCE TO STATUTE.

Section 11.801 implements Insurance Code §§32.041, 401.051, 401.056, 404.005(a)(2), 421.001(c), 441.005, 802.001, 823.012, 843.151, and 843.155.

Section 11.801 implements Insurance Code §843.403 and §843.404.

Section 11.802 implements Insurance Code §843.404 and §843.405.

Section 11.803 implements Insurance Code §§32.041, 401.051, 401.056, 404.005(a)(2), 421.001(c), 423.104, 441.005, 802.001, 843.151, 843.155, 843.401, and 843.403 - 843.406.

Section 11.804 implements Insurance Code §§843.103, 843.403 and 843.404.

Section 11.805 implements Insurance Code §843.403 and §843.404.

Sections 11.806 and 11.807 implement Insurance Code §843.401.

Section 11.808 implements Insurance Code §§32.041, 404.005(a)(2), 441.005, 802.001, 802.052, 802.056, 843.151, and 843.155.

Section 11.808 implements Insurance Code §843.002(28) and §843.405.

Section 11.810 implements Insurance Code §§404.003(a), 404.003(c), 404.003(d), 404.006, 406.003, 843.157, 843.403, and 843.461.

§11.801. Minimum Net Worth.

§11.802. Statutory Deposit Requirements.

§11.803. Investments, Loans, and Other Assets.

§11.804. Investment Management by Affiliate Companies.

§11.805. Fiduciary Responsibility.

§11.806. Liabilities.

§11.807. Dividends.

§11.808. Guarantee from a Sponsoring Organization.

§11.810. Hazardous Conditions for HMOs.

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

Filed with the Office of the Secretary of State on September 21, 2016.

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Norma Garcia
General Counsel
Texas Department of Insurance
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28 TAC §§11.801 - 11.808, 11.810, 11.811

STATUTORY AUTHORITY.

The new sections are proposed under Insurance Code §§32.041, 36.001, 401.051, 401.054, 401.056, 404.003, 404.005, 421.001(c), 423.104, 441.005, 521.102, 541.058, 541.059, 541.401, 542.003 - 542.006, 542.055 - 542.061, 547.051, 801.056, 802.001, 823.012, 843.002(28), 843.151, 843.155 - 843.157, 843.201, 843.2015, 843.205, 843.207, 843.2071, 843.251, 843.361, 843.401, 843.403 - 843.406, and 843.461.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.003(a) provides that if the financial condition of an insurer, when reviewed as provided by Insurance Code §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

Insurance Code §404.003(c) provides that, in an order issued under Insurance Code §404.003(a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by Insurance Code §404.003(a).

Insurance Code §404.003(d) provides that the commissioner may use the remedies available under Insurance Code §404.003(c) in conjunction with the provisions of Insurance Code Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §421.001(c) provides that the commissioner adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under the subsection applies must establish reserves in compliance with that formula.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in certain listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it received during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer's acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.001 provides that the commissioner may change the form of any annual statement an insurance company is required to file and that the form may require only information that relates to the business of the insurance company.

Insurance Code §823.012 provides that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823, including the conducting of business and proceedings under Chapter 823. The section further provides that the commissioner by rule establish procedures to: (1) promptly consider the prepayment notices reported under §823.053(b); (2) annually review each reported ordinary dividend paid within the 12 months preceding the date of the report; and (3) take appropriate actions authorized by the Insurance Code.

Insurance Code §843.002(28) provides that the term "Uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is

not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

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 §843.155 provides the form and contents of annual reports HMOs must file with the commissioner.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.157 provides for the rehabilitation, liquidation, supervision, or conservation of health maintenance organizations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.401 provides that a director, officer, member, employee, or partner of an HMO who receives, collects, disburses, or invests funds in connection with the activities of the HMO is responsible for the funds in a fiduciary relationship to the enrollees.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §843.406(a) provides that if the financial condition of an HMO indicates that the continued operation of the HMO could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing: (1) suspend or revoke the HMO's certificate of authority; or (2) order

the HMO to take action reasonably necessary to correct the condition, including: (A) reducing by reinsurance the total amount of present and potential liability for benefits; (B) reducing the volume of new business being accepted; (C) reducing expenses by specified methods; (D) suspending or limiting for a period the writing of new business; or (E) increasing the HMO's capital and surplus by contribution.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §843.461 provides for the commissioner's power to maintain enforcement actions against HMOs.

CROSS REFERENCE TO STATUTE.

Section 11.801 implements Insurance Code §§32.041, 401.051, 401.056, 404.005(a)(2), 421.001(c), 441.005, 802.001, 823.012, 843.151, and 843.155.

Sections 11.802 and §11.805 implement Insurance Code §843.403 and §843.404.

Section 11.803 implements Insurance Code §843.404 and §843.405.

Section 11.804 implements Insurance Code §§32.041, 401.051, 401.056, 404.005(a)(2), 421.001(c), 423.104, 441.005, 802.001, 843.151, 843.155, 843.401, and 843.403 - 843.406.

Section 11.806 implements Insurance Code §843.103 and §843.404.

Section 11.807 implements Insurance Code §843.401.

Section 11.808 implements Insurance Code §§32.041, 404.005(a)(2), 441.005, 802.001, 802.052, 802.056, 843.151, and 843.155.

Section 11.810 implements Insurance Code §843.002(28) and §843.405.

Section 11.811 implements Insurance Code §§404.003(a), 404.003(c), 404.003(d), 404.006, 406.003, 843.157, 843.403, and 843.461.

§11.801. Accounting Guidance.

To the extent that the accounting guidance given in §7.18 of this title (relating to National Association of Insurance Commissioners Accounting Practices and Procedures Manual) does not conflict with the provisions of this chapter, an HMO must follow that guidance. In the event of a conflict between the provisions of this chapter and §7.18 of this title, the HMO must follow the provisions of this chapter.

§11.802. Minimum Net Worth.

(a) An applicant for a certificate of authority to operate an HMO must have unencumbered assets that satisfy the requirements of Insurance Code §843.403 (concerning Minimum Net Worth).

(b) For the purpose of calculating assets to satisfy the minimum net worth requirements of Insurance Code §843.403, lawful money of the United States of America includes deposits in an institution that is a member of the Federal Deposit Insurance Corporation. Demand deposits, savings deposits, or time deposits, of the type that are federally insured in solvent banks, savings and loan associations, and their branches, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

(1) the amount of federal deposit insurance coverage pertaining to the deposit; or

(2) 10 percent of the issuing financial institution's equity, provided that the institution's equity is in excess of $25 million.

(c) The applicant must maintain unencumbered assets in excess of all of its liabilities by an amount equal to or greater than the minimum net worth requirement until it receives its certificate of authority; then the HMO must meet the minimum net worth requirements of Insurance Code §843.403 by maintaining unencumbered assets in excess of its liabilities by an amount equal to or greater than the minimum net worth requirement.

(d) Foreign HMOs seeking admission to this state, which are actively conducting business in other states, and approved nonprofit health corporations authorized under Insurance Code §844.005 (concerning Provision of Certain Services on Behalf of Health Maintenance Organizations), are required, at a minimum, to comply with Insurance Code §843.403.

§11.803. Statutory Deposit Requirements.

(a) Statutory deposits made under Insurance Code §843.405 (concerning Deposit with Comptroller) consisting of certificates of deposit must be issued by a solvent, federally insured bank.

(b) Before issuance of the certificate of authority, the HMO must submit proof of statutory deposits satisfying the requirements of Insurance Code §843.405 and meeting the investment requirements of §11.802 of this title (relating to Minimum Net Worth), with a completed Statutory Deposit Transaction Form, Form No. FIN407 (rev. 11/15), and Declaration of Trust Form, Form No. FIN453 (rev. 11/15) as adopted in §13.562(b) of this title (relating to Deposit or Letter of Credit Required), as well as a safekeeping receipt showing that the security is pledged to the department, and the applicable fees under §7.1301(d) of this title (relating to Regulatory Fees) to the bond and securities officer of the department.

(c) Each HMO must annually determine the amount of statutory deposit required as specified in Insurance Code §843.405 and adjust the amount of statutory deposit by March 15 of that year.

(d) Any increases, decreases, or substitutions to the deposit funds must be in funds meeting the investment requirements of §11.802 of this title and must be accompanied by the documentation described in subsection (b) of this section.

(e) If the HMO wishes to request a waiver or release, or a waiver and a release, of all or part of the statutory deposit requirements under Insurance Code §843.405, then the request must provide adequate information, including the following, to justify the relief requested:

(1) specification of the pertinent provisions of the Insurance Code under which the relief is being requested;

(2) the amount of the statutory deposit for which the relief is being requested;

(3) supporting documentation that justifies the relief requested including:

(A) reasons for requesting the relief;

(B) discussion of the impact of granting the relief requested and assurance that the HMO and its enrollees will not be harmed if the relief is granted; and

(C) if a request is based on a guarantee:

(i) a copy of the guarantee;

(ii) a copy of the most current audited financial statements of the sponsoring organization, unless the sponsoring organization files financial statements with the National Association of Insurance Commissioners or the Securities Exchange Commission;

(iii) disclosure of the number of guarantees that the sponsoring organization has issued; and

(iv) disclosure of the dollar amount of all obligations guaranteed, the amounts reflected as liabilities, and the amounts guaranteed that are not reflected as liabilities in the sponsoring organization's consolidated financial statements;

(4) if the request is based on projected uncovered expenses:

(A) projections for the next calendar year, including an income statement, a balance sheet, a cash flow statement and enrollment, and assumptions on which the projections are based;

(B) an explanation of why expenses are classified as "covered"; and

(C) a reconciliation with explanation for any differences between submitted projections and the previous calendar year's actual experience;

(5) if an HMO requests a release under Insurance Code §843.405(e) or (f):

(A) evidence that the dollar amount of uncovered health care expenses are likely to continue and will not exceed the amount remaining on deposit; and

(B) an explanation of the reasons for the decrease in uncovered health care expenses from that incurred during previous years;

(6) if a waiver is granted by the commissioner, the assets supporting the uncovered medical expenses may be invested under §11.804(3) of this title (relating to Invested Assets).

(f) When the conditions on which a waiver was granted change to the extent that the HMO is no longer able to qualify for the waiver, the HMO must deposit adequate funds to comply with the requirements of Insurance Code §843.405 within 30 days.

(g) All interest income due on the statutory deposit funds may be paid directly to the HMO by the bank.

§11.804. Invested Assets.

The admitted assets of domestic and foreign HMOs must at all times comply with the provisions of this section.

(1) Investment of minimum net worth. An HMO must have a minimum net worth as required by §11.802 of this title (relating to Minimum Net Worth).

(2) Investment of assets supporting uncovered medical expenses. An HMO must maintain statutory deposits supporting uncovered medical expenses as required by §11.803 of this title (relating to Statutory Deposit Requirements).

(3) Investments of assets in excess of minimum net worth and uncovered medical expenses. An HMO may invest its funds in excess of minimum net worth and uncovered medical expenses only in the following:

(A) any investments allowed in paragraphs (1) or (2) of this section;

(B) direct general obligations of any state of the United States of America for the payment of money, or obligations for the payment of money, to the extent guaranteed or insured as to the payment of principal and interest by any state of the United States of America, provided that:

(i) the state has the power to levy taxes for the prompt payment of the principal and interest of the obligations; and

(ii) the state is not in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of the investment;

(C) bonds, interest-bearing warrants, or other obligations issued by authority of law by any county, city, town, school district, or other municipality or political subdivision that is now or hereafter may be construed or organized under the laws of any state in the United States of America and that is authorized to issue the bonds, warrants, or other obligations under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet the obligations or a special revenue or income to meet the principal and interest payments as they accrue on the obligations has been appropriated, pledged, or otherwise provided; and

(ii) the county, city, town, school district, or other municipality or political subdivision is not in default in the payment of principal or interest on any of its obligations at the date of the investment;

(D) bonds, interest-bearing warrants, or other obligations issued by authority of law by any educational institution that is now or hereafter may be construed or organized under the laws of any state of the United States of America, and that is authorized to issue the bonds and warrants under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet the obligations or a special revenue or income to meet the principal and interest payments as they accrue on the obligations has been appropriated, pledged, or otherwise provided; and

(ii) the educational institution is not in default in the payment of principal or interest on any of its obligations at the date of the investment;

(E) investments issued by insurers or HMOs subject to the following conditions:

(i) an HMO may not make an investment under this subparagraph in any other HMO or insurer unless the other HMO or insurer is duly licensed to do business in its domestic state and at the time of the investment is in compliance with the minimum capital and surplus requirements then applicable under the provisions of that state's statutes and regulations; however, an HMO may make an investment under this paragraph in another HMO that has not yet received its certificate of authority to conduct the business of an HMO in its domestic state or that does not yet possess the minimum capital and surplus required by its domestic state if the investment will be sufficient to give the investing HMO at least 50 percent control in the other HMO;

(ii) an HMO may not invest, except as provided in subparagraphs (F) and (G) of this paragraph, in any other HMO or insurer unless the investments will result, within 180 days of the first investment, in the investing HMO having control in the other HMO or insurer;

(iii) an HMO may not invest more than 50 percent of its net worth in excess of minimum net worth in any other HMO or insurer;

(iv) the total investments made by an HMO in all other HMOs or insurers under this subparagraph may not exceed 75

percent of the investing HMO's net worth in excess of minimum net worth; and

(v) the restrictions of clauses (iii) and (iv) of this subparagraph do not apply if the HMO is purchasing 100 percent of the stock of another HMO for the purpose of a merger anticipated to take place no later than three months from the purchase date, unless the period is extended by the commissioner, and the resulting assets of the surviving HMO meet the requirements set forth in this subchapter within three months after the merger, unless the period is extended by the commissioner;

(F) bonds, debentures, bills of exchange, commercial notes, or any other bills and obligations of any corporation, incorporated under the laws of any state of the United States of America or of the United States of America, that, at the time of investment, is designated highest quality (NAIC designation 1) or high quality (NAIC designation 2) in compliance with the guidance provided by the NAIC Valuation of Securities Manual;

(G) equity interests, including common stocks issued by any business entity created under the laws of the United States of America or of any state of the United States, provided that:

(i) the business entity is solvent, with a net worth of at least $1 million;

(ii) if the business entity is a dividend paying business entity, no cumulative dividends are in arrears;

(iii) an HMO may not invest in a partnership, as a general partner, except through a wholly owned subsidiary; and

(iv) the restrictions of clauses (i) and (ii) of this subparagraph do not apply if the business entity of which the HMO wishes to purchase the equity interest is, or is to be, a contracted provider of services;

(H) shares of mutual funds doing business under the Investment Company Act of 1940 (15 United States Code §80a-1, *et seq.*) and shares in real estate investment trusts as defined in Internal Revenue Code of 1986 (26 United States Code §856), provided that the mutual funds and real estate investment trusts be solvent with at least $1 million of net assets as of the date of its latest annual, or more recent, certified audited financial statement;

(I) mortgage loans by an HMO that are secured by valid first liens on improved real estate, provided that:

(i) there is a title insurance policy or attorney's opinion showing that the borrower owns the real estate;

(ii) there is an appraisal of the real estate and its improvements and the loan does not exceed 75 percent of the appraised value;

(iii) there is an executed note evidencing the loan;

(iv) there is a recorded deed of trust;

(v) the value of the improvements is adequately insured by a company authorized to do business in Texas or in the state in which the real estate is located, and the insurance policy is made payable to the HMO in an amount equal to at least 50 percent of the value of the building, but the insurance coverage need not exceed the outstanding balance owed to the HMO when the outstanding balance falls below 50 percent of the value of the building; and

(vi) the commissioner has the right to obtain an independent appraisal, at the HMO's expense, of real estate securing any loan;

(J) loans secured by collateral, of a nature specified in Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this title (relating to Minimum Net Worth), although the amount loaned may not exceed the value of the securities held as collateral;

(K) loans, whether secured or unsecured and that are not in default, to medical and other health care providers under contract with the HMO for the provision of health care services; however, the admitted value of any loan made under this subparagraph may not exceed the maker's ability to repay the loan, which is calculated by only considering assets that an HMO may hold toward determining any excess of assets over all liabilities of the maker;

(L) real estate acquired in satisfaction of debt; all real property not qualifying under any other provisions of this section must be sold and disposed of within five years after the HMO has acquired title unless the time for disposal is extended by the commissioner;

(M) investments in improved, income-producing real estate;

(N) additional investments that are not otherwise specified by this section, provided that:

(i) the amount of any one investment may not exceed 10 percent of the net worth in excess of the HMO's minimum net worth plus uncovered medical expenses at the time of investment; and

(ii) the total amount of investments authorized by this paragraph may not exceed the HMO's net worth in excess of its minimum net worth plus uncovered medical expenses at the time of investment.

(4) Valuation and Amortization. Except where elsewhere specifically provided, assets must be valued and amortized in compliance with §11.801 of this title (relating to Accounting Guidance) as it applies to entities not required to maintain an asset valuation reserve. If no such standard applies, then the valuation must be at fair value.

(5) Evidence of ownership. A domestic HMO may demonstrate ownership of its securities by complying with §7.86 of this title (relating to Custodied Securities).

(6) Sale of investment. Section 7.4 of this title (relating to Admissible Assets) applies to investments not specifically allowed under this subchapter. The commissioner may require any investment to be sold that would otherwise be authorized under the provisions of this section if the commissioner finds that the investment would cause the investing HMO to operate in a condition that is hazardous to its enrollees, creditors, or the general public.

§11.805. Other Assets.

(a) Other assets an HMO may find necessary in its operations include, but are not limited to, the following:

(1) uncollected premiums or subscriptions with an adequate provision for uncollectable premiums or subscriptions;

(2) advances of capitation or other fees expected to be paid for the next month to medical and other health care service providers under contract with the HMO, provided that no termination of the contract may take place before the end of the period for which advances were paid;

(3) the following items, provided that a detailed inventory is maintained with each item marked by any identifying number and the proof of cost maintained:

(A) furniture, labor-saving devices, machines, and all other office equipment used in the administration of the HMO;

(B) furniture, medical equipment, and vehicles used in connection with the direct provision of health care services; and

(C) electronic machines, constituting a data processing system or systems and operating systems software used directly for the provision of medical services and the administration of the HMO;

(4) inventories of necessary pharmaceutical and surgical supplies used directly in the treatment of medical conditions, it being the duty of the HMO to sufficiently prove the value of the inventories;

(5) real estate and leasehold estates, including buildings and improvements, and leasehold improvements on rented space, for the accommodation of the HMO's current or expected business operations used in the provision or support of health care services, including space for rent to any physician or provider under contract with the HMO, which property will be used in the provision of health care services to members of the HMO by that physician or provider; and

(6) claims overpayments, with the right of offset supported by a contractual agreement, which are specifically identifiable payments, may be admitted to the extent a liability to that physician or provider exists.

(b) All noninvested assets of an HMO must be accounted for in compliance with §11.801 of this title (relating to Accounting Guidance) except that the assets listed in subsection (a) of this section are admissible.

§11.806. Investment Management by Affiliate Companies.

(a) Subject to compliance with Insurance Code Chapter 843 (concerning Health Maintenance Organizations), this chapter, and other applicable insurance laws and regulations of this state, a domestic HMO, which is a member of a holding company system with assets in an aggregate amount in excess of $1 billion and a tangible net worth of at least $100 million and having affiliates licensed in this state may authorize an affiliated corporation that, if other than the ultimate holding company, is solvent with at least $10 million tangible net worth and whose performance and obligations under a written agreement with the HMO are guaranteed by the ultimate holding company to invest, hold, and administer as agent or nominee on behalf of the domestic HMO bonds, notes, or other evidences of indebtedness that are authorized and permissible investments under Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state that apply to HMOs, and which mature within one year of the date of acquisition. The securities must be invested, held, and administered under a written agreement authorized by the board of directors of the HMO or an authorized committee, and submitted to the commissioner for prior approval. Approval must be based on satisfactory evidence that the agreement will facilitate the operations of the domestic HMO and will not unreasonably diminish the service to or protection of the domestic HMO's enrollees within this state.

(b) The agreement may:

(1) specify in which office location it will maintain records adequate to identify and verify the securities (or proportionate interest therein) belonging to the HMO; and

(2) allow the commissioner or the commissioner's designee to examine all records relating to those securities held subject to the agreement and must agree to furnish these records at the principal office of the HMO within 10 business days of a request by the commissioner or any of the department's commissioned examiners.

(c) The HMO may authorize the affiliate to:

(1) hold the securities of the HMO in bulk, in certificates issued in the name of the affiliate or its nominee, and to commingle them with securities owned by other affiliates of the affiliate;

(2) provide for the securities to be held by a custodian, including the custodian of securities of the affiliate, or in a clearing corporation or the Federal Reserve Book Entry System as provided in this subchapter; and

(3) purchase, sell, or otherwise dispose of the securities in compliance with instructions received from the HMO.

(d) If required by the commissioner, the HMO must report annually to the department:

(1) all investments with the affiliate under this section;

(2) the market value of all securities held by the affiliate on behalf of the HMO as of December 31 of the year next preceding or other date as the commissioner may require; and

(3) the financial condition of the affiliate including, at the commissioner's discretion, balance sheets, income statements, and supporting schedules with an opinion on those financial statements by an independent certified public accountant for the most recent fiscal year.

(e) All of the investments and transactions between or among affiliates and the HMO must otherwise comply with all other applicable provisions of Insurance Code Chapters 823 (concerning Insurance Holding Systems) and 843, and other applicable insurance laws and regulations of this state.

(f) If the HMO or the affiliate does not comply with Insurance Code Chapters 823 and 843 and other applicable insurance laws and regulations of this state, or does not comply with the written agreement governing the investing, holding, and administering of securities, then the commissioner's approval will be withdrawn after reasonable notice and ample opportunity to cure the noncompliance. If the HMO wishes to continue the arrangement, it must submit a request to the commissioner for approval.

(g) On the withdrawal of approval of the agreement, the HMO must undertake to obtain, and the affiliated corporation must undertake to return, investments or funds resulting from the sale or maturity of those investments in which the affiliated corporation invested, held, and administered on behalf of the HMO and the return must be accomplished within 90 days unless:

(1) the commissioner determines that the 90-day period creates a hazard to the public, in which case the commissioner may designate that the period may not exceed 30 days from the date of determination; or

(2) the commissioner extends the period for specific investments on request by the HMO and affiliated corporation, but in no event to exceed one year from the date of the withdrawal of approval.

(h) The affiliate must be organized under the laws of one of the states of the United States of America or of the District of Columbia.

§11.807. Fiduciary Responsibility.

Any director, member of a committee, officer, or any representative of a domestic HMO, who is charged with the duty of handling or investing its funds, may not intentionally:

(1) deposit or invest the funds, except in the corporate name of the HMO or in the name of the nominee of the HMO as may be allowed elsewhere in this subchapter; or

(2) take or receive to his or her own use any fee, brokerage, or commission, on account of a loan made by or on behalf of the HMO, except that reasonable interest may be received on amounts loaned to the HMO.

§11.808. Liabilities.

(a) Each HMO must account for liabilities as provided for in §11.801 of this title (relating to Accounting Guidance), and must segregate its liabilities into classifications of "covered" or "uncovered." Agreements to loan money or to make future capital or surplus contributions do not, in themselves, cause liabilities to be covered. Any guarantee of future contributions to surplus that are directed and based on the payment of a debt will allow that debt to be reflected as a covered liability. A liability, for which provision is made other than by the assets of the HMO, may qualify as a covered liability if the amount owed is:

(1) based on a physician or provider contract with a hold-harmless clause as provided in §11.901 of this title (relating to Required and Prohibited Provisions);

(2) subordinated in writing to the uncovered health care liabilities of the HMO; or

(3) unconditionally guaranteed and the guarantee is without monetary limit, as specified in §11.810 of this title (relating to Guarantee from a Sponsoring Organization), by a sponsoring organization that has a tangible net worth of at least $10 million in excess of all amounts that the sponsoring organization has guaranteed.

(b) An HMO may not decrease its liabilities or establish an asset on its balance sheet for any capitated risk or other risk-sharing arrangement with a network physician or provider relating to out-of-service area or emergency care provided by any non-network physician or provider. For purposes of this subsection, non-network physician or provider means a physician or provider who has not directly or indirectly contracted with an HMO or an HMO's network physicians or providers to provide medical or health care services to the HMO's enrollees.

§11.810. Guarantee from a Sponsoring Organization.

(a) The following items must be incorporated into a guarantee from a sponsoring organization for the HMO to report expenses and liabilities as covered:

(1) the guarantee must be approved by a board resolution of the sponsoring organization;

(2) the sponsoring organization must have a tangible net worth of at least $10 million for each guarantee issued;

(3) the sponsoring organization must agree to file audited financial statements annually with the department's Financial Analysis Section within 180 days of the end of the sponsoring organization's fiscal year;

(4) the guarantee must be unconditional and may not be monetarily limited;

(5) the guarantee, at a minimum, must cover otherwise "uncovered" health care expenses and liabilities, including any present or future contingencies that may arise from the delivery of health care. If the HMO is offering Medicaid products, all expenses and liabilities must be covered;

(6) the guarantee must not be limited in duration;

(7) the guarantee must provide for six-months' advance notice to the department before its cancellation; and

(8) the guarantee must be notarized and signed by the president and another officer of the sponsoring organization.

(b) If at any time a guarantee does not comply with every requirement of this section, then the HMO will no longer qualify for covered expenses and liabilities.

(c) If the sponsoring organization has guaranteed the payment of any debts, expenses, or contingent obligations of another person, or guaranteed the performance of any service or other obligation of another person, then the HMO must provide a certification from the sponsoring organization of the following:

(1) the name of each person guaranteed;

(2) the type of business of that person; and

(3) the extent of each guarantee issued, and the dollar amount of debts and contingent obligations guaranteed individually and in the aggregate.

(d) The HMO must also certify that the guaranteed debts are reported as liabilities or contingent liabilities of the guarantor. This certification must be submitted annually with the sponsoring organization's audited financial statements. The certified copy must be notarized and signed by the president or chief financial officer of the sponsoring organization, with an acknowledgment of the guarantee by the HMO's president or chief financial officer.

§11.811. Action under Insurance Code §843.157 and Insurance Code §843.461.

(a) In addition to any other actions available under the Insurance Code, the commissioner may take action against an HMO under §843.157 (concerning Rehabilitation, Liquidation, Supervision, or Conservation of Health Maintenance Organizations) and Insurance Code §843.461 (concerning Enforcement Actions). In evaluating the conditions in this section, the commissioner will evaluate all relevant circumstances concerning the HMO's operation. The evaluation of the information relating to these conditions is a part of the examination process. The conditions listed in this section do not conclusively indicate that action must be taken. One or more of the conditions can exist in an HMO that is in satisfactory condition; however, one or more of these conditions has often been found in an HMO that was unable to perform its obligations to enrollees, creditors, or the general public, or has required the commissioner to initiate regulatory action to protect enrollees, creditors, and the general public.

(b) The commissioner may take action under this section, if the commissioner finds that one or more of the conditions listed below or in §8.3 of this title (relating to Hazardous Conditions and Remedy of Hazardous Conditions) exist:

(1) an HMO's federal qualification designation, or NCQA accreditation, or both, are revoked or discontinued;

(2) an HMO's reported claims in process exceed 12 percent of annualized medical and hospital expenses (12 percent is approximately a 45-day backlog);

(3) an HMO fails to comply with Insurance Code Chapter 843 (concerning Health Maintenance Organizations), this chapter, or other applicable insurance laws and regulations of this state;

(4) an HMO has an inadequate provider network;

(5) an HMO contracts with a management or administrative company on a capitated or percentage of premium basis and the administrative or management company refuses to submit financial statements to the HMO;

(6) a physician or provider that is under contract, directly or indirectly, with an HMO, has a pattern of balance billing; or

(7) an HMO does not have the minimum net worth required by Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this title (relating to Minimum Net Worth).

(c) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

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

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SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

28 TAC §§11.900 - 11.904

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §§36.001, 38.001, 842.002(28), 843.151, 843.203, 843.281, 843.283, 843.3045, 843.306 - 843.309, 843.311, 843.3115, 843.312, 843.315, 843.316, 843.319 - 843.321, 843.323, 843.336, 843.361 - 843.363, 1271.201, 1271.202, 1353.001, 1353.002, 1371.003, 1451.156, and 1661.005.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.002(28) provides that the term "Uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

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 §843.203 provides, in relevant part, an enrollee the opportunity to select and change the enrollee's primary care provider or physician.

Insurance Code §843.281 prohibits retaliatory actions by HMOs against a: (1) group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the HMO or appealed a decision of the HMO; or (2) physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO.

Insurance Code §843.283 provides that a contract between an HMO and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the HMO. The notice must include the department's toll-free telephone number for filing a complaint.

Insurance Code §843.3045 provides that an HMO may not refuse to contract with a nurse first assistant, as defined by Occupations Code §301.1525, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Insurance Code §843.306 provides, in relevant part, that an HMO must provide a written explanation before terminating a contract with a physician or provider, and for the right of a physician or provider to a review by an advisory review panel of the HMO's proposed termination, except in limited circumstances.

Insurance Code §843.307 provides that, on request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the HMO.

Insurance Code §843.308 regulates an HMO's notification of patients of the deselection of a physician or provider.

Insurance Code §843.309 provides that a contract between an HMO and a physician or provider must provide that reasonable advance notice must be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

Insurance Code §843.311 provides a podiatrist's right to an HMO's coding guidelines and payment schedules, prohibits HMOs from making unilateral material retroactive revisions to the coding guidelines and payment schedules, and provides that podiatrists may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Insurance Code §843.3115 provides, in relevant part, that a contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service.

Insurance Code §843.312 provides that HMO may not refuse a request by a physician participating in the HMO delivery net-

work and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Occupations Code Chapter 157, Subchapter B, to identify a physician assistant or advanced practice nurse as a provider in the network, unless the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the HMO for participation in the network by physician assistants and advanced practice nurses.

Insurance Code §843.315 governs the payment of capitation and the assignment of a primary care physician or provider by any HMO that uses capitation to any extent as a method of compensation.

Insurance Code §843.316 provides that as an alternative to the procedures prescribed by §843.315, an HMO may request approval from the department of a capitation payment system that ensures: (1) immediate availability and accessibility of a primary care physician or primary care provider; and (2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed.

Insurance Code §843.319 provides that, notwithstanding §843.304, an HMO may not deny a contract to a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider, satisfies the application procedures of the HMO, and meets the qualification and credentialing requirements for contracting with the HMO.

Insurance Code §843.320 provides that a contract between an HMO and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Insurance Code §843.321 provides a physician or provider's right to an HMO's coding guidelines and the use thereof.

Insurance Code §843.323 provides that, upon request, an HMO must include a provision in the physician's or provider's contract providing that the HMO or the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Chapter 843, Subchapter J, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim, and that the commissioner may issue a cease and desist order against or impose sanctions on an HMO that violates the section or a contract provision adopted under the section.

Insurance Code §843.336 defines the term "clean claim."

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.362 provides, in relevant part, that each contract between an HMO and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the HMO from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence.

Insurance Code §843.363 provides, in relevant part, that an HMO may not: (a) as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to certain matters; (b) as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient; or (c) in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by the section with a current, prospective, or former patient, or a person designated by a patient. The section further provides that a contract provision that violates t section is void.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.202 provides that if an HMO denies a request under §1271.201, the enrollee may appeal the decision through the HMO's established complaint and appeals process.

Insurance Code §1353.001 provides that a managed care entity may not: (1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan; (2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued; (3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or (4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1371.003 provides, in relevant part, that a health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under §§1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

Insurance Code §1451.156 sets forth prohibited conduct by a managed care plan.

Insurance Code §1661.005 provides that a physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. The section does not apply to an overpayment subject to §843.350 or §1301.132.

CROSS REFERENCE TO STATUTE.

Section 11.900 implements Insurance Code §1271.201 and §1271.202.

Section 11.901 implements Insurance Code §§843.002(28), 843.203, 843.281, 843.283, 843.306 843.307, 843.309, 843.315, 843.316, 843.321, 843.323, 843.361, 843.362, 843.307, 843.311, 843.3115, 1371.003, 1451.156, and 1661.005.

Section 11.902 implements Insurance Code §§843.3045, 843.312, 843.319, 843.320, 843.336, and 1451.156.

Section 11.903 implements Insurance Code §843.363 and §1301.067.

Section 11.904 implements Insurance Code §1353.001.

§11.900. Nonprimary Care Physician Specialist as Primary Care Physician.

§11.901. Required Provisions.

§11.902. Prohibited Actions.

§11.903. Physician or Provider Communication.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

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

Filed with the Office of the Secretary of State on September 21, 2016.

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Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 676-6584

28 TAC §§11.900 - 11.904

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§36.001, 842.002(28), 843.151, 843.203, 843.281, 843.283, 843.3045, 843.306 - 843.309, 843.311, 843.3115; 843.312, 843.315, 843.316, 843.319 - 843.321, 843.323, 843.336, 843.361 - 843.363, 1271.201, 1271.202, 1353.001, 1353.002, 1371.003, 1451.156, and 1661.005.

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Insurance Code §843.362 provides, in relevant part, that each contract between an HMO and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the HMO from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence.

Insurance Code §843.363 provides, in relevant part, that an HMO may not: (a) as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to certain matters; (b) as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient; or (c) in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by the section with a current, prospective, or former patient, or a person designated by a patient. The section further provides that a contract provision that violates t section is void.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.202 provides that if an HMO denies a request under §1271.201, the enrollee may appeal the decision through the HMO's established complaint and appeals process.

Insurance Code §1353.001 provides that a managed care entity may not: (1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan; (2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued; (3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or (4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1371.003 provides, in relevant part, that a health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and

42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

Insurance Code §1451.156 sets forth prohibited conduct by a managed care plan.

Insurance Code §1661.005 provides that a physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. The section does not apply to an overpayment subject to §843.350 or §1301.132.

CROSS REFERENCE TO STATUTE.

Section 11.900 implements Insurance Code §1271.201 and §1271.202.

Section 11.901 implements Insurance Code §§843.002(28), 843.203, 843.281, 843.283, 843.306 - 843.309, 843.315, 843.316, 843.321, 843.323, 843.361, 843.362, 843.307, 843.311, 843.3115, 1371.003, 1451.156, and 1661.005.

Section 11.902 implements Insurance Code §§843.3045, 843.3115, 843.312, 843.319, 843.320, 843.336, and 1451.156.

Section 11.903 implements Insurance Code §843.363 and §1301.067.

Section 11.904 implements Insurance Code §1353.001.

§11.900. Nonprimary Care Physician Specialist as Primary Care Physician.

(a) An HMO must allow an enrollee with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician, provided that:

(1) the enrollee makes a request for special consideration that includes:

(A) a certification by the nonprimary care physician specialist of the medical need for the enrollee to use the nonprimary care physician specialist as a primary care physician;

(B) a statement signed by the nonprimary care physician specialist that the specialist is willing to accept responsibility for the coordination of all of the enrollee's health care needs; and

(C) the signature of the enrollee;

(2) the nonprimary care physician specialist meets the HMO's requirements for primary care physician participation, including credentialing;

(3) the HMO has ensured that the contractual obligations of the nonprimary care physician specialist are consistent with the contractual obligations of the HMO's primary care physicians; and

(4) the HMO must provide the nonprimary care physician specialist with a current directory of participating specialist physicians and providers.

(b) An HMO must approve or deny the request for special consideration and provide written notification of the decision to the enrollee not later than 30 days after receiving the request. If the HMO denies the request, the HMO must provide the reasons for denial in the written notification. An HMO must establish written criteria for determining medical need for an enrollee to use a nonprimary care physician specialist as a primary care provider, and must include the criteria in the provider manual.

(c) If the HMO denies a request for special consideration, an enrollee may appeal the decision through the HMO's established complaint and appeal process.

§11.901. Required and Prohibited Provisions.

(a) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding a hold-harmless clause as described in Insurance Code §843.361 of this title (concerning Enrollees Held Harmless).

(1) A hold-harmless clause is a provision in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(2) In compliance with Insurance Code §843.002 (concerning Definitions) relating to an "uncovered expense," if a physician or health care provider agreement contains a hold-harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405 (concerning Deposit with Comptroller).

(3) The following is an example of an approvable hold-harmless clause: "(Physician or Provider) hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency, or breach of this agreement, may (Physician or Provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between HMO and subscriber or enrollee. (Physician or Provider) further agrees that:

(A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and

(B) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Physician or Provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes."

(b) Physician and provider contracts, subcontracts, and arrangements must include provisions:

(1) regarding retaliation as described in Insurance Code §843.281 (concerning Retaliatory Action Prohibited);

(2) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309 (concerning Contracts with Physicians or Providers; Notice to Certain Enrollees of Termination of Physician or Provider Participation Plan) and §843.362 (concerning Continuity of Care; Obligation of Health Maintenance Organization);

(3) regarding written notification to enrollees receiving care from a physician or provider of the termination of that physician or provider in compliance with Insurance Code §843.308 (concerning Notification of Patients of Deselected Physician or Provider) and §843.309 (concerning Contracts With Physicians or Providers: Notice to Certain Enrollees of Termination of Physician or Provider Participation in a Plan);

(4) regarding posting of complaint notices in physician or provider offices as described in Insurance Code §843.283 (concerning

Posting of Information on Complaint Process Required), provided that a representative notice that complies with this requirement may be obtained from the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or the department's website at www.tdi.texas.gov;

(5) regarding indemnification of the HMO as described in Insurance Code §843.310 (concerning Contracts with Physicians or Providers; Certain Indemnity Clauses Prohibited);

(6) regarding prompt payment of claims as described in Insurance Code Chapter 542, Subchapter B, (concerning Prompt Payment of Claims); §1271.005 (concerning Applicability of Other Law); and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J, (concerning Payment of Claims to Physicians and Providers); and Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims) with respect to payment to the physician or provider for covered services rendered to enrollees;

(7) regarding capitation, if applicable, as described in Insurance Code §843.315 (concerning Payment of Capitation; Assignment of Primary care Physician or Provider) and §843.316 (concerning Alternative Capitation System);

(8) regarding selection of a primary care physician or provider, if applicable, as described in Insurance Code §843.203 (concerning Selection of Primary Care Physician or Provider);

(9) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish X-rays and non-prefabricated orthotics covered by the evidence of coverage as described in Insurance Code §843.311 of this title (concerning Contracts With Podiatrists);

(10) regarding electronic health care transactions as set forth in §21.3701 of this title (relating to Electronic Claims Filing Requirements) if the contract requires electronic submission of any information described by that section;

(11) requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005 (concerning Refunds of Overpayments); and

(12) requiring a contracting physician or provider to retain in the contracting physician's or provider's records updated information concerning a patient's other health benefit plan coverage.

(c) Physician and provider contracts, subcontracts, and arrangements must include provisions entitling the physician or provider, on request, to all information necessary to determine that the physician or provider is being compensated in compliance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information provided must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including email, computer disks, or other electronic storage and transfer technology, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided under this paragraph must comply with paragraph (4) of this subsection. The HMO must provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(1) The information provided must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider, including at a minimum, the:

(A) fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM, ICD-10-CM, and successor codes, and modifiers:

(i) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

(ii) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis, along with a toll-free number or electronic address through which the contracting physician or provider may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee, and any other information required by this subsection, that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;

(B) all applicable coding methodologies;

(C) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;

(D) all applicable downcoding policies;

(E) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;

(F) any addenda, schedules, exhibits, or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided under this subsection; and

(G) the published product name and version of any software the HMO uses to determine bundling and unbundling of claims.

(2) In the case of a reference to source information outside the control of the HMO as the basis for fee computation, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides must clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(3) Nothing in this subsection may be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, instead of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services that are rendered to enrollees as required by paragraph (1) of this subsection.

(4) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days written notice to the contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism

for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

(5) The HMO must provide the information required by paragraphs (1) - (4) of this subsection to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(6) A physician or provider receiving information under this subsection may not:

(A) use or disclose the information for any purpose other than:

(i) the physician's or provider's practice management,

(ii) billing activities,

(iii) other business operations, or

(iv) communications with a governmental agency involved in the regulation of health care or insurance;

(B) use the information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; or

(C) rely on information provided under this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(7) A physician or provider that receives information under this subsection may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider must provide for reasonable advance notice to enrollees being treated by the physician or provider before the termination consistent with Insurance Code §843.309.

(8) The provisions of this subsection may not be waived, voided, or nullified by contract.

(d) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding written notification of termination to a physician or provider in compliance with Insurance Code §843.306 (concerning Termination of Participation; Advisory Review Panel) and §843.307 (concerning Expedited Review Process on Termination or Deselection), including provisions providing that:

(1) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days before the effective date of the termination;

(2) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel except in a case involving:

(A) imminent harm to patient health;

(B) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance; and

(3) within 60 days after receipt of the physician or provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider.

(e) On request by a participating physician or provider, an HMO must include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N 837 Transaction Set and identified by a batch control number." This subsection applies to a contract entered into or renewed on or after the effective date of this subsection. For a contract entered into or renewed before the effective date of this subsection, the law and regulations in effect at the time the contract was entered or renewed, whichever is later, governs.

(f) A contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115 (concerning Contracts with Dentists).

§11.902. Prohibited Actions.

An HMO may not:

(1) require a physician to use a hospitalist for a hospitalized patient by contract under Insurance Code §843.320 (concerning Use of Hospitalist);

(2) refuse to contract with a nurse first assistant to be part of a provider network or refuse to reimburse a nurse first assistant under Insurance Code §843.3045 (concerning Nurse First Assistant);

(3) require a physician to use the services of a nurse first assistant as defined by Occupations Code §301.354 (concerning Nurse First Assistants; Assisting at Surgery by Other Nurses);

(4) refuse to contract with a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider under Insurance Code §843.319 (concerning Certain Required Contracts);

(5) refuse a request to identify a physician assistant or advanced practice nurse as a provider in the HMO's network under Insurance Code §843.312 (concerning Physician Assistants and Advanced Practice Nurses);

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156 (concerning Prohibited Conduct); or

(7) contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115.

§11.903. Physician or Provider Communication.

(a) An HMO may not, as a condition of a contract with a physician or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options, or the availability of facilities both in-network and out-of-network for the treatment of a patient's medical condition;

(2) information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient;

(3) the fact that the physician's or provider's contract with the HMO has terminated or that the physician or provider will otherwise no longer be providing medical care or health care services under the health care plan; or

(4) the fact that, if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider and within time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow referral to a non-network physician or provider.

(b) An HMO may not in any way penalize, terminate, or refuse to compensate for covered services, a physician or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any way protected by this section.

(c) An HMO many not require a physician or provider to provide a notification form stating that the physician or provider is an out-of-network provider to a current, prospective, or former patient, or a party designated by a patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

(a) In compliance with Insurance Code Chapter 1353 (concerning Immunization or Vaccination Protocols Under Managed Care Plans), an HMO may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

(b) No contract between an HMO and a pharmacy or pharmacist may prohibit a pharmacist from administering immunizations or vaccinations if the immunizations or vaccinations are administered in compliance with the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551-569 (concerning Pharmacy and Pharmacists), and related rules.

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

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Norma Garcia
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SUBCHAPTER K. REQUIRED FORMS

28 TAC §11.1001

STATUTORY AUTHORITY. The repeal is proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 843.076, 843.078, 843.082, 843.151, 843.154, 843.405, and 1271.251.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that

certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

CROSS REFERENCE TO STATUTE.

Section 11.1001 implements Insurance Code §§32.041, 541.059, 843.076, 843.082, 843.154, 843.405, and 1271.251.

§11.1001. Required Forms.

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

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Norma Garcia
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28 TAC §11.1001

STATUTORY AUTHORITY. The proposed new section is proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 843.076, 843.078, 843.082, 843.151, 843.154, 843.405, and 1271.251.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

CROSS REFERENCE TO STATUTE.

Section 11.1001 implements Insurance Code §§32.041, 541.059, 843.076, 843.082, 843.154, 843.405, and 1271.251.

§11.1001. Required Forms.

The following forms are to be used in conjunction with the rules adopted under this chapter. Copies of these forms may be obtained by contacting the Company Licensing and Registration Office, Mail Code 103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or from the department's website at www.tdi.texas.gov. Each HMO or other person or entity must use the form or forms required by this title as appropriate to its particular activities. The forms are listed as follows:

(1) Name Application Form, (rev. 03/14);

(2) Application for a Certificate of Authority to do business in the State of Texas, (rev. 09/04);

(3) State of Texas Officers and Directors Page, TDI Form FIN306, (rev. 06/10);

(4) State of Texas Biographical Affidavit, NAIC UCAA Form 11, (rev. 04/13);

(5) HMO Certification and Transmittal Form, TDI Form LHL 259, (rev. 07/14);

(6) Reconciliation of Benefits to Schedule of Charges Form, TDI Form LHL 654, (rev. 01/13);

(7) Statutory Deposit Transaction Form, Form No. FIN407 (rev.11/15); and

(8) Declaration of Trust Form, Form No. FIN453 (rev.11/15).

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

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Norma Garcia
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SUBCHAPTER M. ACQUISITION OF, CONTROL OF, OR MERGER OF, A DOMESTIC HMO

28 TAC §§11.1201 - 11.1206

STATUTORY AUTHORITY.

The repeals are proposed under Insurance Code Chapter 823, Subchapters D and E; Insurance Code Chapter 824, Subchapter A; and Insurance Code §§36.001, 843.051(g), and 843.151.

Insurance Code Chapter 823, Subchapter D, contains provisions regarding the control, acquisition, merger, change, or divestiture of domestic insurers.

Insurance Code Chapter 823, Subchapter E, provides for an acquisition statement by an acquiring person.

Insurance Code Chapter 824, Subchapter A, provides for the merger and consolidation of stock insurance corporations.

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

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

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.

CROSS REFERENCE TO STATUTE.

Section 11.1201 implements Insurance Code Chapter 823, Subchapter D; Chapter 823, Subchapter E; Chapter 824, Subchapter A; and Insurance Code §843.051(g).

Sections 11.1202 - 11.1206 implement Insurance Code Chapter 823; Insurance Code Chapter 823, Subchapter E; Insurance Code Chapter 824, Subchapter A; and Insurance Code §843.051(g).

§11.1201. Definitions.

§11.1202. Filing Requirements.

§11.1203. Form Filing.

§11.1204. Form A (HMO).

§11.1205. Approval by Commissioner; Hearings.

§11.1206. Exemptions.

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

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SUBCHAPTER M. ACQUISITION, CONTROL, OR MERGER OF A DOMESTIC HMO

28 TAC §11.1201

STATUTORY AUTHORITY.

The new section is proposed under Insurance Code Chapter 823, Subchapters D and E; Insurance Code Chapter 824, Subchapter A; and Insurance Code §36.001 and §843.051(g).

Insurance Code Chapter 823, Subchapter D, contains provisions regarding the control, acquisition, merger, change, or divestiture of domestic insurers.

Insurance Code Chapter 823, Subchapter E, provides for an acquisition statement by an acquiring person.

Insurance Code Chapter 824, Subchapter A, provides for the merger and consolidation of stock insurance corporations.

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

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

CROSS REFERENCE TO STATUTE.

Section 11.1201 implements Insurance Code Chapter 823, Subchapter D; Chapter 823, Subchapter E; Chapter 824, Subchapter A; and Insurance Code §843.051(g).

§11.1201. Acquisition, Control, or Merger of a Domestic HMO.

An HMO is subject to the requirements of Insurance Code Chapter 823 (concerning Insurance Holding Company Systems); Insurance Code Chapter 824 (concerning Merger and Consolidation of Stock Insurance Corporations); and Chapter 7, Subchapter B, of this title (relating to Insurance Holding Company Systems).

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

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SUBCHAPTER N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION

28 TAC §§11.1301 - 11.1306

STATUTORY AUTHORITY.

The repeals are proposed because of the repeal of Insurance Code §§843.435 - 843.440 by HB 1951, 82nd Legislature, Regular Session (2011).

CROSS REFERENCE TO STATUTE.

Sections 11.1301 - 11.1306 implement the repeal of Insurance Code §§843.435 - 843.440 by HB 1951, 82nd Legislature, Regular Session (2011).

§11.1301. Plan of Operation.
§11.1302. Solvency Survey Committee.
§11.1303. Operations.
§11.1304. Records and Reports.
§11.1305. Appeals.
§11.1306. Conformity of Statute.

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

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SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

28 TAC §§11.1401 - 11.1404

STATUTORY AUTHORITY.

The repeals are proposed under Insurance Code §§32.041, 36.001, 38.001, 843.151, 843.154, 843.305, and 1369.402.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.305 provides, in relevant part, that an HMO providing coverage through one or more physicians or providers who are not partners or employees of the HMO, or one or more physicians or providers who are not owned or operated by the HMO, must provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the HMO for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

Insurance Code §1369.402 provides that a health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for

a fee for any step of or component or mechanism related to the claim adjudication process.

CROSS REFERENCE TO STATUTE.

Section 11.1401 implements Insurance Code §38.001.

Section 11.1402 implements Insurance Code §843.305.

Section 11.1403 implements Insurance Code §36.001.

Section 11.1404 implements Insurance Code §1369.402.

§11.1401. Commissioner's Authority to Require Additional Information.

§11.1402. Notification to Providers.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

§11.1404. Pharmacy Application and Recertification.

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

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28 TAC §§11.1401 - 11.1404

STATUTORY AUTHORITY.

The new sections are proposed under Insurance Code §§32.041, 36.001, 38.001, 843.151, 843.154, 843.305, and 1369.402.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.305 provides, in relevant part, that an HMO providing coverage through one or more physicians or providers who are not partners or employees of the HMO, or one or more physicians or providers who are not owned or operated by the HMO, must provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the HMO for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

Insurance Code §1369.402 provides that a health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process.

CROSS REFERENCE TO STATUTE.

Section 11.1401 implements Insurance Code §38.001.

Section 11.1402 implements Insurance Code §843.305.

Section 11.1403 implements Insurance Code §36.001.

Section 11.1404 implements Insurance Code §1369.402.

§11.1401. Commissioner's Authority to Require Additional Information.

The commissioner may require additional information as needed to make any determination required by Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state.

§11.1402. Notification to Physicians and Providers.

(a) An HMO that provides coverage for health care services or medical care through one or more physicians or providers is required by Insurance Code §843.305 (concerning Annual Application Period for Physician and Providers to Contract) to provide a 20-calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in each of the HMO's networks providing health care services or medical care under the terms and conditions established by the HMO for the provision of the services and the designation of the physicians and providers. Section 843.305 may not be construed to:

(1) require that an HMO use a particular type of provider or physician in its operation;

(2) require that an HMO accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the HMO; or

(3) require that an HMO contract directly with the physicians or providers.

(b) An HMO subject to Insurance Code §843.305 must publish a notice of an application period to physicians and providers either in

the public notice section of at least one major newspaper with general circulation in each of its service areas or on the HMO's website. The notice must be published for at least five consecutive days during the period of January 2 through January 23 of each calendar year and must include the caption "Notice to Physicians and Providers" in bold type, the name and address of the HMO, what networks the HMO provides, and the specific dates of the 20-day period during which physicians and providers may make application to be a participating physician or provider in each network.

(c) An HMO must notify a physician or provider of acceptance or nonacceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider in a network.

(d) An HMO must file a copy of the published notice with the department in compliance with §11.301 of this title (relating to Filing Requirements), for information, within 30 days of publication. The filing must include the following:

(1) if published in the newspaper, the name of the newspaper and the beginning and ending date of the publication; and

(2) if published on the HMO's website, a copy of the website screen shots and the beginning and ending date of the publication.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

(a) HMOs must include the following notice in information provided to new subscribers:
Figure: 28 TAC §11.1403(a)

(b) The entire notice must be in at least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice must be in the same type as the rest of the newsletter or mailing. Paragraphs 1 - 4 of the English notice and paragraphs 1 - 4 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in capital letters. A final print of the mailing must be submitted to the Life and Health Lines Office of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

§11.1404. Pharmacy Application and Recertification.

(a) An HMO may not require any pharmacy or pharmacist participating or applying to participate as a contracted provider in an HMO delivery network to:

(1) provide financial statements to the HMO; or

(2) deposit with the HMO any monies or other form of consideration, except for reasonable application and recertification fees.

(b) An HMO or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of, or component or mechanism related to, the claim adjudication process in violation of Insurance Code §1369.402 (concerning Certain Fees Prohibited).

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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SUBCHAPTER P. PROHIBITED PRACTICES

28 TAC §11.1500

STATUTORY AUTHORITY. The repeal is proposed under Insurance Code §§36.001, 843.151, 843.154, and 1271.252.

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

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

CROSS REFERENCE TO STATUTE.

Section 11.1500 implements Insurance Code §1271.252

§11.1500. Discrimination Based on Health Status-Related Factors.
The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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28 TAC §11.1500

STATUTORY AUTHORITY. The new section is proposed under Insurance Code §§36.001, 843.151, 843.154, and 1271.252.

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

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 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

CROSS REFERENCE TO STATUTE.

Section 11.1500 implements Insurance Code §1271.252.

§11.1500. Discrimination Based on Health Status-Related Factors.

An HMO may not require an enrollee in a group health plan to pay a premium or contribution that is different from the premium or contribution for a similarly situated enrollee based on a health status-related factor. For purposes of this section, the term "similarly situated" has the meaning assigned to it in 45 CFR §146.121 (concerning Prohibiting Discrimination Against Participants and Beneficiaries Based on a Health Factor). An HMO may not establish policies or procedures that are based on health status-related factors for the eligibility of any individual to enroll under a group plan.

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

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SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §§11.1600 - 11.1607

STATUTORY AUTHORITY. The repeals are proposed under Business and Commerce Code Chapter 501, Subchapter A; Health and Safety Code §62.054; Insurance Code §§36.001, 843.082, 843.107, 843.108, 843.151, 843.201, 843.2015, 843.205, 843.206, 843.209, 843.361, 1369.153, 1456.003, 1693.002, 1693.003, 4054.001, and 4151.152; and Occupations Code §162.001.

Business and Commerce Code Chapter 501, Subchapter A, restricts access to, and use of, social security numbers, and provides remedies for violations.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

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 §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.206 provides that an HMO must notify a group contract holder within 30 days of any substantive change to the payment arrangements between the HMO and physicians or providers.

Insurance Code §843.209 provides that an identification card or other similar document issued by an HMO to an enrollee must indicate that the HMO is regulated under the Insurance Code, and display the enrollee's first date of enrollment and a toll-free number a physician or provider may use to obtain that date.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §1369.153 provides for the information that must be included on identification cards issued by issuers of health benefit plans.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1693.002 provides that an identification card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must, in addition to any requirement under other law, including §§843.209, 1301.162, and 1369.153, display on the card or document in a location of the issuer's choice the acronym "QHP."

Insurance Code §1693.003 provides, in relevant part, that the commissioner monitor 45 C.F.R. Section 155.20 for amendments to the definitions listed in §1693.001 and determine if it is in the best interest of the state to adopt an amended definition for purposes of Chapter 1693.

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

Insurance Code §4151.152 provides for information that must be included in identification cards issued by a plan administrator.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE.

Section 11.1600 implements Health and Safety Code §62.054 and Insurance Code §§521.102, 843.107, 843.108, 843.201, 843.2015, and 1456.003.

Section 11.1601 implements Business and Commerce Code Chapter 500, Subchapter A; and Insurance Code §§843.209, 1369.153, 1693.002; 1693.003, and 4151.152.

Section 11.1602 implements Insurance Code §843.205.

Section 11.1603 implements Insurance Code §843.206.

Section 11.1604 implements Occupations Code §162.001, Insurance Code §843.361.

Section 11.1605 implements Insurance Code Chapter 1369.

Section 11.1606 implements Insurance Code §§843.004, 843.078, and 843.082.

Section 11.1607 implements Health and Safety Code §62.054 and Insurance Code §843.082 and §843.201.

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

§11.1601. Enrollee Identification Cards.

§11.1602. Access to Certain Information.

§11.1603. Notification of Change in Payment Arrangements.

§11.1604. Requirements for Certain Contracts between Primary HMOs and ANHCs and Primary HMOs and Provider HMOs.

§11.1605. Pharmaceutical Services.

§11.1606. Organization of an HMO.

§11.1607. Accessibility and Availability Requirements.

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

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28 TAC §§11.1600 - 11.1607, 11.1610 - 11.1612

STATUTORY AUTHORITY. The new sections are proposed under Business and Commerce Code Chapter 501, Subchapter A; Health and Safety Code §62.054; Insurance Code Chapter 1451, Subchapter K; and Insurance Code §§36.001, 521.102, 843.082, 843.084, 843.107, 843.108, 843.151, 843.201, 843.2015, 843.205, 843.206, 843.209, 1271.104, 1271.155, 1369.153, 1456.003, 1693.002, 1693.003, and 4151.152; and Occupations Code §162.001.

Business and Commerce Code Chapter 501, Subchapter A, restricts access to and use of social security numbers, and it provides remedies for violations.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 1451, Subchapter K, provides, in relevant part, that a health benefit plan issuer that offers coverage

for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers must develop and maintain a physician and health care provider directory, provides for certain information to be provided in that directory, and provides for the display of the directory and other information on a public Internet website maintained by the issuer.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.084 provides the duration of a certificate of authority.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

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 §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.206 provides that an HMO must notify a group contract holder within 30 days of any substantive change to the payment arrangements between the HMO and physicians or providers.

Insurance Code §843.209 provides that an identification card or other similar document issued by an HMO to an enrollee must indicate that the HMO is regulated under the Insurance Code, and display the enrollee's first date of enrollment and a toll-free number a physician or provider may use to obtain that date.

Insurance Code §1271.104 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 Chapter 1271, Subchapter C.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1369.153 provides for the information that must be included on identification cards issued by issuers of health benefit plans.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1693.002 provides that an identification card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must, in addition to any requirement under other law, including Sections 843.209, 1301.162, and 1369.153, display on the card or document in a location of the issuer's choice the acronym "QHP."

Insurance Code §1693.003 provides, in relevant part, that the commissioner monitor 45 C.F.R. Section 155.20 for amendments to the definitions listed in §1693.001 and determine if it is in the best interest of the state to adopt an amended definition for purposes of Chapter 1693.

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

Insurance Code §4151.152 provides for information that must be included in identification cards issued by a plan administrator.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

CROSS REFERENCE TO STATUTE.

Section 11.1600. implements Health and Safety Code §62.054 and Insurance Code §§521.102, 843.107, 843.108, 843.201, 843.2015, and 1456.003.

Section 11.1601. implements Business and Commerce Code Chapter 500, Subchapter A; and Insurance Code §§843.209, 1369.153, 1693.002; 1693.003, and 4151.152.

Section 11.1602 implements Insurance Code §843.205.

Section 11.1603 implements Insurance Code §843.206.

Section 11.1604 implements Occupations Code §162.001, Insurance Code §843.361.

Section 11.1605 implements Insurance Code Chapter 1369.

Section 11.1606 implements Insurance Code §§843.004, 843.078, and 843.082.

Section 11.1607 implements Health and Safety Code §62.054 and Insurance Code §843.082 and §843.201.

Section 11.1610 implements Insurance Code §§843.082, 843.084, and 1271.104.

Section 11.1611 implements Insurance Code §843.361 and §1271.155.

Section 11.1612 implements Insurance Code Chapter 1451, Subchapter K; Insurance Code §521.102 and §843.201.

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO must provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. The HMO may deliver the written description of health care plan terms and conditions electronically but must provide a paper copy on request.

(b) The written or electronic plan description must be filed for approval in compliance with §11.301 of this title (relating to Filing Requirements); be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category; and include these items in the following order:

(1) a statement that the entity providing the coverage is an HMO;

(2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including physician and provider information;

(3) a clear, complete, and accurate description of all covered services and benefits, including a description of the options, if any, for prescription drug coverage, both generic and brand name, and if applicable, an explanation of how to access formulary information consistent with §21.3031(b) of this title (relating to Formulary Information on Issuer's Website);

(4) a clear, complete, and accurate description of emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;

(5) a clear, complete, and accurate description of out-of-area services and benefits (if any);

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), statements that:

(A) a facility-based physician or other health care practitioner may not be included in the health benefit plan's physician and provider network;

(B) the facility-based physician or other health care practitioner may balance bill the enrollee for amounts not paid by the health benefit plan; and

(C) if the enrollee receives a balance bill, the enrollee should contact the HMO;

(7) a clear, complete, and accurate explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

(8) a clear, complete, and accurate description of any limitations or exclusions, including the existence of any drug formulary limitations;

(9) a clear, complete, and accurate description of any prior authorization requirements, including limitations or restrictions, and a summary of procedures to obtain approval for referrals to physicians and providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review, and the consequences resulting from the failure to obtain any required authorizations;

(10) a provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(11) a clear, complete, and accurate summary of the HMO's complaint and appeal procedures, a statement of the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(12) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, with the information necessary to fully inform prospective or current enrollees about the network, including the information required by §11.1612 of this title (relating to Mandatory Disclosure Requirements);

(13) a clear, complete, and accurate description of the service area;

(14) when the HMO product includes point-of-service coverage, including when such coverage is provided by an insurer, or when the product is explicitly marketed with the option of purchasing point-of-service coverage, a clear, complete, and accurate explanation of the point-of-service coverage, including:

(A) an explanation of how any deductible is calculated, clearly explaining if multiple deductibles may be applied under the plan as a whole;

(B) a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a non-network provider for a particular service;

(C) a clear, complete, and accurate explanation of how reimbursements of non-network point-of-service services will be determined subject to §11.2503 of this title (relating to Coverage Relating to Point-of-Service Rider Plans) for point-of-service riders or §21.2902 of this title (relating to Arrangements between Indemnity Carriers and HMOs to Provide Coverage) for dual and blended point-of-service arrangements;

(D) if point-of-service coverage is provided under a dual or blended point-of-service arrangement, a clear, complete, and accurate explanation of how the coverage will be coordinated and who the enrollee should contact for common issues, including;

(i) the identity and contact information for each entity, the HMO, the indemnity carrier, or any third party administrator (TPA) that will administer the coverages offered under the point-of-service plan;

(ii) a clear, complete, and accurate description of all duties of the HMO and other carrier to each other relating to the point-of-service plan issued under this subchapter; and

(iii) as applicable, a clear, complete, and accurate explanation of out-of-plan coverage for point-of-service coverage offered in conjunction with plans subject to Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans);

(E) a clear, complete, and accurate explanation that for an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the HMO delivery network.

(c) An HMO may use its member handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under this section.

(d) An HMO offering a Children's Health Insurance Program plan that files its plan description in the form of its member handbook in compliance with §11.301 of this title (relating to Filing Requirements), for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook is exempt from the filing and approval requirements of subsection (b) of this section.

(e) If an HMO limits enrollees' access to health care to a limited provider network, then it must provide a notice in substantially the following form to prospective and current group contract holders: "Choosing Your Physician--Now that you have chosen (Name of HMO), your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a 'network' or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer."

(f) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, then it must provide a notice in compliance with Insurance Code Chapter 1451, Subchapter F, (concerning Access to Obstetrical or Gynecological Care) in substantially the following form to current or prospective enrollees: "ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(g) An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in each limited provider network. An HMO must include an index of the alphabetical listing of all contracted physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(h) An HMO must provide notice to enrollees informing them to contact the HMO on receipt of a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner. The notice must inform enrollees of the method(s) for contacting the HMO for this purpose.

(i) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (for example, a hospital or skilled nursing facility), the plan description must disclose that on admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(j) An HMO that maintains a website must list the information on its website as required by subsections (b) - (g) of this section and Insurance Code §843.2015 (concerning Information Available Through Internet Site) and §1456.003 (concerning Required Disclosure: Health Benefit Plan). The information must be easily accessible from the home page of the HMO's website.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the HMO must issue the ID cards within 30 calendar days of receiving notice of the enrollee's selection of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage that require presentation of the card.

(b) All ID cards an HMO issues must comply with the requirements of Insurance Code §843.209 (concerning Identification Card) and §1693.003 (concerning Identification Card and Required Information) and §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO must issue an ID card in compliance with Insurance Code §1369.153 (concerning Information Required on Identification Card) and §4151.152 (concerning Identification Cards) and §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, Standard Identification Cards, and Issuance of Standard Identification Cards).

(d) All ID cards issued by an HMO must comply with the requirements of Business and Commerce Code §501.001 (concerning Certain Uses of Social Security Number Prohibited) and §501.002 (concerning Certain Uses of Social Security Number Prohibited; Remedies), which restrict the display of social security numbers on ID cards.

(e) An ID card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must display on the card or document in a location of the issuer's choice the acronym "QHP."

§11.1602. Enrollment Form and Access to Certain Information.

(a) An HMO must include on its enrollment form a space in which an enrollee may indicate:

(1) the enrollee's primary language; and

(2) whether the enrollee has a disability affecting the enrollee's ability to communicate or read.

(b) The HMO must provide, at its own expense, a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the language of the major population of the HMO's enrolled population under Insurance Code §843.205 (concerning Member's Handbook; Information About Complaints and Appeals). The HMO may deliver the member handbook and materials electronically but must provide a paper copy on request.

(c) If a member has a disability affecting the member's ability to communicate or read, then the HMO must provide, at its own expense, a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the appropriate format, including, but not limited to:

(1) Braille;

(2) large print, no smaller than 17 point;

(3) audio tape;

(4) TDD access;

(5) an interpreter; or

(6) any combination of the above.

§11.1603. Notification of Change in Payment Arrangements.

An HMO must provide written notification to affected group contract holders of a substantive change in the payment arrangement for physicians and providers within 30 days of any change in the type of payment arrangement; for example, a change from capitation to fee for service, or from fee for service to capitation, for any type of service. The notification of the change must include a description of the changed payment arrangement and a description of the new payment arrangement.

§11.1604. Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services other than medical care or services ancillary to the practice of medicine, or with a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network must:

(1) submit a monitoring plan to the department setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all department regulatory requirements;

(2) file with the department a copy of the form of the written contract with an ANHC or provider HMO, in accordance with §11.301(5) of this title (relating to Filing Requirements), that:

(A) requires that the ANHC or provider HMO cannot terminate the contract without 90-days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members, except for authorized copayments and deductibles, charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC, or provider HMO;

(C) contains a provision stating that nothing in the contract will be construed to in any way limit the HMO's authority or responsibility to comply with all of the department's regulatory requirements;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate, and maintain a health care delivery system, quality assurance system, physician and provider credentialing system, and other systems and programs meeting department standards and is directly accountable for compliance with the standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, utilizing standards approved by the primary HMO, and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to ensure that all HMO systems and functions that are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all department regulatory requirements;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers to ensure compliance with contractual requirements set out in subparagraphs (B) and (C) of this paragraph;

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by an independent certified public accountant, using generally accepted accounting and auditing principles; and

(G) requires the ANHC or provider HMO to provide the primary HMO, on at least a monthly basis and in a usable form necessary for audit purposes, the data necessary for the HMO to comply with department reporting requirements with respect to any services provided under the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) number of primary HMO enrollees served or assigned to the ANHC or primary HMO to receive services, including the number added and terminated since the last reporting period;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO, for example, capitation, fee-for-services, or other risk-sharing arrangements;

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) the time that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits, and subrogation;

(x) physician and provider and enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of the inquiry or investigation; and

(xiii) any other data necessary to ensure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO at least annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all of the department's regulatory requirements, and provide written documentation of each audit to the department on request; and

(4) take prompt action to correct any failure by the ANHC or provider HMO to comply with the department's regulatory requirements relating to any matters delegated by the primary HMO to the ANHC or provider HMO and necessary to ensure the primary HMO's compliance with the regulatory requirements.

§11.1605. Pharmaceutical Services.

(a) Prescription drug coverage that includes copayments must do so for both generic drugs and name-brand drugs. If the negotiated or usual and customary cost of the drug is less than the copayment, the enrollee may only be required to pay the lower cost. The copayments may be the same, or if different, must be applied as follows:

(1) if the prescription is for a generic drug, the enrollee may be required to pay no more than the generic copayment;

(2) if the prescription is for a name-brand drug, the enrollee may be required to pay no more than the name-brand copayment if:

(A) the prescription is written "dispense as written"; or

(B) there is no generic equivalent for the prescribed drug;

(3) if the prescription is written "product selection permitted" and the enrollee elects to receive a name-brand drug when a generic equivalent is available, then the enrollee may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name-brand drug; and

(4) if the enrollee's prescription benefit requires the use of generic-equivalent drugs (required generic) and the enrollee receives a name-brand drug when a generic equivalent is available, then the enrollee may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name-brand drug, even when the prescription is written "dispense as written."

(b) Pharmacy service must be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO must offer the pharmacy services directly or through contracts.

§11.1606. Organization of an HMO.

(a) The governing body of an HMO, as described in Insurance Code §843.004 (concerning Governing Body of Health Maintenance Organization), has ultimate responsibility for the development, approval, implementation, and enforcement of administrative, operational, personnel, and patient care policies and procedures related to the HMO's operation.

(b) The HMO must have a chief executive officer or operations officer who is accountable for the administration of the health plan, including:

(1) developing corporate strategy;

(2) overseeing marketing programs;

(3) overseeing medical management functions; and

(4) ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

(c) The HMO must have a full-time clinical director who:

(1) is licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO, for example:

(A) a basic HMO must have a physician;

(B) a dental HMO must have a dentist or physician;

(C) a vision HMO must have an optometrist or physician; and

(D) a limited services HMO must have a physician;

(2) resides in the state of Texas;

(3) is available at all times to address complaints, clinical issues, utilization review, and any quality of care issues on behalf of the HMO;

(4) demonstrates active involvement in all quality management activities; and

(5) will be subject to the HMO's credentialing requirements and must be credentialed in compliance with NCQA or American Accreditation HealthCare Commission, Inc., standards.

(d) The HMO may establish one or more service areas within Texas; each defined service area must:

(1) demonstrate to the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties, or any portions of counties, included in the service area;

(3) provide a complete physician and provider listing for all enrollees residing, living, or working in the service area, as provided in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(4) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HMO financial reporting.

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network that is adequate and complies with Insurance Code §843.082 (concerning Requirements for Approval of Application).

(b) There must be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days

per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO must make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, the limited provider network must comply with all requirements under this section.

(e) An HMO must make emergency care available and accessible 24 hours per day, seven days per week, without restrictions on where the services are rendered.

(f) All covered services that are offered by an HMO must be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) An HMO must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis on request and consistent with these guidelines:

(1) urgent care must be available within 24 hours for medical, dental, and behavioral health conditions;

(2) routine care must be available within:

(A) three weeks for medical conditions;

(B) eight weeks for dental conditions; and

(C) two weeks for behavioral health conditions.

(3) Preventive health services must be available within:

(A) two months for a child;

(B) three months for an adult; and

(C) four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care, specialty hospitals, and single health care service plan physicians or providers.

(i) Access to certain institutional providers. An HMO network providing access to more than one institutional provider in a region must make a good-faith effort to have a mix of for-profit, nonprofit, and tax-supported institutional participating providers, unless the mix is not feasible due to geographic, economic, or other operational factors. An HMO must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(j) An HMO that is unable to meet the requirements of subsections (b) - (h) of this section must file an access plan for approval with the department in compliance with §11.301 of this title (relating to Filing Requirements). The access plan must specify:

(1) the geographic area within the service area in which a sufficient number of contracted physicians and providers are not available, including a specification of the class of physician or provider;

(2) a map for each specialty, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, and providers are not available;

(3) the reason or reasons that the network does not meet the adequacy requirements specified in this section;

(4) procedures that the HMO will use to assist enrollees in obtaining medically necessary services when no network physician or provider is available, including procedures to coordinate care to hold enrollees harmless and eliminate or limit the likelihood of balance billing;

(5) a list of the physicians and providers within the relevant service area that the HMO attempted to contract with, identified by name and specialty or facility type, with:

(A) a description of how and when the HMO last contacted each physician, provider, or facility; and

(B) a description of the reason each physician, provider, or facility gave for declining to contract with the HMO;

(6) procedures detailing how out-of-network benefit claims will be handled when no physicians or providers are available, including procedures for compliance with §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers);

(7) steps the HMO will take to attempt to bring its network into compliance with this section; and

(8) a process for negotiating with a non-network physician or provider before services being rendered, when feasible.

(k) An HMO must submit an access plan that complies with subsection (j) of this section along with the annual report on network adequacy under §11.1610 of this title (relating to Annual Network Adequacy Report).

(l) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the Children's Health Insurance Program Perinatal Program.

(m) An HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level available within the HMO service area, such as, but not limited to, transplants and treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive the services.

(n) An HMO is not required to expand services outside its service area to accommodate enrollees who live outside the service area but work within the service area.

(o) In compliance with Insurance Code Chapter 1455 (concerning Telemedicine and Telehealth), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or telemedicine service.

§11.1610. Annual Network Adequacy Report.

(a) An HMO must file a network adequacy report with the department on or before October 1 of each year and before marketing any plan in a new service area after October 1, 2017. The network adequacy report must specify:

(1) the trade name of each HMO plan in which enrollees currently participate;

(2) the applicable service area of each plan; and

(3) whether the HMO service delivery network supporting each plan meets the requirements in §11.1607 of this title (relating to Accessibility and Availability Requirements).

(b) If applicable, the network adequacy report must include an access plan that complies with §11.1607 of this title.

(c) As part of the annual network adequacy report, the HMO must provide additional data specified in this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the HMO's plans include a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The HMO report must include the number of:

(1) claims paid for out-of-network benefits that were not based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 (concerning Emergency Care) or §1271.055 (concerning Out-of-Network Services);

(2) claims for out-of-network benefits that were based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 or §1271.055;

(3) complaints by non-network physicians and providers;

(4) complaints by network physicians and providers relating to inability to refer enrollees to network physicians or providers because network physicians or providers are not available;

(5) complaints by enrollees relating to the dollar amount of the HMO's payment for basic health care benefits;

(6) complaints by enrollees concerning balance billing;

(7) complaints by enrollees relating to the unavailability of network physicians or providers;

(8) complaints by enrollees relating to the accuracy of network physician and provider listings; and

(9) complaints by physicians and providers relating to the accuracy of network physician and provider listings.

(d) The annual network adequacy report required under this section must be submitted electronically in a format and by a method acceptable to the department. Unless and until a standardized form and method for submitting the above information is made available by the department, acceptable formats include Microsoft Word and Excel documents. Unless and until another electronic method of submission is required, the report must be submitted to the department's email address, mcqa@tdi.texas.gov, and must indicate in the subject field that the email relates to the filing of the annual network adequacy report.

(e) If the commissioner determines that the HMO's network and any access plan supporting the network are inadequate to ensure that benefits are available to all enrollees or are inadequate to ensure that all covered health care services are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions under the commissioner's authority in Insurance Code Chapter 82 (concerning Sanctions) and Insurance Code Chapter 83 (concerning Emergency Ceases and Desist Orders) to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and

(3) cessation of marketing entirely and withdrawal from the HMO market.

(f) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

§11.1611. Out-of-Network Claims; Non-Network Physicians and Providers.

(a) When services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider, the HMO must fully reimburse the non-network facility-based physician or provider at the usual and customary rate as described in subsection (g) of this section or at an agreed rate.

(b) In circumstances where an enrollee receives emergency care in a non-network facility, the HMO must fully reimburse a non-network physician or provider for emergency care services at the usual and customary rate as described in subsection (g) of this section or at an agreed rate until the enrollee can reasonably be expected to transfer to a network physician or provider.

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider on the request of a contracted network physician or provider, the HMO must:

(1) approve a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) provide for a review by a health care physician or provider with expertise in the same specialty as or a specialty similar to the type of health care physician or provider to whom a referral is requested under paragraph (1) of this subsection before the HMO may deny the referral.

(d) An HMO may facilitate a referral to a non-network physician or provider when medically necessary covered services, excluding emergency care, are not available through a network physician or provider and an enrollee has received the referral from a network physician or provider.

(1) If an HMO chooses to facilitate the referral, the HMO must provide the physician or provider who requests the referral with a list of at least three non-network preferred physicians or providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the enrollee.

(2) If the physician or provider who requests the referral selects a non-network preferred physician or provider from the list provided by the HMO, then subsections (e) - (g) of this section apply.

(3) If the physician or provider who requests the referral selects, with the agreement of the enrollee, a non-network physician or provider that is not included in the list provided by the HMO, then subsections (f) - (g), but not subsection (e), of this section apply to the claims of the non-network physician or provider.

(e) An HMO reimbursing a non-network physician or provider providing services under subsection (a), (b), (c), or (d) of this section must ensure that the enrollee is held harmless for any amounts beyond the copayment or other out-of-pocket amounts that the enrollee would have paid had the HMO network included contracted physicians or providers from whom the enrollee could obtain the services.

(f) After determining that a claim from a non-network physician or provider for services provided under subsection (a), (b), (c), or (d) of this section is payable, an HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider. If the rate was not agreed to by the physician or provider, the HMO must provide an explanation of benefits to the enrollee that in-

cludes a statement that the HMO's payment is at least equal to the usual and customary rate for the service, that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO, of the procedures for contacting the HMO on receipt of a bill from the non-network physician or provider for amount beyond the amount paid by the HMO, and the number for the department's Consumer Protection Section for complaints regarding payment.

(g) Any methodology used by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) if based on usual and customary charges, then the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflect market rates, including geographic differences in costs;

(2) if based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

(4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

§11.1612. Mandatory Disclosure Requirements.

(a) Online directory. An HMO must develop and maintain a directory of contracting physicians and health care providers, display the directory on a public Internet website maintained by the HMO, and ensure that a direct electronic link to the directory is conspicuously displayed on the electronic summary of benefits and coverage of each plan issued by the HMO. The directory must:

(1) include the name, address, and telephone number of each physician and provider;

(2) clearly indicate each health benefit plan issued by the HMO that may provide coverage for services provided by each physician or provider included in the directory;

(3) be electronically searchable by physician or health care provider name and location;

(4) be publicly accessible without the necessity or providing a password, a username, or personally identifiable information; and

(5) be reviewed on an ongoing basis and corrected or updated, if necessary, not less than once each month.

(b) Identification of limited networks and index. An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO must include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(c) Notice of rights under an HMO plan required. An HMO must include the notice specified in Figure: 28 TAC §11.1612(c), in all evidences of coverage certificates, disclosures of plan terms, and member handbooks in at least a 12-point font:

Figure: 28 TAC §11.1612(c)

(d) Disclosure concerning access to network physician and provider listing. An HMO must provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which enrollees may obtain assistance during regular business hours to find available network physicians and providers.

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of:

(1) information that is updated at least annually regarding the following network information for each service area, or for the entire state if the plan is offered on a statewide service-area basis:

(A) the number of enrollees in the service area or region;

(B) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of contracted hospitals in the service area or region, an indication of whether an active access plan in compliance with §11.1607 of this title applies to hospital services in that service area or region, and how the access plan may be obtained or viewed, if applicable;

(2) information that is updated at least annually regarding whether any access plans approved under §11.1607 of this title apply to the plan and that complies with the following:

(A) if an access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the HMO's plan is not offered on a statewide service area basis, or for the entire state if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the access plan.

(f) Website disclosures. An HMO must provide information on its website regarding the HMO or health benefit plans offered by the HMO for use by current or prospective enrollees must provide a:

(1) web-based physician and provider listing for use by current and prospective enrollees; and

(2) web-based listing of the state regions, counties, or three-digit ZIP code areas within the HMO's service area(s), indicating, as appropriate, for each region, county, or ZIP code area, as applicable, that the HMO has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter.

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title (relating to Out-of-Network Claims; Non- Network Physicians and Providers), as applicable, if an enrollee demonstrates that:

(1) in obtaining services, the enrollee reasonably relied on a statement that a physician or provider was a contracted physician or provider as specified in:

(A) a physician and provider listing; or

(B) provider information on the HMO's website;

(2) the physician and provider listing or website information was obtained from the HMO, the HMO's website, or the website of a third party designated by the HMO to provide that information for use by its enrollees;

(3) the physician and provider listing or website information was obtained not more than 30 days before the date of services; and

(4) the physician and provider listing or website information obtained indicates that the provider is a contracted provider within the HMO's network.

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the following requirements:

(1) the physician and provider information must include a method for enrollees to identify the hospitals that have contractually agreed with the HMO to facilitate the usage of contracted providers as follows:

(A) the hospital will exercise good-faith efforts to accommodate requests from enrollees to use contracted physicians and providers.

(B) in those instances where a particular facility-based physician or physician group is assigned at least 48 hours before services being rendered, the hospital will provide the enrollee with information that is:

(i) furnished at least 24 hours before services being rendered; and

(ii) sufficient to enable the enrollee to identify the physician or physician group with enough specificity to permit the enrollee to determine, along with contracted provider listings made available by the HMO, whether the assigned facility-based physician or physician group is a contracted provider;

(2) the physician and provider information must include a method for enrollees to identify, for each contracted hospital, the percentage of the total dollar amount of claims filed with the HMO by or on behalf of facility-based physicians that are not under contract with the HMO. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, assistant surgeons, and neonatologists;

(3) in determining the percentages specified in paragraph (2) of this subsection, an HMO may consider claims filed in a 12-month period designated by the HMO ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the enrollee;

(4) the physician and provider information must indicate whether each contracted physician and provider is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(5) the physician and provider information must provide an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the listing, with specific reference to:

(A) information about the physician's or provider's contract status; and

(B) whether the physician or provider is accepting new patients;

(6) the physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians able to provide services at contracted facilities;

(7) the physician and provider information must include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(8) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), the physician and provider information must give the identity of any health care facilities within the provider network in which facility-based physicians or other health care practitioners do not participate in the health benefit plan's provider network;

(9) the provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based physician or provider, specifying the applicable provider class;

(10) the physician and provider information must be dated; and

(11) the physician and provider information must be provided in at least 10-point font.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available under subsection (e)(2) of this section; and

(2) information on how to obtain or view any access plan or plans the insurer uses.

(j) Disclosure of substantial decrease in the availability of certain contracted physicians. An HMO is required to provide notice as specified in this subsection of a substantial decrease in the availability of contracted facility-based physicians at a contracted facility.

(1) A decrease is substantial if:

(A) the contract between the HMO and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates, and the HMO receives notice as required under §11.901 of this title (relating to Required and Prohibited Provisions).

(2) Despite paragraph (1) of this subsection, no notice of a substantial decrease is required if:

(A) alternative contracted physicians or providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to enrollees at the facility so the percentage level of contracted physicians of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available before the substantial decrease; or

(B) the HMO certifies to the department, by email to mcqa@tdi.texas.gov, that the HMO's determination that the termination of the physician contract has not caused the contracted physician service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician specialty.

(3) An HMO must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of contracted physicians on the portion of the HMO's website where its physician and provider listing is available to enrollees.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of physicians must be maintained on the HMO's website until the earlier of:

(A) the date on which adequate contracted physicians of the same specialty become available to enrollees at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the HMO initially posts the notice; or

(C) the date on which the HMO provides to the department, by email to mcqa@tdi.texas.gov, the certification specified in paragraph (2)(B) of this subsection.

(5) An HMO must post notice as specified in paragraph (3) of this subsection and update its web-based contracted physician and provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an HMO receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(k) Plan designations. An HMO network that complies with the network adequacy requirements for hospitals under §11.1607 of this title, without reliance on an access plan, may be designated by the HMO as having an "Approved Hospital Care Network" (AHCN). If an HMO network does not comply with the network adequacy requirements for hospitals specified in §11.1607 of this title, the HMO is required to disclose that the plan has a Limited Hospital Care Network on the:

(1) HMO's evidence of coverage certificates, disclosures of plan terms, and member handbook; and

(2) cover page of any physician and provider listing describing the network.

(l) Loss of status as an AHCN. If an HMO network designated as an AHCN under subsection (j) of this section no longer complies with the network adequacy requirements for hospitals under §11.1607 of this title and does not correct the noncompliant status within 30 days of becoming noncompliant, the HMO must:

(1) notify the department in writing concerning this change in status at Life and Health Filings Intake, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all enrollees of the change of status at the time of renewal.

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

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Norma Garcia
General Counsel
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SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

28 TAC §§11.1702 - 11.1704

STATUTORY AUTHORITY.

The repeals are proposed under Insurance Code §§36.001, 843.151, 844.004, 844.005, 844.053, 844.054, and 4054.001.

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

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 §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §844.005 provides that an approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of an HMO, and is not required to obtain a certificate of authority

under Chapter 844 or under Chapter 843 to arrange for or provide health care services as provided by §844.005(a).

Insurance Code §844.053 provides that the commissioner grant a provisional certificate of authority to an applicant if: (1) the applicant has applied for accreditation from an accrediting organization described by §844.052(b)(2); (2) the applicant is diligently pursuing accreditation;(3) the accrediting organization has not denied the application for accreditation; and (4) the applicant satisfies each other requirement of Chapter 844.

Insurance Code §844.054 provides that a certificate holder has all the powers granted to and duties imposed on an HMO under the insurance laws of this state, including Chapter 843, is subject to regulation and regulatory enforcement under those laws in the same manner as an HMO, and must maintain accreditation as described by §844.052(b)(2).

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

CROSS REFERENCE TO STATUTE.

Section 11.1702 implements Insurance Code §§844.004, 844.005, and 844.053.

Section 11.1703 implements Insurance Code Chapter 4054 and Insurance Code §844.054.

Section 11.1704 implements Insurance Code §844.054.

§11.1702. Requirements for Issuance of Certificate of Authority to ANHC.

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

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

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Norma Garcia
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28 TAC §§11.1702 - 11.1704

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 4054; and Insurance Code §§36.001, 843.151, 844.004, 844.005, 844.053, 844.054, and 4054.001.

Insurance Code Chapter 4054 regulates life, accident, and health agents.

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

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 §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §844.005 provides that an approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of an HMO, and is not required to obtain a certificate of authority under Chapter 844 or under Chapter 843 to arrange for or provide health care services as provided by §844.005(a).

Insurance Code §844.053 provides that the commissioner grant a provisional certificate of authority to an applicant if: (1) the applicant has applied for accreditation from an accrediting organization described by §844.052(b)(2); (2) the applicant is diligently pursuing accreditation; (3) the accrediting organization has not denied the application for accreditation; and (4) the applicant satisfies each other requirement of Chapter 844.

Insurance Code §844.054 provides that a certificate holder has all the powers granted to and duties imposed on an HMO under the insurance laws of this state, including Chapter 843, is subject to regulation and regulatory enforcement under those laws in the same manner as an HMO, and must maintain accreditation as described by §844.052(b)(2).

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

CROSS REFERENCE TO STATUTE.

Section 11.1702 implements Insurance Code §§844.004, 844.005, and 844.053.

Section 11.1703 implements Insurance Code Chapter 4054 and Insurance Code §844.054.

Section 11.1704 implements Insurance Code §844.054.

§11.1702. Requirements for Issuance of Certificate of Authority to an ANHC.

(a) Before obtaining a certificate of authority under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance

Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state; and

(2) demonstrate by appropriate documentation that the applicant ANHC has established and maintains accreditation by the:

(A) NCQA; or

(B) Joint Commission on Accreditation of Health Care Organizations network accreditation program.

(b) The commissioner may grant a provisional certificate of authority to an applicant ANHC under Insurance Code Chapter 844, if the:

(1) applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code Chapters 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state;

(2) applicant ANHC demonstrates that it has applied for accreditation;

(3) applicant ANHC is diligently pursuing accreditation as determined by the commissioner; and

(4) accrediting organization has not denied the accreditation.

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under Insurance Code Chapter 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state in order to maintain a certificate of authority.

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code Chapters 843 and 844, including an ANHC that contracts to arrange for or provide only medical care as defined in Insurance Code §843.002 (concerning Definitions).

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

Any agent for an ANHC with a certificate of authority or a provisional certificate of authority will be considered an HMO agent and must comply with the applicable requirements of Insurance Code Chapter 4054 (concerning Life, Accident, and Health Agents) and Chapter 19 of this title (relating to Agents' Licensing).

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations) and this subchapter is subject to the same statutes and rules as an HMO and is considered an HMO for purposes of regulation and regulatory enforcement.

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

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Norma Garcia
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SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID

28 TAC §§11.1801 - 11.1806

STATUTORY AUTHORITY. The repeals are proposed under Health and Safety Code §62.054; Insurance Code Chapter 823; and Insurance Code §§36.001, 843.078, 843.151, and 843.404.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

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

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

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 §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

CROSS REFERENCE TO STATUTE.

Section 11.1801 implements Health and Safety Code §62.054 and Insurance Code Chapter 823.

Sections 11.1802- 11.1805 implement Insurance Code Chapter 823.

Section 11.1806 implements Health and Safety Code §62.054 and Insurance Code §843.078 and §843.404.

§11.1801. Entities Covered.

§11.1802. Minimum Surplus or Net Worth.

§11.1803. Statutory Deposits.

§11.1804. Guarantees.

§11.1805. Performance and Fidelity Bonds.

§11.1806. Additional Information That May be Requested From an MCO Participating in Medicaid.

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

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SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

28 TAC §11.1801, §11.1806

STATUTORY AUTHORITY. The new sections are proposed under Health and Safety Code §62.054; Insurance Code Chapter 823; and Insurance Code §§36.001, 843.078, 843.151, and 843.404.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

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

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

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 §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

CROSS REFERENCE TO STATUTE.

Section 11.1801 implements Health and Safety Code §62.054 and Insurance Code Chapter 823.

Section 11.1806 implements Health and Safety Code §62.054 and Insurance Code §843.078 and §843.404.

§11.1801. Entities Covered.

(a) As used in this subchapter, a managed care organization is an entity holding a certificate of authority to operate as an HMO under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), or as an ANHC under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

(b) Any managed care organization or other entity providing the services specified in 42 United States Code §1396b(m)(2)(A) and participating in the State Medicaid Program or Children's Health Insurance Program (CHIP) (MCO) must comply with the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs).

§11.1806. Additional Information That May be Requested from an MCO Participating in Medicaid.

(a) Whenever requested by the department, an MCO participating in Medicaid must file with the department a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be modified or amended by the Texas Health and Human Services Commission. When a request is received, the MCO must then file a Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. These reports must comply with the instructions issued by the Texas Health and Human Services Commission.

(b) For any new or modified request to the Texas Health and Human Services Commission for participation in the Medicaid managed care program, all financial projections, including enrollment projections, from the effective or renewal date of a Medicaid contract that are submitted to the Texas Health and Human Services Commission, must also be submitted to the department. The MCO must submit the same financial projections, including a cash flow statement, submitted to the Texas Health and Human Services Commission with the request to participate in the Medicaid program. This information must be submitted with the application for a certificate of authority if the MCO is not already a licensed MCO. If the MCO is a licensed operation, then the financial projections must be sent with the application for service area expansion.

(c) The MCO must notify the department of any similar financial or statistical reports required by other contracting state agencies and must submit copies of these reports to the department when requested by the department.

(d) Information submitted under this section must be sent to the Financial Analysis Section, Mail Code 303-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

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SUBCHAPTER T. QUALITY OF CARE

28 TAC §11.1901, §11.1902

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §§36.001, 843.102, and 843.151.

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

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

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.

CROSS REFERENCE TO STATUTE.

Section 11.1901 and §11.1902 implement Insurance Code §843.102.

§11.1901. Quality Improvement Structure for Basic and Limited Services HMOs.

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs.

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

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28 TAC §11.1901, §11.1902

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§36.001, 843.102, and 843.151.

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

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

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.

CROSS REFERENCE TO STATUTE.

Section 11.1901 and §11.1902 implement Insurance Code §843.102.

§11.1901. Quality Improvement Structure for Basic, Single Service, and Limited Service HMOs.

(a) Basic, single service, and limited service HMOs must develop and maintain an ongoing QI program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program must include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The HMO governing body is ultimately responsible for the QI program. The governing body must:

(1) appoint a quality improvement committee (QIC) that must include practicing physicians and individual providers, and may include one or more enrollee(s) from throughout the HMO's service area, none of whom may be employees of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet at least annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians, individual providers, and enrollees from the service area.

(A) All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

§11.1902. Quality Improvement Program for Basic, Single Service, and Limited Service HMOs.

The QI program for basic, single service, and limited service HMOs must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO must dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program must include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan must:

(A) include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, responsible individuals, and evaluation methodology; and

(B) address each program area, including:

(i) network adequacy, which includes availability and accessibility of care, including assessment of open and closed physician and individual provider panels;

(ii) continuity of health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of clinical practice guidelines or clinical care standards, which the QI program must ensure:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) enrollee, physician, and individual provider satisfaction;

(vi) the complaint and appeals process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians, and providers from effectively making complaints against the HMO;

(vii) preventive health care through health promotion and outreach activities;

(viii) claims payment processes;

(ix) contract monitoring, including delegation oversight and compliance with filing requirements;

(x) utilization review processes;

(xi) credentialing;

(xii) member services; and

(xiii) pharmacy services, including drug utilization.

(3) Evaluation. The QI program must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO must implement a documented process for selection and retention of contracted physicians and providers. The credentialing process must comply with NCQA or American Accreditation HealthCare Commission, Inc., standards, to the extent that those standards do not conflict with the laws of this state. An HMO must have a documented process for expedited credentialing of physicians, podiatrists, and therapeutic optometrists, including a documented process for payment of claims during the expedited credentialing process, in compliance with Insurance Code Chapter 1452 (concerning Physician and Provider Credentials).

(5) Site visits for cause.

(A) The HMO must have procedures for detecting deficiencies after a site visit. When the HMO identifies new deficiencies, the HMO must reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO may conduct the site visit to evaluate a complaint or other precipitating event, which may include an evaluation of any facilities or services related to a complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program must provide for a peer review procedure for physicians and individual providers, as required by the Medical Practice Act, Occupations Code, Chapter 151, Subchapter A, (concerning General Provisions). The HMO must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state.

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

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SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

28 TAC §§11.2101 - 11.2104

STATUTORY AUTHORITY.

The repeals are proposed under Health and Safety Code §534.101; Insurance Code Chapter 843, 844, and 1271; and Insurance Code §§36.001, 843.002(18), 843.051, 843.053, 843.073, 843.079, 843.084, 843.151, 843.318, and 1271.101.

Health and Safety Code §534.101 provides definitions applicable to Health and Safety Code Chapter 534, Subchapter B-1.

Insurance Code Chapter 843 provides regulation of HMOs.

Insurance Code Chapter 844 provides for certification of certain nonprofit health corporations.

Insurance Code Chapter 1271 regulates the benefits provided by HMOs, evidences of coverage, and charges.

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

Insurance Code §843.002(18) defines "limited health care services."

Insurance Code §843.051 sets out the application of insurance and group hospital service corporation laws.

Insurance Code §843.053 provides that: (a) an HMO that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26; and (b) notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a certificate of authority under Chapter 843 is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26.

Insurance Code §843.073 provides that certain physicians and providers are not required to obtain a certificate of authority under Chapter 843.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.084 provides the duration of a certificate of authority.

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 §843.318 provides for certain permissible contracts entered into by physicians and providers.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

CROSS REFERENCE TO STATUTE.

Section 11.2101 implements Health and Safety Code 534.101 and Insurance Code §843.002(18).

Section 11.2102 implements Insurance Code §§843.051, 843.053, 843.073, 843.079, 843.084, and 843.318.

Section 11.2103 implements Health and Safety Code §534.101; Insurance Code Chapters 843, 844, and 1271; and Insurance Code §§843.051, 843.053, 843.073, 843.079, and 843.318.

Section 11.2104 implements Insurance Code §1271.101.

§11.2101. Definitions.

§11.2102. General Provisions.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

§11.2104. Minimum Standards for Community Health Centers.

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

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28 TAC §§11.2101 - 11.2104

STATUTORY AUTHORITY. The new sections are proposed under Health and Safety Code §534.101; Insurance Code Chapters 843, 844, 1271; Insurance Code §§36.001, 843.002(18), 843.051, 843.053, 843.073, 843.079, 843.084, 843.151, 843.318, and 1271.101.

Health and Safety Code §534.101 provides definitions applicable to Health and Safety Code Chapter 534, Subchapter B-1.

Insurance Code Chapter 843 provides regulation of HMOs.

Insurance Code Chapter 844 provides for certification of certain nonprofit health corporations.

Insurance Code Chapter 1271 regulates the benefits provided by HMOs, evidences of coverage, and charges.

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

Insurance Code §843.002(18) defines "limited health care services."

Insurance Code §843.051 sets out the application of insurance and group hospital service corporation laws.

Insurance Code §843.053 provides that: (a) an HMO that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26; and (b) notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a certificate of authority under Chapter 843 is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26.

Insurance Code §843.073 provides that certain physicians and providers are not required to obtain a certificate of authority under Chapter 843.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.084 provides the duration of a certificate of authority.

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 §843.318 provides for certain permissible contracts entered into by physicians and providers.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

CROSS REFERENCE TO STATUTE.

Section 11.2101 implements Health and Safety Code 534.101 and Insurance Code §843.002(18).

Section 11.2102 implements Insurance Code §§843.051, 843.053, 843.073, 843.079, 843.084, and 843.318.

Section 11.2103 implements Health and Safety Code §534.101; Insurance Code Chapters 843, 844, and 1271; and Insurance Code §§843.051, 843.053, 843.073, 843.079, and 843.318.

Section 11.2104 implements Insurance Code §1271.101.

§11.2101. Community Health Maintenance Organization.

A Community Health Maintenance Organization (CHMO) is an entity created by one or more community centers under Health and Safety Code §534.001 (concerning Establishment), and authorized by the department to provide a plan for limited health care services as defined in Insurance Code §843.002(18) (concerning Definitions).

§11.2102. General Provisions.

(a) Each CHMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(b) Each CHMO must provide coverage for work in progress and must clearly specify that the enrollee must agree to have the work completed by a participating physician or provider in the HMO delivery network, as defined under Insurance Code §843.002(15) (concerning Definitions), or as otherwise arranged by the limited service HMO.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Before obtaining a certificate of authority, an applicant CHMO must comply with each requirement for the issuance of a

certificate of authority imposed on a limited health care service plan under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state.

(b) A CHMO with a certificate of authority must comply with all the appropriate requirements that a limited health care service plan must comply with under Insurance Code Chapters 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO is subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) Nothing in this subchapter prevents one or more community centers from forming a nonprofit corporation under Occupations Code §162.001 (concerning Certification by Board) to provide services on a risk-sharing or capitated basis as permitted under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code §843.051 (concerning Applicability of Insurance and Group Hospital Service Corporation Laws), §843.053 (concerning Laws Relating to Restraint of Trade), §843.073 (concerning Certificate of Authority Requirement; Applicability to Physicians and Providers), or §843.318 (concerning Certain Contracts of Participating Physicians or Provider Not Prohibited).

§11.2104. Minimum Standards for Community Health Centers. Each evidence of coverage providing limited mental health care services by a CHMO must provide benefits as described in Chapter 11, Subchapter Y, of this title (relating to Limited Service HMOs) as minimum covered services for mental illness and chemical dependency.

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

Filed with the Office of the Secretary of State on September 22, 2016.

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SUBCHAPTER W. SINGLE SERVICE HMOS

28 TAC §§11.2200 - 11.2208

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §§36.001, 842.002(26), 843.082, 843.083, 843.102, 843.107, 843.108, 843.112, 843.151, 843.201, 1271.002, 1271.052, 1271.101, 1271.155, and 1273.003.

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

Insurance Code §843.002(26) defines "single health care service plan."

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

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 §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §1271.003 provides that: (a) each enrollee residing in this state is entitled to evidence of coverage under a health care plan; (b) an HMO must issue the evidence of coverage, except that if the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation must issue the evidence of coverage; and (c) by agreement between the HMO, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by the section may be delivered electronically.

Insurance Code §1271.052 provides that an evidence of coverage must state: (1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the plan; (2) the issuance of other benefits, if any, to which the enrollee is entitled under the plan; and (3) any limitation on the services, kinds of services, benefits, or kinds of

benefits to be provided, including any deductible or copayment feature.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1273.002 provides for point-of-service plans.

CROSS REFERENCE TO STATUTE.

Section 11.2200 implements Insurance Code §§843.002(26), 843.112, and 1273.002.

Section 11.2201 implements Insurance Code §§843.002(26), 843.201, 1271.101, and 1271.052

Section 11.2202 implements Insurance Code §36.001 and §843.151.

Section 11.2203 and §11.2204 implement Insurance Code §843.201 and §1271.002.

Section 11.2205 implements Insurance Code §1271.155.

Section 11.2206 implements Insurance Code §843.107 and §843.108.

Section 11.2207 implements Insurance Code §843.102.

Section 11.2208 implements Insurance Code §843.082 and §843.201.

§11.2200. Definitions.

§11.2201. General Provisions.

§11.2202. Limitations and Exclusions.

§11.2203. Minimum Standards, Dental Care Services and Benefits.

§11.2204. Minimum Standards, Vision Care Services and Benefits.

§11.2205. Prohibited Practices.

§11.2206. Mandatory Disclosure Statements, Certification of Compliance.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

§11.2208. Single Health Care Services Accessibility and Availability.

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

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28 TAC §§11.2200 - 11.2206, 11.2208

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§36.001, 842.002(26), 843.082, 843.083, 843.102, 843.107, 843.108, 843.112, 843.151, 843.201, 1271.002, 1271.052, 1271.101, 1271.155, and 1273.002.

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

Insurance Code §843.002(26) defines "single health care service plan."

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

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 §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §1271.002 provides that each enrollee residing in this state is entitled to evidence of coverage under a health care plan, provides for the issuance of the evidence of coverage, and provides for electronic delivery.

Insurance Code §1271.003 provides that: (a) each enrollee residing in this state is entitled to evidence of coverage under a health care plan; (b) an HMO must issue the evidence of coverage, except that if the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation must issue the evidence of coverage; and (c) by agreement between the HMO, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by the section may be delivered electronically.

Insurance Code §1271.052 provides that an evidence of coverage must state: (1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the plan; (2) the issuance of other benefits, if any, to which the enrollee is entitled under the plan; and (3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1273.002 provides for point-of-service plans.

CROSS REFERENCE TO STATUTE.

Section 11.2200 implements Insurance Code §843.002(26), and §843.112, and §1273.002

Section 11.2201 implements Insurance Code §§843.002(26), 843.201, 1271.101, and 1271.052

Section 11.2202 implements Insurance Code §36.001 and §843.151.

Section 11.2203 and §11.2204 implement Insurance Code §843.201 and §1271.002.

Section 11.2205 implements Insurance Code §1271.155.

Section 11.2206 implements Insurance Code §843.107 and §843.108.

Section 11.2207 implements Insurance Code §843.102.

Section 11.2208 implements Insurance Code §843.082 and §843.201.

§11.2200. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context clearly indicates otherwise:

(1) ADA--The American Dental Association.

(2) CDT--The current dental terminology manual developed and revised periodically by the ADA.

(3) ADA code/dental procedure description--Numerical codes and corresponding descriptions specified in the CDT to describe bona fide dental procedures.

(4) Comparable facility--The location where emergency dental services are rendered, including, but not limited to, the office of a licensed dentist, a dental clinic, hospital, freestanding emergency clinic, urgent care clinic, or other facility.

(5) Emergency dental services--Under a single service plan providing dental care services and benefits, emergency dental services are limited to procedures administered in a comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

(6) Insurer--An insurance company, a group hospital service corporation operating under Insurance Code Chapter 842 (concerning Group Hospital Service Corporations), a fraternal benefit society operating under Insurance Code Chapter 885 (concerning Fraternal Benefit Societies), or a stipulated premium insurance company operating under Insurance Code Chapter 884 (concerning Stipulated Premium Insurance Companies).

(7) Point-of-service group disclosure statement--A written statement containing information about dental benefits that the HMO must provide to:

(A) an employer, an association, or other private group arrangement to whom the HMO must offer a dental point-of-service plan; and

(B) any prospective enrollees in a dental point-of-service plan, if the employer, association, or private group arrangement accepts the dental point-of-service plan.

(8) Point-of-service plan--A plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services other than emergency care or emergency dental care are provided by an insurer in conjunction with corresponding benefits arranged or provided by an HMO that provides dental benefits and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the HMO plan in compliance with Insurance Code §843.112 (concerning Dental Point-of-Service Option).

(9) Qualified actuary--As defined in §11.702 of this title (relating to Actuarial Certification).

§11.2201. General Provisions.

(a) Each single service HMO must provide uniquely described services with any corresponding copayments for each covered service and benefit and must provide a single health care service plan as defined in Insurance Code §843.002 (concerning Definitions). Each single service HMO must comply with all requirements for a single health care service plan specified in this subchapter.

(b) Each single service HMO schedule of enrollee copayments must specify an appropriate description of covered services and benefits, as required by §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedures or other information used for the purpose of maintaining a statistical reporting system.

(c) Each single service HMO evidence of coverage must include a glossary of terminology, including the terms used in the evidence of coverage required by §11.501 of this title (relating to Contents of the Evidence of Coverage). The glossary must be included in the information to prospective and current group contract holders and enrollees, as required by Insurance Code §843.201 (concerning Disclosure of Information About Health Care Plan Terms).

(d) In the event of a conflict between the provisions of this subchapter and other provisions of this chapter, this subchapter prevails with regard to single service HMOs. It is not considered a conflict if a topic that is not addressed in this subchapter appears elsewhere in this chapter.

§11.2202. Limitations and Exclusions.
Single service HMOs are prohibited from:

(1) excluding services required for preexisting conditions that would otherwise be covered under the plan; and

(2) establishing waiting periods for coverage of preexisting conditions.

§11.2203. Minimum Standards - Dental Care Services and Benefits.

(a) Each single service HMO evidence of coverage that uses any dental procedure codes must use the codes as specified in the current version of the CDT and certify that the codes referenced in its evidence of coverage are as specified in the current version of the CDT.

(b) Each single service HMO evidence of coverage providing coverage for dental care services must provide benefits for covered dental treatment in progress and may, if clearly disclosed, require the enrollee to have the treatment completed by a participating provider in the HMO delivery network, as defined in Insurance Code §843.002 (concerning Definitions), or as otherwise arranged by the single service HMO.

(c) Each single service HMO evidence of coverage providing coverage for dental care services and benefits must provide services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal disease. The services may include an infection control (sterilization) fee. Single service HMOs providing coverage for dental care services must provide coverage for the following primary and preventive services provided by a general dentist or hygienist, as applicable:

(1) office visit during and after regularly scheduled hours;

(2) oral evaluations;

(3) X-rays;

(4) bitewings;

(5) panoramic film;

(6) dental prophylaxis (adult and child);

(7) topical fluoride treatment for children;

(8) dental sealants for children;

(9) amalgam fillings (one, two, three, and four or more surfaces, primary and permanent, including polishing);

(10) anterior resin fillings (one, two, three, and four or more surfaces, or involving incisal angle, primary and permanent, including polishing);

(11) simple oral extractions;

(12) surgical incision and drainage of abscess, intraoral soft tissue; and

(13) palliative (emergency) treatment of dental pain, provided that the enrollee may obtain emergency treatment of dental pain in a comparable facility.

(d) Each single service HMO evidence of coverage providing coverage for dental care services and benefits may provide secondary dental care services and benefits. Each single service HMO evidence of coverage providing coverage for dental care services and benefits may include an infection control (sterilization) fee, and may provide secondary dental care services and benefits, including:

(1) posterior resin restorations, one, two, three, and four or more surfaces (to include polishing);

(2) crowns and crown recementation;

(3) composite resin crowns, anterior-primary;

(4) sedative fillings;

(5) core buildup, including any pins, and pin retention;

(6) pulp cap (direct and indirect);

(7) therapeutic pulpotomy;

(8) root canal therapy, anterior, bicuspid, and molar;

(9) gingival curettage;

(10) osseous surgery;

(11) periodontal scaling and root planing;

(12) periodontal maintenance procedures;

(13) complete denture (maxillary and mandibular);

(14) partial denture (maxillary and mandibular);

(15) root removal-exposed roots;

(16) surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone or section of tooth;

(17) removal of impacted tooth (soft tissue and completely bony);

(18) tooth reimplantation or stabilization, or both, of accidentally evulsed or displaced tooth or alveolus, or both;

(19) alveoplasty;

(20) occlusal guard (bruxism appliance); or

(21) orthodontia.

(e) Each single service HMO providing coverage for dental care services and benefits may also offer a preventive services plan as a supplement to a basic health care service plan offered by an affiliate or another carrier, as long as a plan described in subsection (c) of this section has first been offered to and rejected in writing by the group contract holder. The preventive plan must include:

(1) oral evaluations;

(2) X-rays;

(3) bitewings;

(4) panoramic film; and

(5) prophylaxis.

§11.2204. Minimum Standards - Vision Care Services and Benefits.

(a) Each single service HMO evidence of coverage providing vision care services and benefits must provide the following as covered primary and preventive vision services:

(1) comprehensive eye examination to include medical history;

(2) visual acuities, with and without correction (distance and near);

(3) cover test at 20 feet and at 16 inches;

(4) versions;

(5) external examination of the eye lids, cornea, conjunctiva, pupillary reaction (neurological integrity), and muscle function;

(6) binocular measurements for far and near;

(7) internal eye examination (ophthalmoscopy);

(8) autorefraction/refraction (far point and near point);

(9) tonometry (reasonable attempt or equivalent testing if contraindicated);

(10) retinoscopy;

(11) biomicroscopy;

(12) intraocular pressure glaucoma test;

(13) slit lamp examination; and

(14) urgent care.

(b) A single service HMO evidence of coverage providing vision care services and benefits may provide coverage for secondary vision care services, which include:

(1) contact lens examination;

(2) fitting;

(3) training;

(4) follow-up visits; or

(5) eye glasses.

§11.2205. Prohibited Practices.

(a) Under an individual plan, a single service HMO may not limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year.

(b) A single service HMO may not limit coverage for emergency services under a single health care service plan.

(c) A single service HMO may not charge an emergency fee in addition to a copayment for emergency services.

§11.2206. Mandatory Disclosure Statements; Certification of Compliance.

(a) Each point-of-service group enrollment application and, if the employer, association, or private group arrangement elects to offer the point-of-service option, each enrollment form, must include a disclosure statement written in a readable and understandable format that includes the following information:

(1) a statement that the dental indemnity benefits are provided through an insurer and that the dental care services are offered or arranged by the HMO;

(2) the name of the insurer and the name of the HMO offering the benefits; and

(3) an explanation that, in order to receive benefits:

(A) under the HMO, an enrollee must use only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage;

(B) under the indemnity plan, an enrollee may use any provider but before receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the policy or certificate.

(b) Each HMO offering a point-of-service plan must retain on file a certification by an HMO officer that the point-of-service plan includes dental indemnity benefits that correspond to the benefits contained in the HMO evidence of coverage. The HMO may enter into agreement with the insurer or a qualified actuary to prepare the certification, provided that the HMO retains responsibility for obtaining the certification and must keep the certification in its possession.

§11.2208. Single Service Accessibility and Availability.

A single service HMO that chooses to offer a particular service to an enrolled population must comply with §11.1607 of this title (relating to Accessibility and Availability Requirements). Any single service must be provided directly by the HMO or by contract.

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

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SUBCHAPTER X. PROVIDER SPONSORED ORGANIZATIONS

28 TAC §§11.2301 - 11.2315

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code §36.001 and §843.151.

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

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.

CROSS REFERENCE TO STATUTE.

Sections 11.2301 - 11.2315 implement Insurance Code §36.001 and §843.151.

§11.2301. Purpose and Scope.
§11.2302. Definitions.
§11.2303. Application for Certificate of Authority.
§11.2304. Financial Plan Requirement.
§11.2305. Issuance of Certificate of Authority.
§11.2306. Solvency Standards.
§11.2307. Minimum Net Worth Amount.
§11.2308. Liquidity.
§11.2309. Deposits.
§11.2310. Guarantees.
§11.2311. Dissolution; Liquidation; Rehabilitation.
§11.2312. Reports.
§11.2313. Examinations.
§11.2314. Suspension or Revocation of Certificate of Authority.
§11.2315. Application of Other Insurance Laws.

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SUBCHAPTER Y. LIMITED SERVICE HMOS

28 TAC §§11.2401 - 11.2406

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code Chapter 1651; and Insurance Code §§36.001, 843.002(17), 843.102, 843.151, 1271.101, 1368.004 - 1368.007.

Insurance Code Chapter 1651 provides for long term care benefit plans.

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

Insurance Code §843.002(17) defines "limited health care service plan."

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

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 §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1368.004 provides that a group health benefit plan must provide coverage for the necessary care and treatment of chemical dependency, and details how that coverage may be provided.

Insurance Code §1368.005 sets minimum coverage requirements under Chapter 1368.

Insurance Code §1368.006 defines "treatment series" and provides that coverage required under Chapter 1368 is limited to a lifetime maximum of three separate treatment series for each covered individual.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

CROSS REFERENCE TO STATUTE.

Section 11.2401, §11.2403 and §11.2404 implement Insurance Code §36.001 and §843.151.

Section 11.2402 implements Insurance Code §843.002(17) and §843.102.

Section 11.2405 implements Insurance Code Chapter 1355 and Insurance Code §§1271.101, 1368.004 - 1368.007.

Section 11.2406 implements Insurance Code Chapter 1651.

§11.2401. Definitions.

§11.2402. General Provisions.

§11.2403. Limitations and Exclusions.

§11.2404. Prohibited Practices.

§11.2405. Minimum Standards, Mental Health and Chemical Dependency Services and Benefits.

§11.2406. Minimum Standards, Long Term Care Services and Benefits.

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

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28 TAC §§11.2401 - 11.2403, 11.2405, 11.2406

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 1651 and Insurance Code §§36.001, 843.002(17), 843.102, 843.151, 1271.101, 1368.004 - 1368.007.

Insurance Code Chapter 1651 provides for long term care benefit plans.

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

Insurance Code §843.002(17) defines "limited health care service plan."

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

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 §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1368.004 provides that a group health benefit plan must provide coverage for the necessary care and treatment of chemical dependency, and details how that coverage may be provided.

Insurance Code §1368.005 sets minimum coverage requirements under Chapter 1368.

Insurance Code §1368.006 defines "treatment series" and provides that coverage required under Chapter 1368 is limited to a lifetime maximum of three separate treatment series for each covered individual.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

CROSS REFERENCE TO STATUTE.

Section 11.2401 and §11.2403 implement Insurance Code §36.001 and §843.151.

Section 11.2402 implements Insurance Code §843.002(17) and §843.102.

Section 11.2405 implements Insurance Code Chapter 1355 and Insurance Code §§1271.101, 1368.004 - 1368.007.

Section 11.2406 implements Insurance Code Chapter 1651.

§11.2401. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context clearly indicates otherwise:

(1) Acute day treatment--Program-based services focused on the short-term, acute treatment of individuals who require multi-disciplinary treatment to obtain maximum control of psychiatric symptoms. Services are provided in a highly structured and safe environment with constant supervision. Contacts with staff are frequent, activities and services constantly available, and developmental and social supports encouraged and facilitated. Staff receive specialized training in crisis management. Activities are goal oriented, focusing on improving peer interaction, appropriate social behavior, and stress tolerance.

(2) Assessment--The clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental,

or other information from the individual and family seeking services to determine level of need (including urgency) and specific treatment needs (including the preferences of the individual seeking services).

(3) Case management--Case management activities are provided to assist individuals in gaining access to medical, social, educational, and other appropriate services that will help them achieve a quality of life and community participation acceptable to each individual. The role of individuals who provide case management activities is to support and assist the person in achieving goals.

(4) Crisis hotline--A continuously available, staffed telephone service providing information, support, and referrals to callers 24 hours per day, seven days per week.

(5) Crisis respite--Services provided for temporary, short term, periodic relief to individuals or their primary caregivers during a crisis. Program-based respite services involve temporary residential placement outside the usual living situation. Community-based respite services involve introducing respite staff into the usual living situation or providing a place for the individual to go during the day or other services considered to provide respite.

(6) Crisis services--Services, including crisis hotline, crisis intervention, and crisis respite.

(7) Intensive outpatient service--An organized nonresidential service providing structured group and individual therapy, educational services, and life-skills training for less than 24 hours per day.

(8) Medication administration--A service provided to an individual by a licensed nurse or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law to ensure the direct application of a medication to the body of the individual by any means including handing the individual a single dose of medication to be taken orally.

(9) Medication monitoring--A service provided to an individual, family member, or other collateral by a licensed nurse or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law for the purpose of assessment of medication actions, target symptoms, side effects and adverse effects, potential toxicity, and the impact of medication for the individual and family in compliance with the plan of care.

(10) Medication training--A service to an individual, family member, or other collateral by a licensed nurse or other appropriately trained professional or paraprofessional as provided by state law for the purpose of teaching the knowledge and skills needed by the individual, family member, or other collateral in the proper administration and monitoring of prescribed medication in compliance with the individual's plan of care.

(11) Medication-related services--Services, including medication administration, medication monitoring, medication training, and pharmacological management.

(12) Partial hospitalization--The provision of treatment for mental health care or chemical dependency for individuals who require care or support or both in a hospital or chemical dependency treatment center but who do not require 24-hour supervision.

(13) Pharmacological management--Service provided to an individual, family member, or collateral by a physician or other appropriately trained and certified professional as provided by state law for the purpose of determining symptom remission and the medication regimen needed to initiate or maintain an individual's plan of care.

(14) Screening--Gathering triage information necessary to determine a need for in-depth assessment. This information is collected through interview, in person or by phone, with the individual, family member, or collateral as part of the admission or intake process or as necessary.

(15) Treatment planning--Activities for the purpose of medically necessary, prioritized, comprehensive, collaborative, and measurable treatment that reflects the needs and wishes of the individual and builds on the strengths of the individual.

§11.2402. General Provisions.

(a) A limited service HMO must develop and maintain an ongoing quality improvement structure and program that complies with Chapter 11, Subchapter T, of this title (relating to Quality of Care).

(b) Each limited service HMO must provide uniquely described services with any corresponding copayments for each covered service and benefit, and provide a limited health care service plan as defined in Insurance Code §843.002 (concerning Definitions). Each limited service HMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(c) Each limited service HMO schedule of enrollee copayments must specify an appropriate description of covered services and benefits, as required by §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedure codes or other information used for maintaining a statistical reporting system.

(d) Each limited service HMO evidence of coverage must include a glossary of terms, including the terms used in the evidence of coverage required by §11.501 of this title (relating to Contents of the Evidence of Coverage). The glossary must be included in the information to prospective and current group contract holders and enrollees, as required by Insurance Code §843.201 (concerning Disclosure of Information about Health Care Plan Terms).

§11.2403. Prohibited Practices.

A limited service HMO may not:

(1) exclude services required for preexisting conditions which would otherwise be covered under the plan;

(2) establish waiting periods for coverage of preexisting conditions;

(3) impose a lifetime coverage maximum for any covered service or benefit;

(4) limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year;

(5) limit coverage for emergency services under a limited health care service plan;

(6) charge an emergency fee in addition to a copayment for emergency services; or

(7) count medication-related services and services provided by telephone toward the annual outpatient visit total for either serious or nonserious mental illness.

§11.2405. Minimum Standards - Mental Health and Chemical Dependency Services and Benefits.

Each limited service HMO evidence of coverage providing coverage for mental health and chemical dependency services and benefits must:

(1) cover, in compliance with the limited service HMO's standards of medical necessity, court-ordered mental health and chemical dependency treatment and may, if clearly disclosed, require the

enrollee to have the treatment completed by a participating physician or provider in the HMO delivery network, as defined in Insurance Code §843.002 (concerning Definitions), or as otherwise arranged by the limited service HMO;

(2) comply with Chapter 21, Subchapter P, of this title (relating to Mental Health Parity)

(3) provide primary mental health and chemical dependency services and benefits, including:

(A) for treatment of serious mental illness, as defined in Insurance Code Chapter 1355, Subchapter A, (concerning Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders), up to 45 inpatient days per year and up to 60 outpatient visits per year, which include assessment or screening, treatment planning, and crisis services;

(B) for treatment of nonserious mental illness, up to 30 inpatient days per year and up to 30 outpatient visits per year, which include screening and assessment, treatment planning, and crisis services;

(C) treatment of chemical dependency in compliance with the levels of care and clinical criteria specified in Chapter 3, Subchapter HH, of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers); and

(D) any other services necessary and appropriate to treat mental health and chemical dependency services or required by the Insurance Code, Health and Safety Code, and other applicable laws and regulations of this state; and

(4) demonstrate the capacity to provide, and may provide, secondary intensive rehabilitative, and community support services for mental illness and chemical dependency, including, but not limited to, case management, partial hospitalization, residential, acute day treatment, intensive outpatient service, Assertive Community Treatment teams, and habilitative or rehabilitative services for pervasive developmental disorders.

§11.2406. Minimum Standards - Long Term Care Services and Benefits.

Each limited service HMO evidence of coverage providing long-term care services and benefits must comply with Insurance Code Chapter 1651 (concerning Long-Term Care Benefit Plans) and Chapter 3, 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).

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SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

28 TAC §§11.2501 - 11.2503

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code Chapters 541 - 544, 547, 843, and 1273; and Insurance Code §§36.001, 843.107, 843.108; 843.151, 843.403, and 1201.211 - 1201.217.

Insurance Code Chapter 541 contains provisions concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices.

Insurance Code Chapter 542 regulates the processing and settlement of claims.

Insurance Code Chapter 543 contains provisions regarding prohibited practices related to policies or certificates of membership.

Insurance Code Chapter 544 contains provisions prohibiting certain forms of discrimination.

Insurance Code Chapter 547 prohibits false advertising by unauthorized insurers.

Insurance Code Chapter 843 regulates HMOs.

Insurance Code Chapter 1273 regulates Point-Of-Service Plans.

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

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

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 §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §§1201.211- 1201.217 contain provisions relating to required policy provisions.

CROSS REFERENCE TO STATUTE.

Section 11.2501 implements Insurance Code §843.107 and §843.108.

Section 11.2502 implements Insurance Code §843.108 and §843.403.

Section 11.2503 implements Insurance Code Chapters 541 - 547, and 1273; and Insurance Code §§843.107, 843.108, 1201.211 - 1201.217.

§11.2501. Definitions.

§11.2502. Issuance of Point-of-Service Riders.

§11.2503. Coverage Relating to POS Rider Plans.

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

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28 TAC §§11.2501 - 11.2503

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 541 - 544, Insurance Code Chapter 547, 843, and 1273; Insurance Code §§36.001, 843.107, 843.108, 843.151, 843.403, 1201.211 - 1201.217.

Insurance Code Chapter 541 contains provisions (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices. Insurance Code Chapter 542 regulates the processing and settlement of claims.

Insurance Code Chapter 543 contains provisions regarding prohibited practices related to policies or certificates of membership.

Insurance Code Chapter 544 contains provisions prohibiting certain forms of discrimination.

Insurance Code Chapter 547 prohibits false advertising by unauthorized insurers.

Insurance Code Chapter 843 regulates HMOs.

Insurance Code Chapter 1273 regulates Point-Of-Service Plans.

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

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

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 §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §§1201.211 - 1201.217 contain provisions relating to required policy provisions.

CROSS REFERENCE TO STATUTE.

Section 11.2501 implements Insurance Code §843.107 and §843.108.

Section 11.2502 implements Insurance Code §843.108 and §843.403.

Section 11.2503 implements Insurance Code Chapters 541 - 544, 547, and 1273; and Insurance Code §§843.107, 843.108, and 1201.211 - 1201.217.

§11.2501. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context indicates otherwise:

(1) Coinsurance--An amount in addition to the premium and copayments due from an enrollee who accesses out-of-plan covered benefits, for which the enrollee is not reimbursed.

(2) Corresponding benefits--Benefits provided under a point-of-service rider or the indemnity portion of a point-of-service plan, as defined in Insurance Code §843.108 (concerning Point-of-Service Rider) and §1273.001 (concerning Definitions), that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(3) Cost containment requirements--Provisions in a point-of-service rider requiring a specific action, such as the provision of specified information to the HMO, that must be taken by an enrollee or by a physician or provider on behalf of the enrollee to avoid the imposition of a specified penalty on the coverage provided under the rider for proposed service or treatment.

(4) Coverage--Any benefits available to an enrollee through an indemnity contract or rider, any services available to an enrollee under an evidence of coverage, or combination of the benefits and services available to an enrollee under a point-of-service plan.

(5) Health plan products--Any health care plan issued by an HMO under the Insurance Code or a rule adopted by the commissioner.

(6) In-plan covered services--Health care services, benefits, and supplies to which an enrollee is entitled under the evidence of coverage issued by an HMO, including emergency services, approved out-of-network services, and other authorized referrals.

(7) Nonparticipating physicians and providers--Physicians and providers who are not part of an HMO delivery network.

(8) Out-of-plan covered benefits--All covered health care services, benefits, and supplies that are not in-plan covered services. Out-of-plan covered benefits include health care services, benefits, and supplies obtained from participating physicians and providers under

circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

(9) Participating physicians and providers--Physicians and providers that are part of an HMO delivery network.

(10) Point-of-service blended contract plan--A point-of-service plan evidenced by a single contract, policy, certificate, or evidence of coverage that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services that are provided by an HMO under a point-of-service plan.

(11) Point-of-service dual contracts plan--A point-of-service plan providing a combination of indemnity benefits and HMO services through separate contracts, one being the contract, policy, or certificate offered by an indemnity carrier for which the indemnity carrier is at risk and the other being the evidence of coverage offered by the HMO.

(12) Point-of-service rider--A rider issued by an HMO that meets the solvency requirements of §11.2502 of this title (relating to Issuance of Point-of-Service Riders) and that provides coverage for out-of-plan services, including services, benefits, and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining approval for in-plan covered services.

(13) Point-of-service rider plan--A point-of-service plan provided by an HMO in compliance with this subchapter under an evidence of coverage that includes a point-of-service rider.

§11.2502. Issuance of Point-of-Service Riders.

(a) Financial requirements. An HMO that issues a point-of-service rider is subject to the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs).

(b) Termination, cancellation, and renewability. An HMO must comply with all state and federal laws and rules applicable to termination, cancellation, and renewability of a point-of-service rider plan.

§11.2503. Coverage Relating to Point-of-Service Rider Plans.

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the point-of-service rider.

(b) An HMO may not require an enrollee to use either the point-of-service rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) may not limit the access, under the point-of-service rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, to either participating physicians and providers or nonparticipating physicians and providers;

(2) may not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the point-of-service rider, accesses a participating physician or provider outside the limited provider network, that differ from the cost-sharing arrangements for in-plan covered services obtained by the enrollee from a physician or provider in the limited provider network; and

(3) may provide for cost-sharing arrangements for benefits obtained from nonparticipating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50 percent of the total amount to be covered.

(d) An HMO that issues or offers to issue a point-of-service rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of Insurance Code Chapters 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), 543 (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544 (concerning Prohibited Discrimination), 547 (concerning False Advertising by Unauthorized Insurers), 843 (concerning Health Maintenance Organizations), and 1273 (concerning Point-Of-Service Plans).

(e) A point-of-service rider plan offered under this subchapter must contain:

(1) a point-of-service rider that:

(A) includes coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) may not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F), and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage so long as the allowances and limits comply with applicable federal and state laws;

(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50 percent of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) may not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the point-of-service rider;

(I) if applicable, must disclose:

(i) how the point-of-service rider cost-sharing arrangements differ from those in the evidence of coverage;

(ii) any reduction of benefits as set forth in subparagraph (G) of this paragraph;

(iii) any deductible that must be met by the enrollee under the point-of-service rider; and

(iv) whether copayments made for in-plan covered services apply toward the point-of-service rider deductible;

(J) must provide coverage for services obtained without the HMO's authorization from a participating physician or provider, but the enrollee must comply with any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the point-of-service rider;

(K) must include a description of how an enrollee may access out-of-plan covered benefits under the point-of-service rider, including coverage contained in other riders attached to the evidence of coverage;

(L) must disclose all precertification requirements for coverage under the point-of-service rider including any penalties for failure to comply with any precertification or cost containment provisions, provided that the penalties will not reduce benefits more than 50 percent in the aggregate;

(M) if it is issued to a group, must contain provisions that comply with Insurance Code Chapter 1251, Subchapter C, (concerning Partnership for Long-Term Care Program); and

(N) if it is issued to an individual, must contain provisions that comply with Insurance Code §§1201.211 - 1201.217 (concerning Policy Provision: Notice of Claim, Policy Provision: Claim Forms, Policy Provision: Proof of Loss, Policy Provision: Time of Payment of Claims, Policy Provision: Payment of Claims, Policy Provision: Physical Examinations and Autopsy, Policy Provision: Legal Actions);

(2) an evidence of coverage that includes a description and reference to the point-of-service rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as nonparticipating physicians and providers for out-of-plan covered benefits, and that accessing these benefits through the point-of-service rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the point-of-service rider and services, benefits, and supplies available in the evidence of coverage that together constitute the point-of-service rider plan.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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For further information, please call: (512) 676-6584

SUBCHAPTER AA. DELEGATED ENTITIES

28 TAC §§11.2601 - 11.2612

STATUTORY AUTHORITY. The repeals are proposed under Insurance Code Chapter 1271, Subchapters B and D; and Insurance Code §§36.001, 38.001, 843.151, 1272.001, 1272.051 - 1272.053, 1272.056, 1272.064, 1272.102, 1272.103, 1272.202, 1272.203, and 1272.205 - 1272.208.

Insurance Code Chapter 1272, Subchapter B, regulates delegation agreements.

Insurance Code Chapter 1272, Subchapter D, provides reserve requirements for delegated networks.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

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 §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.051 provides that Chapter 1272, Subchapter B, does not apply to a group model HMO, as defined by §843.111.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.053 provides that a delegation agreement required by §1272.052 must establish a monitoring plan and sets requirements for those plans.

Insurance Code §1272.056 provides that a delegation agreement required by §1272.052 must provide that: (1) the agreement does not limit in any way the HMO's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and (2) the delegated entity must comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.102 provides that the commissioner determine the information a HMO must provide to a delegated entity with which the HMO has entered into a delegation agreement, sets requirements for that information, and provides for the information to be provided in a standard electronic format.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.202 provides that if an HMO becomes aware of information that indicates a delegated entity with which the HMO has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to

the enrollees, the HMO must in writing: (1) notify the entity of those findings; and (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition. The section provides that the HMO must provide to the commissioner a copy of each notice and request submitted to a delegated entity under the section and each response or other documentation the HMO receives or generates in response to the notice and request.

Insurance Code §1272.203 provides that a delegated entity must respond in writing to a request from an HMO under §1272.202 not later than the 30th day after the date the entity receives the request.

Insurance Code §1272.205 provides for examinations by the department of a delegated entity and reports of those examinations.

Insurance Code §1272.206 provides that the delegated entity and HMO must respond to the department's report under §1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

Insurance Code §1272.207 provides that the department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that: (1) relate to a function delegated by the HMO to the entity; or (2) are necessary to ensure the HMO's compliance with each statutory or regulatory requirement.

Insurance Code §1272.208 provides that the commissioner may order an HMO with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the HMO is complying with Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B.

CROSS REFERENCE TO STATUTE.

Section 11.2601 implements Insurance Code §§1272.051, 1271.052, and 1272.053.

Section 11.2602 implements Insurance Code §1272.001.

Section 11.2603 implements Insurance Code §§1272.051, 1271.052, 1272.053, 1272.056, and 1272.061.

Section 11.2604 implements Insurance Code §§1272.051, 1271.052, 1272.053, 1272.056, 1272.061 - 1272.063.

Section 11.2605 implements Insurance Code §1272.102.

Section 11.2606 implements Insurance Code §1272.202, and §1272.203.

Section 11.2607 implements Insurance Code §1272.205, and §1272.206.

Section 11.2608 implements Insurance Code §1272.207.

Section 11.2609 implements Insurance Code Chapter 1271, Subchapter B.

Section 11.2610 implements Insurance Code §1272.208.

Section 11.2611 implements Insurance Code §1272.052.

Section 11.2612 implements Insurance Code §36.001 and §843.151.

§11.2601. General Provisions.

§11.2602. Definitions.

§11.2603. Requirements for Delegation by HMOs.

§11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO.

§11.2605. Delegation Agreements - Information to be Provided by HMO to Delegated Entity.

§11.2606. Reporting Requirements.

§11.2607. Examinations of Delegated Entities.

§11.2608. Department May Order Corrective Action.

§11.2609. Reserve Requirements for Delegated Networks.

§11.2610. Penalties for Non-Compliance.

§11.2611. Filing of Delegation Agreements.

§11.2612. Applicability.

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

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Norma Garcia
General Counsel
Texas Department of Insurance
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28 TAC §§11.2601 - 11.2611

STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 1271, Subchapters B and D; and Insurance Code §§36.001, 38.001, 843.151, 1272.001, 1272.051 - 1272.053, 1272.056, 1272.064, 1272.102, 1272.103, 1272.202, 1272.203, and 1272.205 - 1272.208.

Insurance Code Chapter 1272, Subchapter B, regulates delegation agreements.

Insurance Code Chapter 1272, Subchapter D, provides reserve requirements for delegated networks.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

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 §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.051 provides that Chapter 1272, Subchapter B, does not apply to a group model HMO, as defined by §843.111.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.053 provides that a delegation agreement required by §1272.052 must establish a monitoring plan and sets requirements for those plans.

Insurance Code §1272.056 provides that a delegation agreement required by §1272.052 must provide that: (1) the agreement does not limit in any way the HMO's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and (2) the delegated entity must comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.102 provides that the commissioner determine the information a HMO must provide to a delegated entity with which the HMO has entered into a delegation agreement, sets requirements for that information, and provides for the information to be provided in a standard electronic format.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.202 provides that if an HMO becomes aware of information that indicates a delegated entity with which the HMO has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the HMO must in writing: (1) notify the entity of those findings; and (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition. The section provides that the HMO must provide to the commissioner a copy of each notice and request submitted to a delegated entity under the section and each response or other documentation the HMO receives or generates in response to the notice and request.

Insurance Code §1272.203 provides that a delegated entity must respond in writing to a request from an HMO under §1272.202 not later than the 30th day after the date the entity receives the request.

Insurance Code §1272.205 provides for examinations by the department of a delegated entity and reports of those examinations.

Insurance Code §1272.206 provides that the delegated entity and HMO must respond to the department's report under §1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

Insurance Code §1272.207 provides that the department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that: (1) relate to a function delegated by the HMO to the entity; or (2) are necessary to ensure the HMO's compliance with each statutory or regulatory requirement.

Insurance Code §1272.208 provides that the commissioner may order an HMO with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the HMO is complying with Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B.

CROSS REFERENCE TO STATUTE.

Section 11.2601 implements Insurance Code §§1272.051, 1271.052, and 1272.053.

Section 11.2602 implements Insurance Code §1272.001.

Section 11.2603 implements Insurance Code §§1272.051, 1271.052, 1272.053, 1272.056, and 1272.061.

Section 11.2604 implements Insurance Code §§1272.051, 1271.052, 1272.053, 1272.056, 1272.061 - 1272.063.

Section 11.2605 implements Insurance Code §1272.102.

Section 11.2606 implements Insurance Code §1272.202 and §1272.203.

Section 11.2607 implements Insurance Code §1272.205 and §1272.206.

Section 11.2608 implements Insurance Code §1272.207.

Section 11.2609 implements Insurance Code Chapter 1271, Subchapter B.

Section 11.2610 implements Insurance Code §1272.208.

Section 11.2611 implements Insurance Code §1272.052.

§11.2601. General Provisions.

(a) A delegating HMO must:

(1) identify all responsibilities relating to the function being delegated;

(2) create an agreement that enables the HMO and department to monitor both the delegated entity's financial solvency and performance or subsequent delegation of all delegated functions; and

(3) retain ultimate responsibility for ensuring that all delegated functions are performed in compliance with applicable statutes and rules.

(b) This subchapter applies to all contracts entered into or renewed on and after the effective date of these rules.

(c) This subchapter does not apply to a group model HMO, as defined in Insurance Code §843.111 (concerning Group Model Health Maintenance Organizations).

§11.2602. Definitions.

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

(1) Delegated entity--An entity, other than an HMO authorized to do business under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning to Delegation of Certain Functions by Health Maintenance Organization) and other applicable insurance laws and regulations of this state, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to physicians and providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar-year basis.

(2) Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Occupations Code §551.003 (concerning Definitions). The term does not include a delegated entity that shares risk for a category of services with an HMO.

(3) Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state.

(4) Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, dental care, hospitalization, or incident to the furnishing of the services, care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

§11.2603. Requirements for Delegation by HMOs.

(a) Any delegation of any function under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state by an HMO must comply with this subchapter.

(b) Oversight by the department does not relieve an HMO of responsibility for monitoring and oversight of its delegated entities.

(c) Before entering into, renewing, or amending a delegation agreement, an HMO must make a reasonable effort to evaluate the delegated entity's current and prospective ability to perform the functions to be delegated, including, but not limited to, the solvency and financial operations of the delegated entity and the projected financial effects of the agreement on the delegated entity.

(d) An HMO that delegates functions to a delegated entity must have a written contingency plan to resume any and all delegated functions, including, as applicable:

(1) quality of care;

(2) continuity of care, including a plan for transferring enrollees to new physicians and providers in the event of termination of the delegation agreement; and

(3) processing, adjudication, and payment of claims.

(e) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state.

(f) An HMO retains ultimate responsibility for any and all functions delegated.

(g) A delegated entity's failure to comply with applicable statutes or rules constitutes a violation of Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state by the delegating HMO.

(h) An HMO is responsible for monitoring each delegated entity with which it contracts to ensure compliance with all applicable statutes and rules, as well as for solvency.

(i) An HMO must report to the department, within a reasonable time, all penalties assessed against a delegated entity under the provisions of the delegation agreement.

(j) If an HMO cannot ensure that a delegated entity is performing all delegated functions in compliance with all applicable statutes, rules, or an order issued by the department under this subchapter, the HMO must resume all delegated functions from the delegated entity.

(k) If a license is required for any function delegated by an HMO, the HMO must ensure that the delegated entity or third party performing the function has a current appropriate license.

(l) On termination of a delegation agreement by either party, the HMO must notify the department.

§11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO.

(a) An HMO that delegates any function required by Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state to a delegated entity must execute a written agreement with that delegated entity.

(b) Written agreements must include:

(1) a provision that the delegated entity and any delegated third parties must agree to comply with all statutes and rules applicable to the functions being delegated by the HMO;

(2) a provision that the HMO will monitor the acts of the delegated entity through a monitoring plan, which must be set forth in the delegation agreement, and contain, at a minimum:

(A) provisions for the review of the delegated entity's solvency status and financial operations, including, at a minimum, review of the delegated entity's financial statements, consisting of at least a balance sheet, income statement, and statement of cash flows for the current and preceding year;

(B) provisions for the review of the delegated entity's compliance with the terms of the delegation agreement as well as with all applicable statutes and rules affecting the functions delegated by the HMO under the delegation agreement;

(C) a description of the delegated entity's financial practices in sufficient detail that will ensure that the delegated entity tracks and timely reports to the HMO liabilities including incurred but not reported obligations;

(D) a method by which the delegated entity must report monthly a summary of the total amount paid by the delegated entity to physicians and providers under the delegation agreement; and

(E) a monthly log, maintained by the delegated entity, of oral and written complaints from physicians, providers, and enrollees regarding any delay in payment of claims or nonpayment of claims pertaining to the delegated function, including the status of each complaint;

(3) a statement that the HMO will use the monitoring plan on an ongoing basis; compliance with this requirement must be documented by the HMO maintaining, at a minimum:

(A) periodic signed statements from the individual identified by the HMO in paragraph (23) of this subsection that the HMO has reviewed the information required in the monitoring plan; and

(B) periodic signed statements from the chief financial officer of the HMO acknowledging that the most recent financial statements of the delegated entity have been reviewed;

(4) a provision establishing the penalties to be paid by the delegated entity for failure to provide information required by this subchapter;

(5) a provision requiring quarterly assessment and payment of penalties under the agreement, if applicable;

(6) a provision that the agreement cannot be terminated without cause by the delegated entity or the HMO without written notice provided to the other party and the department before the 90th day preceding the termination date, provided that the commissioner may order the HMO to terminate the agreement under §11.2608 of this title (relating to Department May Order Corrective Action);

(7) a provision that requires the delegated entity, and any entity or physician or provider with which it has contracted to perform a function of the HMO, to hold harmless an enrollee under any circumstance, including the insolvency of the HMO or delegated entity, for payments for covered services other than copayments and deductibles authorized under the evidence of coverage;

(8) a provision that the delegation agreement may not be construed to limit in any way the HMO's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(9) a provision that any failure by the delegated entity to comply with applicable statutes and rules or monitoring standards permits the HMO to terminate delegation of any or all delegated functions;

(10) a provision that the delegated entity must permit the commissioner to examine at any time any information the department reasonably considers is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the HMO;

(11) a provision that the delegated entity, in contracting with a delegated third party directly or through a third party, will require the delegated third party to comply with the requirements of paragraph (10) of this subsection;

(12) a provision that the delegated entity must provide the license number of any delegated third party performing any function that requires a license as a third party administrator under Insurance Code Chapter 4151 (concerning Third-Party Administrators), or a license as a utilization review agent under Insurance Code Chapter 4201 (concerning Utilization Review Agents), or that requires any other license under the Insurance Code or another insurance law of this state;

(13) if utilization review is delegated, a provision stating that:

(A) enrollees will receive notification at the time of enrollment identifying the entity that will be performing utilization review;

(B) the delegated entity or delegated third party performing utilization review must do so in compliance with Insurance Code Chapter 4201 and related rules; and

(C) utilization review decisions made by the delegated entity or a delegated third party must be forwarded to the HMO on a monthly basis;

(14) a provision that any agreement in which the delegated entity directly or indirectly delegates to a delegated third party any function delegated to the delegated entity by the HMO under Insurance Code Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state, including any handling of funds, must be in writing;

(15) a provision that on any subsequent delegation of a function by a delegated entity to a delegated third party, the executed updated agreements must be filed with the department and enrollees must be notified of the change of any party performing a function for which notification of an enrollee is required by this chapter or Insurance Code Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state;

(16) an acknowledgment and agreement by the delegated entity that the HMO is not prevented from requiring that the delegated entity provide any and all evidence requested by the HMO or the department relating to the delegated entity's or delegated third party's financial viability;

(17) a provision acknowledging that any delegated third party with which the delegated entity subcontracts will be limited to performing only those functions set forth and delegated in the agreement, using standards approved by the HMO and that are in compliance with applicable statutes and rules;

(18) a provision that any delegated third party is subject to the HMO's oversight and monitoring of the delegated entity's performance and financial condition under the delegation agreement;

(19) a provision that requires the delegated entity to make available to the HMO samples of each type of contract the delegated entity executes or has executed with physicians and providers to ensure compliance with the contractual requirements described by paragraphs (6) and (7) of this subsection, except that the agreement may not require that the delegated entity make available to the HMO contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(20) a provision that requires the delegated entity to provide information to the HMO on a quarterly basis and in a format determined by the HMO to permit an audit of the delegated entity and to ensure compliance with the department's reporting requirements with respect to any functions delegated by the HMO to the delegated entity and to ensure that the delegated entity remains solvent to perform the delegated functions, including:

(A) a summary:

(i) describing any payment methods, including capitation or fee for services, that the delegated entity uses to pay its physi-

cians and providers and any other third party performing a function delegated by the HMO; and

(ii) of the breakdown of the percentage of physicians and providers and any other third party paid by each payment method listed in clause (i) of this subparagraph;

(B) the period that claims and any other obligations for health care filed with the delegated entity, under this and any other delegation agreements to which the delegated entity is a party, have been pending but remain unpaid, divided into categories of 0-to-45 days, 46-to-90 days, and 91-or-more days. The summary must include aggregate information for all delegation agreements entered into by the delegated entity and information for the specific delegation agreement entered into between the parties;

(C) the aggregate dollar amount of claims and other obligations for health care owed by the delegated entity to any physician or provider, including estimates for incurred but not reported obligations;

(D) information that the HMO requires in order to file claims for reinsurance, coordination of benefits, and subrogation; and

(E) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Occupations Code, Chapter 160, Subchapter A, (concerning Requirements Relating to Medical Peer Review), that relates to:

(i) any regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the HMO; and

(ii) the final resolution of any regulatory agency's inquiry or investigation;

(21) a provision relating to enrollee complaints that requires the delegated entity to ensure that on receipt of a complaint, as defined in Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state, a copy of the complaint must be sent to the HMO within two business days, except that in a case in which a complaint involves emergency care, as defined in Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state, the delegated entity must forward the complaint immediately to the HMO, provided that nothing in this paragraph prohibits the delegated entity from attempting to resolve a complaint;

(22) a provision that the HMO, the delegated entity, and any delegated third party must comply with the provisions of Chapter 22 of this title (relating to Privacy);

(23) a provision identifying an officer of the HMO as the representative of the HMO for all matters related to the delegation agreement; and

(24) a provision identifying which party to the agreement will bear the expense of compliance with each requirement set forth in this subsection, including the cost of any examinations performed under this subchapter.

§11.2605. Delegation Agreements - Information to be Provided by HMO to Delegated Entity.

(a) An HMO must provide to each delegated entity with which the HMO has a delegation agreement, at least monthly unless otherwise stated in the agreement and provided in standard electronic format agreed to by the parties, the following information:

(1) the name and either the date of birth or social security number of each enrollee of the HMO who is eligible or assigned to receive health care from the delegated entity, including the enrollees added and terminated since the previous reporting period;

(2) the age, sex, evidence of coverage, and any riders to that evidence of coverage, and, if applicable, the name of the employer, for the enrollees of the HMO who are eligible or assigned to receive health care from the delegated entity;

(3) a summary of the number and amount of claims paid by the HMO on behalf of the delegated entity during the previous reporting period; provided that an HMO is not prevented from providing, on request, additional nonproprietary information regarding the claims if the HMO pays any claims for the delegated entity;

(4) a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the delegated entity has taken partial risk during the previous reporting period, provided that an HMO is not prevented from providing, on request, additional nonproprietary information regarding the claims, if the HMO pays any claims for the delegated entity;

(5) information that is needed by the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation; and

(6) patient complaint data that relates to the delegated entity.

(b) An HMO must provide to each delegated entity with which the HMO has a delegation agreement the following information, as applicable, provided in standard electronic format agreed to by the parties at least quarterly unless otherwise stated in the agreement:

(1) detailed risk-pool data, reported quarterly and on settlement, sufficient to allow the delegated entity to adequately monitor its position in the risk pool; and

(2) the percent of premium attributable to hospital or facility costs, if hospital or facility costs impact the delegated entity's costs and, if there are changes in hospital or facility contracts with the HMO, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of the changes.

§11.2606. Reporting Requirements.

(a) On receipt of a financial statement indicating that a delegated entity or delegated third party has an amount of total liabilities greater than its total assets, the HMO must immediately forward a copy of the financial statement to the department.

(b) An HMO that becomes aware of any information, including the information described in subsection (a) of this section, that suggests or indicates that the delegated entity or delegated third party is not operating in compliance with its written agreement or is operating in a condition that may render the continuance of its business hazardous to the enrollees, must immediately:

(1) notify the delegated entity in writing of those findings; and

(2) request, in writing, a written explanation with supporting documentation of:

(A) the delegated entity's or delegated third party's apparent noncompliance with the written agreement; or

(B) the existence of the condition that apparently renders the continuance of the delegated entity's or delegated third party's business hazardous to the enrollees.

(c) A delegated entity must respond in writing to a request from an HMO under subsection (b) of this section not later than the 30th day after the date the request is received. The response must include a corrective action plan.

(d) A copy of all written communications required by subsections (b) and (c) of this section must be sent to the department simultaneously with transmission to the HMO or delegated entity or delegated third party.

(e) The HMO must cooperate with the delegated entity to correct any failure by the delegated entity to comply with the applicable statutes and rules relating to any matters:

(1) delegated to the delegated entity by the HMO; or

(2) necessary for the HMO to ensure compliance with statutory or regulatory requirements.

§11.2607. Examinations of Delegated Entities.

(a) On receipt of complaints, a notice under §11.2606 of this title (relating to Reporting Requirements), or as otherwise permitted under the Insurance Code or related rules, the department may examine any matter relating to the financial solvency of the delegated entity or delegated third party or the delegated entity's ability to meet its responsibilities under the delegation agreement.

(b) The department may request documents, perform on-site examinations, and require any other action of the delegated entity and any delegated third party that the department determines necessary to perform an examination under this section.

(c) A delegated entity's failure to comply with a request under subsection (b) of this section may result in either or both:

(1) notification to the HMO that the delegated entity is subject to penalties under the delegation agreement; or

(2) entry of an order by the commissioner to resume or redelegate any functions delegated to the delegated entity or terminate the agreement in its entirety.

(d) The department will issue a report to the delegated entity and HMO on completion of the department's examination. The report will detail the results of the examination and any corrective actions necessary by the delegated entity or HMO.

(e) The delegated entity and the HMO must respond to the department's report and submit a corrective action plan to the department not later than the 30th day after the date of receipt of the department's report.

§11.2608. Department May Order Corrective Action.

(a) The department may require at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relates to any matters delegated by the HMO to the delegated entity;

(2) is necessary to ensure the HMO's compliance with statutory and regulatory requirements; or

(3) relates to the financial solvency and operations of the delegated entity.

(b) The commissioner may order the HMO to take any action the commissioner determines is necessary to ensure that the HMO maintains compliance with the Insurance Code, this chapter, and other applicable insurance laws and regulations of this state, including but not limited to:

(1) resumption of any or all functions delegated to the delegated entity, including claims processing, adjudication, and payments for health care previously rendered to enrollees of the HMO;

(2) temporarily or permanently ceasing assignment of new enrollees to the delegated entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive health care; or

(4) termination of the HMO's delegation agreement with the delegated entity.

§11.2609. Reserve Requirements for Delegated Networks.

In addition to any other requirements set forth in this subchapter, an HMO that contracts with a delegated network must ensure that the delegated network complies with Insurance Code Chapter 1272, Subchapter D, (concerning Reserve Requirements). The HMO's agreement with the delegated network must include a provision:

(1) that records related to the requirements of Insurance Code Chapter 1272, Subchapter D, must be accessible at all times to the HMO;

(2) requiring all financial records and related information necessary to show the delegated network's compliance with the requirements of Insurance Code Chapter 1272, Subchapter D;

(3) making the records described in paragraph (1) of this section available to the department on request; and

(4) that records be kept providing evidence that the HMO has adequately monitored the delegated network for compliance with the requirements of Insurance Code Chapter 1272, Subchapter D.

§11.2610. Penalties for Noncompliance.

(a) Failure of any party to any agreement under this subchapter to comply with any requirement of this subchapter may result in an order from the commissioner that the HMO must terminate the delegation agreement and resume or redelegate any or all delegated functions as well as the imposition of penalties provided under the Insurance Code and related rules.

(b) Any action by an HMO relating to a delegation agreement that does not comply with this subchapter or takes place under a provision of a delegation agreement not in compliance with this subchapter constitutes a violation under this subchapter.

§11.2611. Filing of Delegation Agreements.

(a) An HMO must file the written executed agreement described in this subchapter and any subsequently executed amendments to the agreement with the department as required under §11.301 of this title (relating to Filing Requirements).

(b) Every agreement must include as an attachment a completed Delegated Entity Data form, form SN014, (rev. 02/16).

(c) Every agreement must include, as an attachment, a table of contents that allows the department to track the agreement's compliance with the requirements of §11.2604 of this title (relating to Delegation Agreements - General Requirements and Information to be Provided to HMO) and §11.2605 of this title (relating to Delegation Agreements - Information to be Provided by HMO to Delegated Entity).

(d) On notification from the department of a deficiency in a delegation agreement or filing required under this subchapter, the HMO must respond within 10 business days with a proposed correction for the defect.

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

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For further information, please call: (512) 676-6584

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 115. CONTROL OF AIR POLLUTION FROM VOLATILE ORGANIC COMPOUNDS

SUBCHAPTER B. GENERAL VOLATILE ORGANIC COMPOUND SOURCES

DIVISION 1. STORAGE OF VOLATILE ORGANIC COMPOUNDS

30 TAC §§115.112, 115.114, 115.118, 115.119

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) proposes to amend §§115.112, 115.114, 115.118, and 115.119.

If adopted, the amended sections will be submitted to the United States Environmental Protection Agency (EPA) as revisions to the state implementation plan (SIP).

Background and Summary of the Factual Basis for the Proposed Rules

The 1990 Federal Clean Air Act (FCAA) Amendments (42 United States Code, §§7401, *et seq.)* require the EPA to establish primary National Ambient Air Quality Standards (NAAQS) that protect public health and to designate areas exceeding the NAAQS as nonattainment areas. For each designated nonattainment area, the state is required to submit a SIP revision to the EPA that provides for attainment and maintenance of the NAAQS.

FCAA, §172(c)(1) requires that the SIP incorporate all reasonably available control measures, including reasonably available control technology (RACT), for sources of relevant pollutants. The EPA defines RACT as the lowest emission limitation that a particular source is capable of meeting by the application of control technology that is reasonably available considering technological and economic feasibility (44 FR 53761, September 17, 1979). For ozone nonattainment areas classified as moderate and above, FCAA, §182(b)(2) requires the state to submit a SIP revision that implements RACT for sources of volatile organic compounds (VOC) addressed in a control techniques guidelines (CTG) document and for all non-CTG major sources.

Under the 2008 eight-hour ozone NAAQS, the Houston-Galveston-Brazoria (HGB) 2008 eight-hour ozone nonattainment area (HGB area), consisting of Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties, was classified as a marginal ozone nonattainment area with a July 20, 2015 attainment deadline (77 FR 30088, May 21, 2012). The HGB area did not attain the 2008 eight-hour ozone standard in 2014 but qualified for a one-year attainment date extension in accordance with FCAA, §181(a)(5). The EPA granted a one-year extension on May 4, 2016, extending the HGB area's attainment deadline to July 20, 2016 with a 2015 attainment year (81 FR 26697). Because the HGB area's 2015 design value of 80 parts per billion exceeded the 2008 eight-hour ozone NAAQS, the EPA is required by the FCAA to reclassify the HGB area to moderate. The EPA is expected to set a determination of nonattainment and reclassification of the HGB 2008 eight-hour ozone nonattainment area from marginal to moderate per the FCAA requirements. A reclassification of the HGB 2008 eight-hour ozone nonattainment area requires the state to submit an attainment demonstration SIP revision that addresses the ozone standard moderate nonattainment area requirements. As indicated in the EPA's 2008 ozone standard SIP requirements rule, the attainment deadline for moderate classification is July 20, 2018 with an attainment year of 2017 (80 FR 12264, March 6, 2015). These proposed rules will address updated RACT for the future required reclassification of the HGB nonattainment area.

The major source threshold for moderate nonattainment areas is a potential to emit (PTE) 100 tons per year (tpy) or more of VOC. However, a PTE of 25 tpy is retained as the major source threshold for the HGB area, which was classified as a severe nonattainment area under the 1997 eight-hour ozone NAAQS because this is the most stringent classification currently in effect for the HGB area. The TCEQ submitted a redesignation substitute report to the EPA demonstrating the HGB area attained and would continue to attain the one-hour ozone NAAQS on July 22, 2014, which was approved by the EPA on October 20, 2015 (80 FR 63429). On August 18, 2015, the TCEQ submitted a redesignation substitute report to the EPA demonstrating the HGB area has attained and will continue to attain the 1997 eight-hour ozone NAAQS. On May 25, 2016, the EPA published its proposed approval of the HGB area redesignation substitute and a finding of attainment for the 1997 eight-hour ozone NAAQS (81 FR 33166). The EPA's final approval of the 1997 eight-hour ozone NAAQS redesignation substitute would change the HGB area's major source threshold. Upon this approval, the HGB area would no longer be required to retain the major source threshold based on the severe nonattainment classification for the 1997 eight-hour ozone NAAQS, so the major source threshold would be based on the current marginal classification for the 2008 eight-hour ozone NAAQS, provided that no reclassification of the area has occurred. Upon the effective date of the EPA's expected reclassification for the HGB area, the major source threshold would then be based on the area's moderate classification for the 2008 eight-hour ozone NAAQS. However, such a reclassification would not apply retroactively, i.e., sources in the HGB area currently subject to the rule based on the current major source threshold for a severe classification would not become exempt from the rule. The proposed Chapter 115, Subchapter B, Division 1 rule revisions would address RACT for both CTG and non-CTG major source VOC storage tanks in the HGB area. Crude oil and condensate VOC storage tanks are non-CTG sources; therefore, rule provisions for these sources would only apply at or above the major source threshold, which is currently 25 tpy.

The proposed rulemaking would revise Chapter 115, Subchapter B, Division 1, to update the RACT requirements for VOC storage tanks in the HGB area. The proposed updates mirror revisions incorporated during the December 2011 (36 TexReg 8862) rulemaking (Rule Project Number 2010-025-115-AI) for the Dallas-Fort Worth (DFW) 1997 eight-hour ozone nonattainment area (Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker,

Rockwall, and Tarrant Counties) and the June 2015 (40 TexReg 3907) rulemaking (Rule Project Number 2013-048-115-AI) for the DFW 2008 eight-hour ozone nonattainment area (Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise Counties) for VOC storage tanks. The proposed rule changes include: updating the control efficiency requirement for control devices other than vapor recovery units or flares; expanding the applicability to include the aggregate of storage tanks at a pipeline breakout station into the control requirements prescribing flashed gas controls; and adding inspection, repair, and recordkeeping requirements for consistency with existing requirements in the DFW area. The 95% control efficiency requirement adopted as part of the December 2011 rulemaking and being proposed as part of this rulemaking, was approved as RACT for all CTG and non-CTG VOC storage tanks by the EPA in 2014 (79 FR 53299) for the 1997 eight-hour DFW nonattainment area. The proposed inspection, repair, and recordkeeping requirements are necessary to ensure compliance with the level of RACT established for crude oil and condensate storage tanks. The applicability, inspection, recordkeeping, and increased control efficiency requirements proposed in this rulemaking are already in place for crude oil and condensate storage tanks in the DFW area.

The commission is proposing to update the control efficiency requirement for control devices other than vapor recovery units and flares in §115.112(e)(3)(A) from 90% to 95% for all storage tanks in the HGB area currently subject to §115.112(e)(3)(A) to be consistent with the commission's RACT determination for storage tanks in the DFW area. The commission expects that all facilities that are currently subject to the 90% control efficiency requirement are already meeting the proposed 95% control efficiency requirement and that this change will not require any of those subject to the current rule to replace their current control device. Vapor control devices, vapor recovery units, and flares are all viable control device options available under the existing control requirements. Sources already meeting the current 90% control efficiency requirement are likely to be operating a vapor recovery unit, a flare, or both. Although this proposed rulemaking would increase the required control efficiency of vapor control devices, vapor recovery units and flares are already assumed under the existing rule to at least meet a 95% control efficiency.

This proposal expands the applicability to include the aggregate of crude oil and condensate storage tanks at pipeline breakout stations in the HGB area. Emissions from all of the crude oil and condensate tanks at each pipeline breakout station would now be considered when determining applicability to the Chapter 115 VOC storage tank rules. Therefore, owners and operators currently not triggering applicability to the control requirements may now have to comply. There may be some newly affected owners and operators of these sources that would need to install a vapor control system, vapor recovery unit, or flare to meet the rule requirements. As discussed in the Fiscal Note section of this preamble, the commission anticipates that there are potentially six sites that may be made subject to the rule as a result of the proposed change to consider the aggregate of crude oil and condensate storage tanks at pipeline breakout stations. Generally, the commission expects the proposed requirements to place minimal burden on affected owners and operators and that the proposed compliance date provides an adequate amount of time for these owners and operators to make all necessary installations and adjustments for compliance purposes. However, the commission's requirements for crude oil and condensate storage tanks in Chapter 115, Subchapter B, Division 1 implement non-CTG RACT, which applies to major sources. As discussed, the HGB area's major source threshold may change between proposal and adoption. The commission solicits comment on the issue of the expected transition from a severe to a marginal or moderate major source threshold as it pertains to the proposed change regarding the aggregate of crude oil and condensate storage tanks at pipeline breakout stations in the HGB area.

As indicated in the 2008 ozone standard SIP requirements rule, the EPA is expected to set the RACT compliance date on a reasonable schedule that the EPA Administrator will establish in the notice and comment rulemaking reclassifying the HGB area from marginal to moderate. The SIP requirements rule included a July 20, 2018 attainment deadline for moderate areas, with an attainment year of 2017. Because the EPA has not yet reclassified the HGB area to moderate, this rule proposal contains a RACT compliance deadline of July 20, 2018. According to the EPA's 2008 ozone standard SIP requirements rule, adopted measures must be implemented "no later than the outside attainment date for the area's classification, which would be July 20, 2018 for the HGB area (80 FR 12264 and 80 FR 12268)." Establishing a July 20, 2018 compliance deadline provides approximately a year and a half to make any necessary installations and adjustments needed to comply with the proposed rule requirements.

Demonstrating Noninterference under FCAA, §110(l)

The revisions proposed in this rulemaking would update rule language for major source crude oil and condensate storage vessels in the HGB area, as required under FCAA, §172(c)(1) and §182(b)(2) for nonattainment areas classified as moderate and above. The inspection, recordkeeping, and increased control efficiency requirements proposed in this rulemaking are already in place for crude oil and condensate storage vessels in the DFW area and have been determined necessary to implement RACT in the HGB area. As part of this rulemaking, revisions are also being proposed that would correct rule citations. These revisions are only proposed for the sections that are simultaneously being revised to implement RACT. Therefore, the commission determined that the proposed revisions would not negatively affect the status of the state's progress towards attainment with the ozone NAAQS, would not interfere with control measures, and would not prevent reasonable further progress toward attainment of the ozone NAAQS.

Section by Section Discussion

Subchapter B, General Volatile Organic Compounds

Division 1, Storage of Volatile Organic Compounds

The proposed rulemaking would revise Chapter 115, Subchapter B, Division 1, to implement RACT requirements for the HGB 2008 eight-hour ozone nonattainment area. These proposed requirements would establish greater stringency to be consistent with the level of RACT established for this emission source category in the DFW 2008 eight-hour ozone nonattainment area, as well as establishing the compliance date. The proposed rule would update control requirements for VOC storage tanks by increasing the required control efficiency for all vapor control systems, other than vapor recovery systems and flares, from 90% to 95%. The proposed rule would also update inspection and repair requirements after tank opening/loading, quarterly seal integrity inspections, and corresponding recordkeeping requirements for these crude oil and condensate storage tanks. In addition, the commission proposes other non-substantive revisions to update rule citations and for *Texas Register* style and formatting requirements. Some of the non-substantive changes for style and for-

matting purposes may affect areas other than the HGB area, such as the DFW area.

§115.112, Control Requirements

The commission proposes revisions to the existing §115.112(e) to reflect the new compliance schedules that are proposed in subsection (e)(3). The current wording of subsection (e) states that the control requirements of the section begin on March 1, 2013; however, the updates to this rule would require new control requirements in the HGB area to be achieved by July 20, 2018.

The commission proposes revisions to existing §115.112(e)(3)(A) to establish a 95% control efficiency of control devices, other than vapor recovery units and flares, in the HGB area and to accommodate the incorporation of this provision into the existing rule language. Proposed subsection (e)(3)(A)(i) would specify that the 90% control efficiency prescribed in clause (i) no longer applies in the HGB area as of the date specified in clause (ii). The proposed changes to clause (ii) would delete the current wording of the DFW area control efficiency specification of 95% to incorporate the newly proposed control efficiency requirement for the HGB area. Proposed clause (ii) would indicate that beginning July 20, 2018, a 95% control efficiency is required in the HGB area. The rule language is being reformatted to improve reader usability. Finally, proposed clause (iii) would contain the 95% control efficiency requirement for the DFW area. The proposed changes to the wording of existing clause (ii), which has been re-numbered to clause (iii) is simply a formatting change and does not impact the existing control requirements for the DFW area. These proposed changes ensure RACT is being implemented for VOC storage tanks in the HGB area consistent with currently required 95% control efficiency in place for the DFW area.

The commission proposes an amendment to §115.112(e)(5) to harmonize the applicability of the control requirement for crude oil and condensate storage tanks prior to custody transfer and at pipeline breakout stations in the HGB area. The proposed change would require the aggregate of all storage tanks at a pipeline breakout station to control flashed gases using a vapor control system just as individual storage tanks and the aggregate of storage tanks at an upstream tank battery are currently required. In existing subsection (e)(5), only the aggregate of all storage tanks at a pipeline breakout station in the DFW area are required to comply with the control requirement. This proposed change expands the existing applicability of affected storage tanks in the HGB area. Because all of the crude oil and condensate tanks at each pipeline breakout station would now be considered when determining applicability to the Chapter 115 VOC storage tank rule, as specified in existing §115.112(e)(6), owners and operators currently not triggering applicability to subsection (e) control requirements may now have to comply. The commission relied on the 2014 point source emissions inventory to attempt estimating the number of affected pipeline breakout stations that were assumed to contain multiple condensate or crude oil tanks that are currently not reporting any control device operation. Barring meeting exemption criteria in §115.111, approximately six pipeline breakout stations were identified as potentially needing to install controls to comply with the applicable control requirements in §115.112. The rule provides affected owners and operators the flexibility to choose the vapor control system best suited for their operation. Vapor recovery units, vapor control devices, and flares are all viable options available under the existing control requirements that would potentially affect these six pipeline breakout stations. Although this proposed rulemaking would increase the control efficiency of vapor control devices, vapor recovery units and flares are already assumed to at least meet a 95% control efficiency. The proposed change ensures storage tanks in the HGB area that are intended to be included in the applicability are subject to the RACT control specifications, consistent with the DFW area.

Proposed changes to subsection (e)(7) would incorporate the HGB area into the existing control requirements that currently apply to crude oil and condensate storage tanks in the DFW area. Paragraph (7) requires such storage tanks prior to custody transfer or at a pipeline breakout station for which the owner or operator is required under subsection (e) to control flashed gases to maintain such tanks in accordance with manufacturer instructions. Paragraph (7) also requires these tanks to be equipped with closure devices maintained according to the manufacturer's instructions or industry standards if manufacturer instructions are not available. These closure devices should be operated in accordance with subparagraphs (A) - (D) of paragraph (7), for all openings in the tank through which vapors are not routed to a vapor recovery unit or other vapor control device. These are existing requirements in the DFW area and the proposed rule would impose the same standards for crude oil and condensate storage tanks in the HGB area.

§115.114, Inspection and Repair Requirements

The proposed changes to §115.114(a)(5) would incorporate the HGB area into the existing inspection and repair requirements for crude oil and condensate fixed roof storage tanks prior to custody transfer or at a pipeline breakout station that are already in place for the DFW area.

Existing subparagraph (A), being proposed to apply in the HGB area, would require owners and operators of crude oil and condensate storage tanks in the HGB area to now engage in a visual, audio, and olfactory inspection of closure devices (e.g., thief hatches) not connected to a vapor control device. Inspections must occur when liquids are not being added to or unloaded from the tank and by the end of the business day during which the closure device was opened for sampling, gauging, or any unloading event. If the owner or operator finds the closure device open for reasons not allowed in §115.112(e)(7)(A), an attempt must be made to close the device during the inspection. If multiple events occur on a single day, a single inspection within one business day after the last event is sufficient. The inspection requirement is limited to closure devices not connected to a vapor control device because connected closure devices are designed to pass vapors to the control device in the presence of sufficient pressure. If a closure device not connected to a control device allows vapors to escape to the atmosphere without control, all flashed gases are not being controlled, as required. These repair requirements are the same repair requirements currently applicable in the DFW area and are similar to leak detection and repair requirements in other divisions of Chapter 115.

Existing subparagraph (B), being proposed to apply in the HGB area, would require owners and operators of crude oil and condensate storage tanks to conduct an audio, visual, and olfactory inspection of all gaskets and vapor sealing surfaces for closure devices not connected to a vapor control device at least once per calendar quarter. This inspection is designed to assure that the sealing surfaces are and will continue to function correctly. If a closure device is not sealing properly, the owner or operator is required to repair it. The first attempt at repair must take place no later than five calendar days after the inspection, and the repair

must be complete within 15 calendar days, with some exceptions. If parts are unavailable, they must be ordered promptly and the repair completed within five days of arrival. There is a delay of repair provision that allows delay until the next shutdown if the repair would require a shutdown that would create more emissions in a day than the daily emissions of delayed repair. All repairs are considered complete when the closure device no longer exudes process gases based on sight, smell, or sound. These repair requirements are the same repair requirements currently applicable in the DFW area and are similar to leak detection and repair requirements in other divisions of Chapter 115.

§115.118, Recordkeeping Requirements

Proposed changes to §115.118(a)(6)(D) and (E) would remove language that specifies the rules apply only in the DFW area because the commission is proposing to expand the applicability of these recordkeeping provisions to the HGB area. Existing subparagraph (D) requires the owner or operator of any storage tank that stores crude oil or condensate prior to custody transfer or at a pipeline breakout station and is required by §115.112(e) to control flash emissions, to keep records that detail manufacturer or industry standard instructions used to maintain the storage tanks and tank closure devices in use. Existing subparagraph (E) requires the owner or operator of any storage tank that stores crude oil or condensate prior to custody transfer or at a pipeline breakout station to maintain records of the results of each inspection and repair required in §115.112(e)(7) or §115.114(a)(5), including the date of the inspection; the status of the device during inspection; the amount of time a closure device was open since the last inspection for reasons not allowed in §115.112(e)(7)(A); the date repair was attempted and completed; and the list of closure devices awaiting delayed repair as allowed by §115.112(e)(7)(D).

The commission proposes amendments to existing §115.118(a)(7) to include a new requirement indicating that any records created on or after January 1, 2017 must be maintained for at least five years. The language extends the record retention time from two years to five years starting with records that would originate on January 1, 2017. This proposed change ensures that all applicable records are retained appropriately for the five-year timeframe. The five-year retention schedule being proposed for the HGB area is consistent with other major source recordkeeping requirements and was adopted for the DFW area during the December 2011 rulemaking.

§115.119, Compliance Schedules

The commission proposes revising §115.119(a)(1) and (2) to reference §115.112(e)(1) - (6) instead of §115.112(e) to correctly identify which requirements are intended to be complied with by the specified compliance dates. As currently written, subsection (a)(1) implies the HGB area is subject to all of the requirements in §115.112(e)(1) - (7); however, paragraph (7) only applies to the DFW area in the existing rules. The compliance dates in subsection (a)(1) and (2) have already passed and these changes would have no bearing on the compliance obligations for owners and operators affected by these paragraphs. These proposed changes are intended to distinguish between the compliance date for existing requirements in the HGB area under §115.112(e)(1) - (6) and the requirements being proposed to apply in the HGB area as part of this rulemaking under §115.112(e)(7).

In addition, the commission proposes to clarify that beginning July 20, 2018 the control efficiency requirement in §115.112(e)(3)(A)(ii) no longer applies in the HGB area. Currently, subsection (a)(1) specifies a March 1, 2013 compliance date for owners and operators subject to existing §115.112(e)(3)(A)(i) in the HGB area. The 90% control efficiency requirement in §115.112(e)(3)(A)(i) is being increased in stringency as part of this proposed rulemaking and would therefore be superseded by the 95% control efficiency requirement being proposed as §115.112(e)(3)(A)(ii).

Additional changes proposed to subsection (a)(2) clarify that §115.112(e)(3)(A)(i) no longer applies beginning July 20, 2018 and that prior to July 20, 2018, the owner or operator of a storage tank subject to the 90% control efficiency requirement of §115.112(e)(3)(A)(i) should continue to comply with §115.112(e)(3)(A)(i) until compliance has been demonstrated with the 95% control efficiency proposed in §115.112(e)(3)(A)(ii).

The commission proposes adding subsection (a)(3) to establish the compliance date for the requirements being proposed in the HGB area as part of this rulemaking. Proposed paragraph (3) requires the affected owner or operator to comply with §§115.112(e)(3)(A)(ii), 115.112(e)(7), 115.114(a)(5), and 115.118(a)(6)(D) and (E) as soon as practicable, but no later than July 20, 2018. These rule references cite the 95% control efficiency requirement, and the inspection, repair, and recordkeeping requirements of the rule. As indicated in the 2008 ozone standard SIP requirements rule, the EPA is expected to set the RACT compliance date on a reasonable schedule that the Administrator will establish in the notice and comment rulemaking reclassifying the HGB area from marginal to moderate. The SIP requirements rule included a July 20, 2018 attainment deadline for moderate areas, with an attainment year of 2017. In order to satisfy the requirements of the attainment demonstration, adopted measures must be implemented no later than the outside attainment date for the area's classification. The July 20, 2018 compliance deadline provides approximately a year and a half for affected owners and operators to make all necessary installations and adjustments for compliance purposes.

The commission proposes deleting §115.119(h) because sources in Wise County are required to comply with the requirements of this division. This subsection was adopted as part of the December 2015 rulemaking for the DFW area (Rule Project Number 2013-048-115-AI) because litigation was still ongoing at the time the rulemaking was adopted. Litigation has since ended making this provision obsolete. Owners and operators of storage tanks in Wise County remain subject to §115.119(f).

Fiscal Note: Costs to State and Local Government

Jeffrey Horvath, Analyst in the Chief Financial Officer's Division, determined that for the first five-year period the proposed rules are in effect, no significant fiscal implications are anticipated for the agency and no fiscal implications are expected for other units of state or local government as a result of administration or enforcement of the proposed rule.

The proposed rulemaking would fulfill the state's obligation to implement RACT for VOC storage tanks in the future required reclassification of the HGB nonattainment area to moderate. FCAA, §182(b)(2) requires states to revise their SIP to include RACT for CTG emission source categories and non-CTG major sources of VOC emissions for nonattainment areas classified as moderate and above. These revisions are required to be submitted to the EPA. Because the HGB ozone nonattainment

area was originally classified as marginal nonattainment under the 2008 eight-hour ozone NAAQS, a RACT analysis was not required as part of the SIP revision submitted to the EPA. The HGB area did not attain the 2008 ozone NAAQS by the required date but received an attainment deadline extension from the EPA. However, the HGB area did not attain the NAAQS by the attainment deadline extension. For this reason, the FCAA requires the HGB area to be reclassified under the 2008 ozone NAAQS to moderate nonattainment. At that time, the HGB area will become subject to the RACT requirements under FCAA, §182(b)(2).

The proposed rulemaking provides the same level of control for VOCs from storage tanks in the HGB area that currently exists in the DFW nonattainment area. The proposed rulemaking would establish a new level of control for VOC storage tanks by increasing the control efficiency for all vapor control systems, other than vapor recovery systems and flares, from 90% to 95%. Vapor recovery systems and flares are already expected to achieve the 95% control efficiency and are therefore excluded from the rulemaking. The proposed rulemaking would also implement inspection requirements after tank opening/loading and quarterly seal integrity inspections and corresponding recordkeeping requirements for these crude oil and condensate storage tanks.

All affected owners and operators in the HGB nonattainment area must comply with the proposed requirements no later than July 20, 2018. The July 20, 2018 compliance date provides affected owners and operators approximately a year and a half to make any necessary changes and become compliant.

Implementation of the proposed rules is not expected to result in significant fiscal implications for the agency. TCEQ regional staff would perform investigations of affected facilities to verify compliance with the proposed rules. These investigations would be combined with existing Title V permit program compliance requirements, investigations in response to complaints, or through a facility search and survey to determine compliance. Therefore, the proposed rules are not anticipated to have significant fiscal implications for TCEQ regional or main campus offices.

No fiscal implications are anticipated for other units of state or local government. No other state agencies or local governments were identified in the emissions inventory as owners or operators of affected units.

Public Benefits and Costs

Mr. Horvath also determined that for each year of the first five years the proposed rules are in effect, the public benefit anticipated from the changes seen in the proposed rules could be lower ozone levels in the HGB area and compliance with federal law. The EPA asserts that the general public in the HGB ozone nonattainment area may benefit from improved air quality as a result of lower ozone levels.

In general, the proposed rules are not expected to result in significant fiscal implications for businesses or individuals. Owners or operators of VOC storage tanks in the HGB area will have new compliance requirements under the proposed rules. The proposal requires control devices other than vapor recovery units or flares to meet a 95% control efficiency requirement. Owners and operators of major source crude oil and condensate storage tanks would be required to maintain their tanks; inspect tank openings periodically to assure that they are closed tightly and VOC vapors are being controlled; repair any leaks found during inspection; and keep records of the inspections.

Agency staff estimates that there would be 47 entities with 118 facilities that operate crude oil or condensate storage tanks in the HGB area that have an uncontrolled emission factor over 25 tpy of VOC. Agency staff anticipates all of these entities and facilities are already maintaining the new 95% control requirement with their current practices. Because they are anticipated to already meet the proposed control requirement, no additional costs are expected for these facilities from increasing the control requirement from 90% to 95%.

However, the proposed rules would also expand the applicability requirements to include the aggregate of crude oil and condensate tanks at a pipeline breakout station in the HGB area. There are six potential sites that fall under this expanded applicability. These six sites may need to install controls if they do not meet the exemption criterion. If these affected sites must install vapor recovery units to control emissions, they would be expected to have one-time capital costs estimated to be $60,000 - $110,000. In addition, the proposed rules would include requirements for monitoring vapor recovery units. These requirements would require a compressor run-time meter and a flow meter on the recovered vapor line. Many vapor recovery units are made with a run-time meter and the estimated cost to add one is $300. Estimated cost to install a flow meter is $3,000.

Other costs from the proposed rules would include the use of flares to control VOC emissions from tanks. The flares must be designed and operated in accordance with 40 Code of Federal Regulations (CFR) §60.18(b) - (f) and require the flare to be lit at all times when there is an emissions stream being vented to the flare. If the flare is already subject to the requirements in 40 CFR §60.18, then there is no additional fiscal impact associated with this requirement. If the flare is not already subject to the requirements in 40 CFR §60.18 the cost of a temperature monitor would range from $1,000 to $5,000. A design verification inspection to satisfy 40 CFR §60.318, would cost approximately $3,000. A flare or vapor recovery unit is assumed for each controlled tank battery, not both, and owners and operators are expected to choose the most economical option. These costs would only be incurred by those sources not already subject to the HGB VOC RACT requirements.

The commission expects that affected owners and operators would use existing personnel to perform the proposed closure device inspections, thus incurring no additional labor costs. If an owner or operator chose to add staff to accomplish the inspections or seek an outside contractor, a 30-minute inspection with a labor rate of $30.46 per hour is assumed, as the EPA has used in technical support documents for New Source Performance Standards. Each inspection could account for $15.23 of labor charges. Assuming the maximum number of required inspections of one per day, the total cost could be up to $5,559 per year. The low end of crude oil condensate production requiring inspection would likewise yield inspection costs of $442 per year. The average of these is $3,001 per year. Proposed quarterly inspection of closure device gaskets and seals is included in the maintenance costs, since it is assumed that the inspection will occur during the maintenance activity.

Maintenance costs are estimated at $487 per tank battery. Assuming one repair per year at each tank battery with a labor rate of $30.46 per hour and a two-hour time, repair labor is estimated at $61. Assuming $100 per year for parts, the total estimated repair cost is $161 per tank battery. An additional $100 per year may be required to keep records generated at each tank battery.

In most instances, all of these costs will be offset by revenue generated from the operation of installed vapor recovery units. In 2006, the EPA's Natural Gas Star program estimated annual savings of $44,000 - $1 million depending on system configuration, the amount and sale price of recovered product, operations, and maintenance costs. Recovered condensate at 25 tpy in the HGB area would be 204 barrels saved through the recovery. The West Texas Intermediate Crude oil price is valued at $40.06 as of August 1, 2016 making the value of the recovered condensate $8,172. These costs and benefits would only be incurred by those sources not already subject to the HGB VOC RACT requirements and overall are not expected to be significant.

Small Business and Micro-Business Assessment

In general, no adverse fiscal implications are anticipated due to the implementation or administration of the proposed rules for the first five-year period the proposed rules are in effect for small or micro-businesses. Agency staff did identify one entity that may be a small business, but for the most part all affected entities were large businesses. There would be fiscal implications for this small business the first year the proposed rules are in effect, though any cost is not expected to be significant and would be offset from the sale of recovered condensate.

Small Business Regulatory Flexibility Analysis

The commission reviewed this proposed rulemaking and determined that a small business regulatory flexibility analysis is not required because the proposed rules are necessary under federal law and do not adversely affect a small or micro-business in a material way for the first five years the proposed rules are in effect.

Local Employment Impact Statement

The commission reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five years that the proposed rules are in effect.

Draft Regulatory Impact Analysis Determination

The commission reviewed the proposed rulemaking in light of the regulatory impact analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking does not meet the definition of a major environmental rule as defined in that statute, and in addition, if it did meet the definition, would not be subject to the requirement to prepare a regulatory impact analysis.

A major environmental rule means a rule, the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure, and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The specific intent of the proposed amendments is to revise Chapter 115, Subchapter B, Division 1, to update the RACT requirements for VOC storage tanks in the HGB area. Potentially affected sources in the HGB area that are already responsible for complying with RACT for the 1997 eight-hour ozone NAAQS must meet an existing 90% control efficiency requirement. The commission expects that all facilities that are currently subject to the 90% control efficiency requirement are already meeting the proposed 95% control efficiency requirement that is required by the proposed amendments, and that this change will not require any of those subject to the current rules to replace their current control device. Generally, the commission expects the proposed requirements to place minimal burden on affected owners and operators and that the proposed compliance date provides an adequate amount of time for these owners and operators to make all necessary installations and adjustments for compliance purposes. As discussed in the fiscal note portion of this preamble, the proposed amendments are not anticipated to add any significant additional costs to affected individuals or businesses beyond what is already required to comply with these federal standards on the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

Additionally, these amendments do not meet any of the four applicability criteria for requiring a regulatory impact analysis for a major environmental rule, which are listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225, applies only to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. The proposed amendments will update RACT requirements for VOC storage tanks in the HGB area.

The state previously adopted Chapter 115 RACT rules for VOC sources in the HGB area as part of the SIP for the 1997 eight-hour ozone standard. On March 27, 2008, the EPA revised both the primary and secondary ozone standard (the eight-hour ozone NAAQS) to a level of 0.075 parts per million with an effective date of May 27, 2008 (73 FR 16436). Under the 2008 eight-hour ozone NAAQS, the HGB area, consisting of Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties, was classified as a marginal nonattainment area with a July 20, 2015 attainment deadline (77 FR 30088, May 21, 2012). However, the HGB area did not attain the 2008 eight-hour ozone standard by its attainment date, and is expected to be reclassified by the EPA as a moderate ozone nonattainment area for the 2008 eight-hour ozone NAAQS. For nonattainment areas classified as moderate and above, FCAA, §172(b)(1) and §182(b)(2) requires the state to submit a SIP revision that implements RACT for sources of VOC addressed in a CTG document and for all non-CTG major sources. The proposed rules update RACT requirements in Chapter 115, Subchapter B, Division 1, to update the RACT requirements for CTG storage tanks and for non-CTG major source crude oil and condensate storage tanks in the HGB area. The proposed updates mirror revisions incorporated during the December 2011 (36 TexReg 8862) rulemaking for the DFW 1997 eight-hour ozone nonattainment area (Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker, Rockwall, and Tarrant Counties) and the June 2015 (40 TexReg 3907) rulemaking for the DFW 2008 eight-hour ozone nonattainment area (Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise Counties) for VOC storage tanks.

The proposed rulemaking implements requirements of 42 USC, §7410, which requires states to adopt a SIP that provides for the implementation, maintenance, and enforcement of the NAAQS in each air quality control region of the state. While 42 USC, §7410 generally does not require specific programs, methods, or reductions in order to meet the standard, the SIP must include enforceable emission limitations and other control mea-

sures, means or techniques (including economic incentives such as fees, marketable permits, and auctions of emissions rights), as well as schedules and timetables for compliance as may be necessary or appropriate to meet the applicable requirements of this chapter (42 USC, Chapter 85, Air Pollution Prevention and Control). The provisions of the FCAA recognize that states are in the best position to determine what programs and controls are necessary or appropriate in order to meet the NAAQS. This flexibility allows states, affected industry, and the public, to collaborate on the best methods for attaining the NAAQS for the specific regions in the state. Even though the FCAA allows states to develop their own programs, this flexibility does not relieve a state from developing a program that meets the requirements of 42 USC, §7410. States are not free to ignore the requirements of 42 USC, §7410, and must develop programs to assure that their contributions to nonattainment areas are reduced so that these areas can be brought into attainment on schedule. The proposed rulemaking will revise rules in Chapter 115, Subchapter B, Division 1, to update RACT requirements for CTG storage tanks and for non-CTG major source crude oil and condensate storage tanks in the HGB area.

The requirement to provide a fiscal analysis of proposed regulations in the Texas Government Code was amended by Senate Bill (SB) 633 during the 75th Legislature, 1997. The intent of SB 633 was to require agencies to conduct a regulatory impact analysis of extraordinary rules. These are identified in the statutory language as major environmental rules that will have a material adverse impact and will exceed a requirement of state law, federal law, or a delegated federal program, or are adopted solely under the general powers of the agency. With the understanding that this requirement would seldom apply, the commission provided a cost estimate for SB 633 concluding that "based on an assessment of rules adopted by the agency in the past, it is not anticipated that the bill will have significant fiscal implications for the agency due to its limited application." The commission also noted that the number of rules that would require assessment under the provisions of the bill was not large. This conclusion was based, in part, on the criteria set forth in the bill that exempted proposed rules from the full analysis unless the rule was a major environmental rule that exceeds a federal law.

As discussed earlier in this preamble, the FCAA does not always require specific programs, methods, or reductions in order to meet the NAAQS; thus, states must develop programs for each area contributing to nonattainment to help ensure that those areas will meet the attainment deadlines. Because of the ongoing need to address nonattainment issues, and to meet the requirements of 42 USC, §7410, the commission routinely proposes and adopts SIP rules. The legislature is presumed to understand this federal scheme. If each rule proposed for inclusion in the SIP was considered to be a major environmental rule that exceeds federal law, then every SIP rule would require the full regulatory impact analysis contemplated by SB 633. This conclusion is inconsistent with the conclusions reached by the commission in its cost estimate and by the Legislative Budget Board (LBB) in its fiscal notes. Since the legislature is presumed to understand the fiscal impacts of the bills it passes, and that presumption is based on information provided by state agencies and the LBB, the commission believes that the intent of SB 633 was only to require the full regulatory impact analysis for rules that are extraordinary in nature. While the SIP rules will have a broad impact, the impact is no greater than is necessary or appropriate to meet the requirements of the FCAA. For these reasons, rules adopted for inclusion in the SIP fall under the exception in Texas Government Code, §2001.0225(a), because they are required by federal law.

The commission has consistently applied this construction to its rules since this statute was enacted in 1997. Since that time, the legislature has revised the Texas Government Code but left this provision substantially unamended. It is presumed that "when an agency interpretation is in effect at the time the legislature amends the laws without making substantial change in the statute, the legislature is deemed to have accepted the agency's interpretation." *Central Power & Light Co. v. Sharp,* 919 S.W.2d 485, 489 (Tex. App. Austin 1995), *writ denied with per curiam opinion respecting another issue,* 960 S.W.2d 617 (Tex. 1997); *Bullock v. Marathon Oil Co.,* 798 S.W.2d 353, 357 (Tex. App. Austin 1990, *no writ). Cf. Humble Oil & Refining Co. v. Calvert,* 414 S.W.2d 172 (Tex. 1967); *Dudney v. State Farm Mut. Auto Ins. Co.,* 9 S.W.3d 884, 893 (Tex. App. Austin 2000); *Southwestern Life Ins. Co. v. Montemayor,* 24 S.W.3d 581 (Tex. App. Austin 2000, pet. denied); and *Coastal Indust. Water Auth. v. Trinity Portland Cement Div.,* 563 S.W.2d 916 (Tex. 1978).

The commission's interpretation of the regulatory impact analysis requirements is also supported by a change made to the Texas Administrative Procedure Act (APA) by the legislature in 1999. In an attempt to limit the number of rule challenges based upon APA requirements, the legislature clarified that state agencies are required to meet these sections of the APA against the standard of "substantial compliance." The legislature specifically identified Texas Government Code, §2001.0225, as falling under this standard. The commission has substantially complied with the requirements of Texas Government Code, §2001.0225.

The specific intent of the proposed rulemaking is to update the RACT requirements for CTG storage tanks and for non-CTG major source crude oil and condensate storage tanks in the HGB area as required by the FCAA. The proposed rulemaking does not exceed a standard set by federal law or exceed an express requirement of state law. No contract or delegation agreement covers the topic that is the subject of this proposed rulemaking. Therefore, this proposed rulemaking is not subject to the regulatory analysis provisions of Texas Government Code, §2001.0225(b), because it does not meet the definition of a "major environmental rule"; it also does not meet any of the four applicability criteria for a major environmental rule.

The commission invites public comment regarding the Draft Regulatory Impact Analysis Determination during the public comment period.

Written comments on the Draft Regulatory Impact Analysis Determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission evaluated the proposed rulemaking and performed an assessment of whether Texas Government Code, Chapter 2007, is applicable. For nonattainment areas classified as moderate and above, FCAA, §172(b)(1) and §182(b)(2) requires the state to submit a SIP revision that implements RACT for all CTG emission source categories and for major stationary sources of VOC. The specific purpose of the proposed rulemaking is to revise rules in Chapter 115, Subchapter B, Division 1, to update the RACT requirements for CTG storage tanks and for non-CTG major source crude oil and condensate storage tanks in the HGB moderate eight-hour 2008 ozone nonattainment

area. Texas Government Code, §2007.003(b)(4), provides that Texas Government Code, Chapter 2007 does not apply to this proposed rulemaking because it is an action reasonably taken to fulfill an obligation mandated by federal law.

In addition, the commission's assessment indicates that Texas Government Code, Chapter 2007 does not apply to these proposed rules because this is an action that is taken in response to a real and substantial threat to public health and safety; that is designed to significantly advance the health and safety purpose; and that does not impose a greater burden than is necessary to achieve the health and safety purpose. Thus, this action is exempt under Texas Government Code, §2007.003(b)(13). The proposed rules fulfill the FCAA requirement to implement RACT in nonattainment areas. These revisions will result in more stringent VOC emission specifications in the HGB ozone nonattainment area, which may contribute to the timely attainment of the ozone standard and reduced public exposure to VOCs. Consequently, the proposed rulemaking meets the exemption criteria in Texas Government Code, §2007.003(b)(4) and (13). For these reasons, Texas Government Code, Chapter 2007 does not apply to this proposed rulemaking.

Consistency with the Coastal Management Program

The commission reviewed the proposed rulemaking and found the proposal is a rulemaking identified in the Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) (or 31 TAC §505.11(b)(4), whichever is applicable) relating to rules subject to the Coastal Management Program (CMP), and will, therefore, require that goals and policies of the CMP be considered during the rulemaking process.

The commission reviewed this rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Advisory Committee and determined that the rulemaking is editorial in nature and will have no substantive effect on commission actions subject to the CMP and is, therefore, consistent with CMP goals and policies.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Effect on Sites Subject to the Federal Operating Permits Program

Chapter 115 is an applicable requirement under 30 TAC Chapter 122, Federal Operating Permits Program. Owners or operators subject to the federal operating permits program must, consistent with the revision process in Chapter 122, upon the effective date of the rulemaking, revise their operating permit to include the adopted Chapter 115 requirements.

Announcement of Hearing

The commission will hold a public hearing on this proposal in Houston on October 24, 2016, at 2:00 p.m. in the Texas Department of Transportation District Office Auditorium at 7600 Washington Avenue, Houston, Texas 77007. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services at (512) 239-1802 or 1-800-RELAY-TX (TDD). Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Derek Baxter, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www1.tceq.texas.gov/rules/ecomments/.* File size restrictions may apply to comments being submitted via the eComments system. All comments should reference Rule Project Number 2016-039-115-AI. The comment period closes on October 24, 2016. Copies of the proposed rulemaking can be obtained from the commission's website at *http://www.tceq.texas.gov/rules/propose_adopt.html.* For further information, please contact Graham Bates, Air Quality Planning, (512) 239-2606.

Statutory Authority

The amendments are proposed under Texas Water Code (TWC), §5.102, concerning General Powers, that provides the commission with the general powers to carry out its duties under the TWC; TWC, §5.103, concerning Rules, that authorizes the commission to adopt rules necessary to carry out its powers and duties under the TWC; TWC, §5.105, concerning General Policy, that authorizes the commission by rule to establish and approve all general policy of the commission; and under Texas Health and Safety Code (THSC), §382.017, concerning Rules, that authorizes the commission to adopt rules consistent with the policy and purposes of the Texas Clean Air Act. The amendments are also proposed under THSC, §382.002, concerning Policy and Purpose, that establishes the commission's purpose to safeguard the state's air resources, consistent with the protection of public health, general welfare, and physical property; THSC, §382.011, concerning General Powers and Duties, that authorizes the commission to control the quality of the state's air; and THSC, §382.012, concerning State Air Control Plan, that authorizes the commission to prepare and develop a general, comprehensive plan for the proper control of the state's air. The amendments are also proposed under THSC, §382.016, concerning Monitoring Requirements; Examination of Records, that authorizes the commission to prescribe reasonable requirements for the measuring and monitoring of air contaminant emissions. The amendments are also proposed under Federal Clean Air Act (FCAA), 42 United States Code (USC), §§7401, *et seq.,* which requires states to submit state implementation plan revisions that specify the manner in which the National Ambient Air Quality Standards will be achieved and maintained within each air quality control region of the state.

The amended sections implement THSC, §§382.002, 382.011, 382.012, 382.016, 382.017, and FCAA, 42 USC, §§7401, *et seq.*

§115.112. Control Requirements.

(a) The following requirements apply in the Beaumont-Port Arthur, Dallas-Fort Worth, and El Paso areas, as defined in §115.10 of this title (relating to Definitions). The control requirements in this subsection no longer apply in the Dallas-Fort Worth area beginning March 1, 2013.

(1) No person shall place, store, or hold in any storage tank any volatile organic compounds (VOC) unless the storage tank is capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or is in compliance with the control requirements specified in Table I (a) of this paragraph for VOC

other than crude oil and condensate or Table II (a) of this paragraph for crude oil and condensate.
Figure: 30 TAC §115.112(a)(1) (No change.)

(2) For an external floating roof or internal floating roof storage tank subject to the provisions of paragraph (1) of this subsection, the following requirements apply.

(A) All openings in an internal floating roof or external floating roof except for automatic bleeder vents (vacuum breaker vents) and rim space vents must provide a projection below the liquid surface or be equipped with a cover, seal, or lid. Any cover, seal, or lid must be in a closed (i.e., no visible gap) position at all times except when the device is in actual use.

(B) Automatic bleeder vents (vacuum breaker vents) must be closed at all times except when the roof is being floated off or landed on the roof leg supports.

(C) Rim vents, if provided, must be set to open only when the roof is being floated off the roof leg supports or at the manufacturer's recommended setting.

(D) Any roof drain that empties into the stored liquid must be equipped with a slotted membrane fabric cover that covers at least 90% of the area of the opening.

(E) There must be no visible holes, tears, or other openings in any seal or seal fabric.

(F) For an external floating roof storage tank, secondary seals must be the rim-mounted type (the seal must be continuous from the floating roof to the tank wall). The accumulated area of gaps that exceed 1/8 inch in width between the secondary seal and storage tank wall may not be greater than 1.0 square inch per foot of tank diameter.

(3) Vapor control systems, as defined in §115.10 of this title, used as a control device on any storage tank must maintain a minimum control efficiency of 90%. If a flare is used, it must be designed and operated in accordance with 40 Code of Federal Regulations §60.18(b) - (f) [~~§60.18(b-f)~~] (as amended through December 22, 2008 (73 FR 78209)) and be lit at all times when VOC vapors are routed to the flare.

(b) The following requirements apply in Gregg, Nueces, and Victoria Counties.

(1) No person shall place, store, or hold in any storage tank any VOC, unless the storage tank is capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or is in compliance with the control requirements specified in Table I(a) in subsection (a)(1) of this section for VOC other than crude oil and condensate or Table II(a) in subsection (a)(1) of this section for crude oil and condensate. If a flare is used as a vapor recovery system, as defined in §115.10 of this title, it must be designed and operated in accordance with 40 Code of Federal Regulations §60.18(b) - (f) (as amended through December 22, 2008 (73 FR 78209)) and be lit at all times when VOC vapors are routed to the flare.

(2) For an external floating roof or internal floating roof storage tank subject to the provisions of paragraph (1) of this subsection, the following requirements apply.

(A) All openings in an internal floating roof or external floating roof, except for automatic bleeder vents (vacuum breaker vents) and rim space vents, must provide a projection below the liquid surface or be equipped with a cover, seal, or lid. Any cover, seal, or lid must be in a closed (i.e., no visible gap) position at all times, except when the device is in actual use.

(B) Automatic bleeder vents (vacuum breaker vents) must be closed at all times except when the roof is being floated off or landed on the roof leg supports.

(C) Rim vents, if provided, must be set to open only when the roof is being floated off the roof leg supports or at the manufacturer's recommended setting.

(D) Any roof drain that empties into the stored liquid must be equipped with a slotted membrane fabric cover that covers at least 90% of the area of the opening.

(E) There must be no visible holes, tears, or other openings in any seal or seal fabric.

(F) For an external floating roof storage tank, secondary seals must be the rim-mounted type (the seal shall be continuous from the floating roof to the tank wall). The accumulated area of gaps that exceed 1/8 inch in width between the secondary seal and tank wall may not be greater than 1.0 square inch per foot of tank diameter.

(c) The following requirements apply in Aransas, Bexar, Calhoun, Matagorda, San Patricio, and Travis Counties.

(1) No person may place, store, or hold in any storage tank any VOC, other than crude oil or condensate, unless the storage tank is capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or is in compliance with the control requirements specified in Table I (b) of this paragraph for VOC other than crude oil and condensate.
Figure: 30 TAC §115.112(c)(1) (No change.)

(2) For an external floating roof or internal floating roof storage tank subject to the provisions of paragraph (1) of this subsection, the following requirements apply.

(A) There must be no visible holes, tears, or other openings in any seal or seal fabric.

(B) All tank gauging and sampling devices must be vapor-tight except when gauging and sampling is taking place.

(3) No person in Matagorda or San Patricio Counties shall place, store, or hold crude oil or condensate in any storage tank unless the storage tank is a pressure tank capable of maintaining working pressures sufficient at all times to prevent vapor or gas loss to the atmosphere or is equipped with one of the following control devices, properly maintained and operated:

(A) an internal floating roof or external floating roof, as defined in §115.10 of this title. These control devices will not be allowed if the VOC has a true vapor pressure of 11.0 pounds per square inch absolute (psia) or greater. All tank-gauging and tank-sampling devices must be vapor-tight, except when gauging or sampling is taking place; or

(B) a vapor control system as defined in §115.10 of this title.

(d) The following requirements apply in the Houston-Galveston-Brazoria area, as defined in §115.10 of this title. The requirements in this subsection no longer apply beginning March 1, 2013.

(1) No person shall place, store, or hold in any storage tank any VOC unless the storage tank is capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or is in compliance with the control requirements specified in either Table I(a) of subsection (a)(1) of this section for VOC other than crude oil and condensate or Table II(a) of subsection (a)(1) of this section for crude oil and condensate.

(2) For an external floating roof or internal floating roof storage tank subject to the provisions of paragraph (1) of this subsection, the following requirements apply.

(A) All openings in an internal floating roof or external floating roof as defined in §115.10 of this title except for automatic bleeder vents (vacuum breaker vents), and rim space vents must provide a projection below the liquid surface. All openings in an internal floating roof or external floating roof except for automatic bleeder vents (vacuum breaker vents), rim space vents, leg sleeves, and roof drains must be equipped with a deck cover. The deck cover must be equipped with a gasket in good operating condition between the cover and the deck. The deck cover must be closed (i.e., no gap of more than 1/8 inch) at all times, except when the cover must be open for access.

(B) Automatic bleeder vents (vacuum breaker vents) and rim space vents must be equipped with a gasketed lid, pallet, flapper, or other closure device and must be closed (i.e., no gap of more than 1/8 inch) at all times except when required to be open to relieve excess pressure or vacuum in accordance with the manufacturer's design.

(C) Each opening into the internal floating roof for a fixed roof support column may be equipped with a flexible fabric sleeve seal instead of a deck cover.

(D) Any external floating roof drain that empties into the stored liquid must be equipped with a slotted membrane fabric cover that covers at least 90% of the area of the opening or an equivalent control that must be kept in a closed (i.e., no gap of more than 1/8 inch) position at all times except when the drain is in actual use. Stub drains on an internal floating roof storage tank are not subject to this requirement.

(E) There must be no visible holes, tears, or other openings in any seal or seal fabric.

(F) For an external floating roof storage tank, secondary seals must be the rim-mounted type (the seal must be continuous from the floating roof to the tank wall with the exception of gaps that do not exceed the following specification). The accumulated area of gaps that exceed 1/8 inch in width between the secondary seal and storage tank wall may not be greater than 1.0 square inch per foot of storage tank diameter.

(G) Each opening for a slotted guidepole in an external floating roof storage tank must be equipped with one of the following control device configurations:

(i) a pole wiper and pole float that has a seal or wiper at or above the height of the pole wiper;

(ii) a pole wiper and a pole sleeve;

(iii) an internal sleeve emission control system;

(iv) a retrofit to a solid guidepole system;

(v) a flexible enclosure system; or

(vi) a cover on an external floating roof tank.

(H) The external floating roof or internal floating roof must be floating on the liquid surface at all times except as specified in this subparagraph. The external floating roof or internal floating roof may be supported by the leg supports or other support devices, such as hangers from the fixed roof, during the initial fill or refill after the storage tank has been cleaned or as allowed under the following circumstances:

(i) when necessary for maintenance or inspection;

(ii) when necessary for supporting a change in service to an incompatible liquid;

(iii) when the storage tank has a storage capacity less than 25,000 gallons or the vapor pressure of the material stored is less than 1.5 psia;

(iv) when the vapors are routed to a control device from the time the floating roof is landed until the floating roof is within ten percent by volume of being refloated;

(v) when all VOC emissions from the tank, including emissions from roof landings, have been included in a floating roof storage tank emissions limit or cap approved under Chapter 116 of this title (relating to Control of Air Pollution by Permits for New Construction or Modification); or

(vi) when all VOC emissions from floating roof landings at the regulated entity, as defined in §101.1 of this title (relating to Definitions), are less than 25 tons per year.

(3) Vapor control systems, as defined in §115.10 of this title, used as a control device on any storage tank must maintain a minimum control efficiency of 90%.

(4) For a storage tank storing condensate, as defined in §101.1 of this title, prior to custody transfer, flashed gases must be routed to a vapor control system if the liquid throughput through an individual tank or the aggregate of tanks in a tank battery exceeds 1,500 barrels (63,000 gallons) per year.

(5) For a storage tank storing crude oil or condensate prior to custody transfer or at a pipeline breakout station, flashed gases must be routed to a vapor control system if the uncontrolled VOC emissions from an individual storage tank, or from the aggregate of storage tanks in a tank battery, equal or exceed 25 tons per year on a rolling 12-month basis. Uncontrolled emissions must be estimated by one of the following methods; however, if emissions determined using direct measurements or other methods approved by the executive director under subparagraph [~~subparagraphs~~] (A) or (D) of this paragraph are higher than emissions estimated using the default factors or charts in subparagraph [~~subparagraphs~~] (B) or (C) of this paragraph, the higher values must be used.

(A) The owner or operator may make direct measurements using the measuring instruments and methods specified in §115.117 of this title (relating to Approved Test Methods).

(B) The owner or operator may use a factor of 33.3 pounds of VOC per barrel (42 gallons) of condensate produced or 1.6 pounds of VOC per barrel (42 gallons) of oil produced.

(C) For crude oil storage only, the owner or operator may use the chart in Exhibit 2 of the United States Environmental Protection Agency publication *Lessons Learned from Natural Gas Star Partners: Installing Vapor Recovery Units on Crude Oil Storage Tanks,* October 2003, and assuming that the hydrocarbon vapors have a molecular weight of 34 pounds per pound mole and are 48% by weight VOC.

(D) Other test methods or computer simulations may be allowed if approved by the executive director.

(e) The control requirements in this subsection apply in the Houston-Galveston-Brazoria and Dallas-Fort Worth areas beginning March 1, 2013, except as specified in §115.119 of this title (relating to Compliance Schedules) and in paragraph (3) of this subsection.

(1) No person shall place, store, or hold VOC in any storage tank unless the storage tank is capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or is in compliance with the control requirements specified in Table 1

of this paragraph for VOC other than crude oil and condensate or Table 2 of this paragraph for crude oil and condensate.
Figure: 30 TAC §115.112(e)(1) (No change.)

(2) For an external floating roof or internal floating roof storage tank subject to the provisions of paragraph (1) of this subsection, the following requirements apply.

(A) All openings in an internal floating roof or external floating roof must provide a projection below the liquid surface. Automatic bleeder vents (vacuum breaker vents) and rim space vents are not subject to this requirement.

(B) All openings in an internal floating roof or external floating roof must be equipped with a deck cover. The deck cover must be equipped with a gasket in good operating condition between the cover and the deck. The deck cover must be closed (i.e., no gap of more than 1/8 inch) at all times, except when the cover must be open for access. Automatic bleeder vents (vacuum breaker vents), rim space vents, leg sleeves, and roof drains are not subject to this requirement.

(C) Automatic bleeder vents (vacuum breaker vents) and rim space vents must be equipped with a gasketed lid, pallet, flapper, or other closure device and must be closed (i.e., no gap of more than 1/8 inch) at all times except when required to be open to relieve excess pressure or vacuum in accordance with the manufacturer's design.

(D) Each opening into the internal floating roof for a fixed roof support column may be equipped with a flexible fabric sleeve seal instead of a deck cover.

(E) Any external floating roof drain that empties into the stored liquid must be equipped with a slotted membrane fabric cover that covers at least 90% of the area of the opening or an equivalent control that must be kept in a closed (i.e., no gap of more than 1/8 inch) position at all times except when the drain is in actual use. Stub drains on an internal floating roof storage tank are not subject to this requirement.

(F) There must be no visible holes, tears, or other openings in any seal or seal fabric.

(G) For an external floating roof storage tank, secondary seals must be the rim-mounted type. The seal must be continuous from the floating roof to the tank wall with the exception of gaps that do not exceed the following specification. The accumulated area of gaps that exceed 1/8 inch in width between the secondary seal and storage tank wall may not be greater than 1.0 square inch per foot of storage tank diameter.

(H) Each opening for a slotted guidepole in an external floating roof storage tank must be equipped with one of the following control device configurations:

(i) a pole wiper and pole float that has a seal or wiper at or above the height of the pole wiper;

(ii) a pole wiper and a pole sleeve;

(iii) an internal sleeve emission control system;

(iv) a retrofit to a solid guidepole system;

(v) a flexible enclosure system; or

(vi) a cover on an external floating roof tank.

(I) The external floating roof or internal floating roof must be floating on the liquid surface at all times except as allowed under the following circumstances:

(i) during the initial fill or refill after the storage tank has been cleaned;

(ii) when necessary for preventive maintenance, roof repair, primary seal inspection, or removal and installation of a secondary seal, if product is not transferred into or out of the storage tank, emissions are minimized, and the repair is completed within seven calendar days;

(iii) when necessary for supporting a change in service to an incompatible liquid;

(iv) when the storage tank has a storage capacity less than 25,000 gallons;

(v) when the vapors are routed to a control device from the time the storage tank has been emptied to the extent practical or the drain pump loses suction until the floating roof is within 10% by volume of being refloated;

(vi) when all VOC emissions from the storage tank, including emissions from floating roof landings, have been included in an emissions limit or cap approved under Chapter 116 of this title prior to March 1, 2013; or

(vii) when all VOC emissions from floating roof landings at the regulated entity are less than 25 tons per year.

(3) A control device used to comply with this subsection must meet one of the following conditions at all times when VOC vapors are routed to the device.

(A) A control device, other than a vapor recovery unit or a flare, must maintain the following minimum control efficiency:

(i) 90% in the Houston-Galveston-Brazoria area until the date specified in clause (ii) of this subparagraph; [~~, 90%; and~~]

(ii) 95% in the Houston-Galveston-Brazoria area beginning July 20, 2018; and [~~in the Dallas-Fort Worth area, 95%.~~]

(iii) 95% in the Dallas-Fort Worth area.

(B) A vapor recovery unit must be designed to process all vapor generated by the maximum liquid throughput of the storage tank or the aggregate of storage tanks in a tank battery and must transfer recovered vapors to a pipe or container that is vapor-tight, as defined in §115.10 of this title.

(C) A flare must be designed and operated in accordance with 40 Code of Federal Regulations §60.18(b) - (f) (as amended through December 22, 2008 (73 FR 78209)) and be lit at all times when VOC vapors are routed to the flare.

(4) For a storage tank storing condensate prior to custody transfer, flashed gases must be routed to a vapor control system if the condensate throughput of an individual tank or the aggregate of tanks in a tank battery exceeds:

(A) in the Houston-Galveston-Brazoria area, 1,500 barrels (63,000 gallons) per year on a rolling 12-month basis;

(B) in the Dallas-Fort Worth area except Wise County:

(i) 3,000 barrels (126,000 gallons) per year on a rolling 12-month basis; or

(ii) 15 months after the date the commission publishes notice in the *Texas Register* as specified in §115.119(b)(1)(C) of this title that the Dallas-Fort Worth area has been reclassified as a severe nonattainment area for the 1997 Eight-Hour Ozone National Ambient Air Quality Standard, 1,500 barrels (63,000 gallons) per year on a rolling 12-month basis; and

(C) in Wise County, 6,000 barrels (252,000 gallons) per year on a rolling 12-month basis.

(5) For a storage tank storing crude oil or condensate prior to custody transfer or at a pipeline breakout station, flashed gases must be routed to a vapor control system if the uncontrolled VOC emissions from an individual storage tank, or from the aggregate of storage tanks in a tank battery, or from the aggregate of storage tanks at a pipeline breakout station [~~in the Dallas-Fort Worth area~~], equal or exceed:

(A) in the Houston-Galveston-Brazoria area, 25 tons per year on a rolling 12-month basis;

(B) in the Dallas-Fort Worth area, except Wise County:

(i) 50 tons per year on a rolling 12-month basis; or

(ii) 15 months after the date the commission publishes notice in the *Texas Register* as specified in §115.119(b)(1)(C) of this title that the Dallas-Fort Worth area has been reclassified as a severe nonattainment area for the 1997 Eight-Hour Ozone National Ambient Air Quality Standard, 25 tons per year on a rolling 12-month basis; and

(C) in Wise County, 100 tons per year on a rolling 12-month basis.

(6) Uncontrolled emissions from a storage tank or tank battery storing crude oil or condensate prior to custody transfer or at a pipeline breakout station must be estimated by one of the following methods. However, if emissions determined using direct measurements or other methods approved by the executive director under subparagraph [~~subparagraphs~~] (A) or (B) of this paragraph are higher than emissions estimated using the default factors or charts in subparagraph [~~subparagraphs~~] (C) or (D) of this paragraph, the higher values must be used.

(A) The owner or operator may make direct measurements using the measuring instruments and methods specified in §115.117 of this title.

(B) The owner or operator may use other test methods or computer simulations approved by the executive director.

(C) The owner or operator may use a factor of 33.3 pounds of VOC per barrel (42 gallons) of condensate produced or 1.6 pounds of VOC per barrel (42 gallons) of oil produced.

(D) For crude oil storage only, the owner or operator may use the chart in Exhibit 2 of the United States Environmental Protection Agency publication *Lessons Learned from Natural Gas Star Partners: Installing Vapor Recovery Units on Crude Oil Storage Tanks,* October 2003, and assuming that the hydrocarbon vapors have a molecular weight of 34 pounds per pound mole and are 48% by weight VOC.

(7) Storage tanks in the Dallas-Fort Worth area and Houston-Galveston-Brazoria area storing crude oil or condensate prior to custody transfer or at a pipeline breakout station for which the owner or operator is required by this subsection to control flashed gases must be maintained in accordance with manufacturer instructions. All openings in the storage tank through which vapors are not routed to a vapor recovery unit or other vapor control device must be equipped with a closure device maintained according to the manufacturer's instructions, and operated according to this paragraph. If manufacturer instructions are unavailable, industry standards consistent with good engineering practice can be substituted.

(A) Each closure device must be closed at all times except when normally actuated or required to be open for temporary access or to relieve excess pressure or vacuum in accordance with the manufacturer's design and consistent with good air pollution control practices. Such opening, actuation, or use must be limited to minimize vapor loss.

(B) Each closure device must be properly sealed to minimize vapor loss when closed.

(C) Each closure device must either be latched closed or, if designed to relieve pressure, set to automatically open at a pressure that will ensure all vapors are routed to the vapor recovery unit or other vapor control device under normal operating conditions other than gauging the tank or taking a sample through an open thief hatch.

(D) No closure device may be allowed to have a VOC leak for more than 15 calendar days after the leak is found unless delay of repair is allowed. For the purposes of this subparagraph, a leak is the exuding of process gasses from a closed device based on sight, smell, or sound. If parts are unavailable, repair may be delayed. Parts must be ordered promptly and the repair must be completed within five days of receipt of required parts. Repair may be delayed until the next shutdown if the repair of the component would require a shutdown that would create more emissions than the repair would eliminate. Repair must be completed by the end of the next shutdown.

§115.114. Inspection and Repair Requirements.

(a) The following inspection requirements apply in the Beaumont-Port Arthur, Dallas-Fort Worth, El Paso, and Houston-Galveston-Brazoria areas, as defined in §115.10 of this title (relating to Definitions).

(1) For an internal floating roof storage tank, the internal floating roof and the primary seal or the secondary seal (if one is in service) must be visually inspected through a fixed roof inspection hatch at least once every 12 months.

(A) If the internal floating roof is not resting on the surface of the volatile organic compounds (VOC) inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the internal floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank in accordance with Subchapter F, Division 3 of this chapter (relating to Degassing of Storage Tanks, Transport Vessels, and Marine Vessels).

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(2) For an external floating roof storage tank, the secondary seal gap must be physically measured at least once every 12 months to insure compliance with §115.112(a)(2)(F), (d)(2)(F), and (e)(2)(G) of this title (relating to Control Requirements).

(A) If the secondary seal gap exceeds the limitations specified by §115.112(a)(2)(F), (d)(2)(F), and (e)(2)(G) of this title, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank in accordance with Subchapter F, Division 3 of this chapter.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program

with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(3) If the storage tank is equipped with a mechanical shoe or liquid-mounted primary seal, compliance with §115.112(a)(2)(F), (d)(2)(F), and (e)(2)(G) of this title can be determined by visual inspection.

(4) For an external floating roof storage tank, the secondary seal must be visually inspected at least once every six months to ensure compliance with §115.112(a)(2)(E) and (F), (d)(2)(E) and (F), and (e)(2)(F) and (G) of this title.

(A) If the external floating roof is not resting on the surface of the VOC inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the external floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank in accordance with Subchapter F, Division 3 of this chapter.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(5) For fixed roof storage tanks in the Dallas-Fort Worth and Houston-Galveston-Brazoria areas [~~area~~] storing crude oil or condensate prior to custody transfer or at a pipeline breakout station for which the owner or operator is required by §115.112(e) of this title to control flashed gases, the owner or operator shall inspect and repair all closure devices not connected to a vapor recovery unit or other vapor control device according to the schedule in this paragraph.

(A) The owner or operator shall conduct an audio, visual, and olfactory inspection of each closure device not connected to a vapor recovery unit or other vapor control device to ensure compliance with §115.112(e)(7)(A) of this title. The inspection must occur when liquids are not being added to or unloaded from the tank. If the owner or operator finds the closure device open for reasons not allowed in §115.112(e)(7)(A) of this title, the owner or operator shall attempt to close the device during the inspection. The inspection must occur before the end of one business day after each opening of a thief or access hatch for sampling or gauging, and before the end of one business day after each unloading event. If multiple events occur on a single day, a single inspection within one business day after the last event is sufficient.

(B) The owner or operator shall conduct an audio, visual, and olfactory inspection of all gaskets and vapor sealing surfaces of each closure device not connected to a vapor recovery unit or other vapor control device once per calendar quarter to ensure compliance with §115.112(e)(7)(B) of this title. If the owner or operator finds an improperly sealed closure device, the owner or operator shall make a first attempt at repair no later than five calendar days after the inspection and repair the device no later than 15 calendar days after the inspection unless delay of repair is allowed. If parts are unavailable, repair may be delayed. Parts must be ordered promptly and the repair must be completed within five days of receipt of required parts. Repair may be delayed until the next shutdown if the repair of the component would require a shutdown that would create more emissions than the repair would eliminate. Repair must be completed by the end of the next shutdown. For the purpose of this subparagraph, a repair is complete if the closure device no longer exudes process gasses based on sight, smell, or sound.

(b) The following inspection requirements apply in Gregg, Nueces, and Victoria Counties.

(1) For an internal floating roof storage tank, the following inspection requirements apply.

(A) If during an inspection of an internal floating roof storage tank, the internal floating roof is not resting on the surface of the VOC inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the internal floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(2) For an external floating roof storage tank, the secondary seal gap must be physically measured at least once every 12 months to insure compliance with §115.112(b)(2)(F) of this title.

(A) If the secondary seal gap exceeds the limitations specified by §115.112(b)(2)(F) of this title, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(3) If the storage tank is equipped with a mechanical shoe or liquid-mounted primary seal, compliance with §115.112(b)(2)(F) of this title can be determined by visual inspection.

(4) For an external floating roof storage tank, the secondary seal must be visually inspected at least once every 12 months to insure compliance with §115.112(b)(2)(E) - (F) of this title.

(A) If the external floating roof is not resting on the surface of the VOC inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the external floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(c) The following inspection requirements apply in Aransas, Bexar, Calhoun, Matagorda, San Patricio, and Travis Counties.

(1) For an internal floating roof storage tank, the following inspection requirements apply.

(A) If during an inspection of an internal floating roof storage tank, the internal floating roof is not resting on the surface of the VOC inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the internal floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

(2) For an external floating roof storage tank, the following inspection requirements apply.

(A) If during an inspection of an external floating roof storage tank, the external floating roof is not resting on the surface of the VOC inside the storage tank and is not resting on the leg supports; or liquid has accumulated on the external floating roof; or the seal is detached; or there are holes or tears in the seal fabric; or there are visible gaps between the seal and the wall of the storage tank, within 60 days of the inspection the owner or operator shall repair the items or shall empty and degas the storage tank.

(B) If a failure cannot be repaired within 60 days and if the storage tank cannot be emptied within 60 days, the owner or operator may submit written requests for up to two extensions of up to 30 additional days each to the appropriate regional office. The owner or operator shall submit a copy to any local air pollution control program with jurisdiction. Each request for an extension must include a statement that alternate storage capacity is unavailable and a schedule that will assure that the repairs will be completed as soon as possible.

§115.118. Recordkeeping Requirements.

(a) The following recordkeeping requirements apply in the Beaumont-Port Arthur, Dallas-Fort Worth, El Paso, and Houston-Galveston-Brazoria areas, as defined in §115.10 of this title (relating to Definitions).

(1) The owner or operator of storage tank claiming an exemption in §115.111 of this title (relating to Exemptions) shall maintain records sufficient to demonstrate continuous compliance with the applicable exemption criteria. Where applicable, true vapor pressure, volatile organic compounds (VOC) content type, or a combination of the two must be recorded initially and at every change of service or when the storage tank is emptied and refilled.

(2) The owner or operator of an external floating roof storage tank that is exempt from the requirement for a secondary seal in accordance with §115.111(a)(1), (6), and (7) of this title and is used to store VOC with a true vapor pressure greater than 1.0 pounds per square inch absolute (psia) shall maintain records of the type of VOC stored and the average monthly true vapor pressure of the stored liquid.

(3) The owner or operator shall maintain records of the results of inspections required by §115.114(a) of this title (relating to Inspection and Repair Requirements). For secondary seal gaps that are required to be physically measured during inspection, these records must include a calculation of emissions for all secondary seal gaps that exceed 1/8 inch where the accumulated area of such gaps is greater than 1.0 square inch per foot of tank diameter. These calculated emissions inventory reportable emissions must be reported in the annual emissions inventory submittal required by §101.10 of this title (relating to Emissions Inventory Requirements). The emissions must be calculated using the following equation.

Figure: 30 TAC §115.118(a)(3) (No change.)

(4) The owner or operator shall maintain records of any operational parameter monitoring required in §115.115(a) of this title (relating to Monitoring Requirements). Such records must be sufficient to demonstrate proper functioning of those devices to design specifications and must include, but are not limited to, the following.

(A) For a direct-flame incinerator, the owner or operator shall continuously record the exhaust gas temperature immediately downstream of the device.

(B) For a condensation system, the owner or operator shall continuously record the outlet gas temperature to ensure the temperature is below the manufacturer's recommended operating temperature for controlling the VOC vapors routed to the device.

(C) For a carbon adsorption system or carbon adsorber, the owner or operator shall:

(i) continuously record the exhaust gas VOC concentration of any carbon adsorption system monitored according to §115.115(a)(3)(A) of this title; or

(ii) record the date and time of each switch between carbon containers and the method of determining the carbon replacement interval if the carbon adsorption system or carbon adsorber is switched according to §115.115(a)(3)(B) of this title.

(D) For a catalytic incinerator, the owner or operator shall continuously record the inlet and outlet gas temperature.

(E) For a vapor recovery unit, the owner or operator shall maintain records of the continuous operational parameter monitoring required in §115.115(a)(5) of this title.

(F) For any other control device not listed in this paragraph, the owner or operator shall maintain records of the continuous operational parameter monitoring required in §115.115(a)(6) of this title sufficient to demonstrate proper functioning of the control device to design specifications.

(5) The owner or operator shall maintain the results of any testing conducted in accordance with §115.116 of this title (relating to Testing Requirements) or §115.117 of this title (relating to Approved Test Methods) at an affected site. Results may be maintained at an off-site location if made available for review within 24 hours.

(6) In the Houston-Galveston-Brazoria and Dallas-Fort Worth areas, the owner or operator shall maintain the following additional records.

(A) The owner or operator of a fixed roof storage tank that is not required in §115.112(d)(1) or (e)(1) of this title (relating to Control Requirements) to be equipped with an external floating roof, internal floating roof, or vapor control system shall maintain records of the type of VOC stored, the starting and ending dates when the material is stored, and the true vapor pressure at the average monthly storage temperature of the stored liquid. This requirement does not apply to a storage tank with storage capacity of 25,000 gallons or less storing VOC other than crude oil or condensate, or to a storage tank with storage capacity of 40,000 gallons or less storing crude oil or condensate.

(B) The owner or operator of any storage tank that stores crude oil or condensate prior to custody transfer or at a pipeline breakout station and is not equipped with a vapor control system shall maintain records of the estimated uncontrolled emissions from the storage tank on a rolling 12-month basis. The records must be made available for review within 72 hours upon request by authorized representatives of the executive director, the United States Environmental Protection Agency, or any local air pollution control agency with jurisdiction.

(C) The owner or operator of an external floating roof or internal floating roof storage tank meeting the extended compliance date in §115.119(a)(1)(A) or (b)(1)(A) of this title (relating to Compliance Schedules) shall maintain records of the date of the last time the storage tank was emptied and degassed.

(D) The owner or operator of any storage tank that stores crude oil or condensate prior to custody transfer or at a pipeline breakout station [~~in the Dallas-Fort Worth area and~~] is required by §115.112(e) of this title to control flash emissions shall maintain records of the manufacturer or industry standard instructions used to maintain the storage tanks and tank closure devices in use.

(E) The owner or operator of any storage tank that stores crude oil or condensate prior to custody transfer or at a pipeline breakout station [~~in the Dallas-Fort Worth area~~] shall maintain records of the results of each inspection and repair required in §115.112(e)(7) or §115.114(a)(5) [~~or §115.112(e)(7)~~] of this title, including the following items:

(i) the date of the inspection;

(ii) the status of the device during inspection;

(iii) the amount of time a closure device was open since the last inspection for reasons not allowed in §115.112(e)(7)(A) of this title;

(iv) the date repair was attempted and completed; and

(v) the list of closure devices awaiting delayed repair as allowed by §115.112(e)(7)(D) of this title.

(7) All records must be maintained for two years and be made available for review upon request by authorized representatives of the executive director, the United States Environmental Protection Agency, or any local air pollution control agency with jurisdiction. In the Dallas-Fort Worth area, any records created on or after March 1, 2011, must be maintained for at least five years. In the Houston-Galveston-Brazoria area, any records created on or after January 1, 2017 must be maintained for at least five years.

(b) The following recordkeeping requirements apply in Gregg, Nueces, and Victoria Counties.

(1) The owner or operator of an external floating roof storage tank that is exempt from the requirement for a secondary seal in accordance with §115.111(b)(1), (6), and (7) of this title and used to store VOC with a true vapor pressure greater than 1.0 psia shall maintain records of the type of VOC stored and the average monthly true vapor pressure of the stored liquid.

(2) The owner or operator shall record the results of inspections required by §115.114(b) of this title.

(3) In Victoria County, the owner or operator shall continuously record operational parameters of any of the following emission control devices installed to meet applicable control requirements in §115.112 of this title. Such records must be sufficient to demonstrate proper functioning of those devices to design specifications, including:

(A) the exhaust gas temperature immediately downstream of a direct-flame incinerator;

(B) the inlet and outlet gas temperature of a condensation system or catalytic incinerator; and

(C) the exhaust gas VOC concentration of any carbon adsorption system or carbon adsorber, to determine if breakthrough has occurred.

(4) The owner or operator shall maintain records of the results of any testing conducted in accordance with §115.117 of this title at an affected site.

(5) All records must be maintained for two years and be made available for review upon request by authorized representatives of the executive director, the United States Environmental Protection Agency, or any local air pollution control agency with jurisdiction.

§115.119. Compliance Schedules.

(a) In Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties, the compliance date has passed and the owner or operator of each storage tank in which any volatile organic compounds (VOC) are placed, stored, or held shall continue to comply with this division except as follows.

(1) The affected owner or operator shall comply with the requirements of §§115.112(d); 115.115(a)(1),(2),(3)(A), and (4); 115.117; and 115.118(a) [~~§§115.112(d); §115.115(a)(1), (2), (3)(A), and (4); §115.117; and §115.118(a)~~] of this title (relating to Control Requirements; Monitoring Requirements; Approved Test Methods; and Recordkeeping Requirements, respectively) no later than January 1, 2009. Section 115.112(d) of this title no longer applies in the Houston-Galveston-Brazoria area beginning March 1, 2013. Prior to March 1, 2013, the owner or operator of a storage tank subject to §115.112(d) of this title shall continue to comply with §115.112(d) of this title until compliance has been demonstrated with the requirements of §115.112(e)(1) - (6) [~~§115.112(e)~~] of this title. Section 115.112(e)(3)(A)(i) of this title no longer applies beginning July 20, 2018.

(A) If compliance with these requirements would require emptying and degassing of the storage tank, compliance is not required until the next time the storage tank is emptied and degassed but no later than January 1, 2017.

(B) The owner or operator of each storage tank with a storage capacity less than 210,000 gallons storing crude oil and condensate prior to custody transfer shall comply with the requirements of this division no later than January 1, 2009, regardless if compliance with these requirements would require emptying and degassing of the storage tank.

(2) The affected owner or operator shall comply with §§115.112(e)(1) - (6) [~~§§115.112(e)~~], 115.115(a)(3)(B), (5), and (6), and 115.116 of this title (relating to Testing Requirements) as soon as practicable, but no later than March 1, 2013. Section 115.112(e)(3)(A)(i) of this title no longer applies beginning July 20, 2018. Prior to July 20, 2018, the owner or operator of a storage tank subject to §115.112(e)(3)(A)(i) of this title shall continue to comply with §115.112(e)(3)(A)(i) of this title until compliance has been demonstrated with the requirements of §115.112(e)(3)(A)(ii) of this title. After July 20, 2018, the owner or operator of a storage tank is subject to §115.112(e)(3)(A)(ii) of this title.

(A) If compliance with these requirements would require emptying and degassing of the storage tank, compliance is not required until the next time the storage tank is emptied and degassed but no later than January 1, 2017.

(B) The owner or operator of each storage tank with a storage capacity less than 210,000 gallons storing crude oil and condensate prior to custody transfer shall comply with these requirements no later than March 1, 2013, regardless if compliance with these requirements would require emptying and degassing of the storage tank.

(3) The affected owner or operator shall comply with §§115.112(e)(3)(A)(ii), 115.112(e)(7), 115.118(a)(6)(D) and (E), and 115.114(a)(5) of this title (relating to Inspection and Repair Requirements) as soon as practicable, but no later than July 20, 2018.

(b) In Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker, Rockwall, and Tarrant Counties, the owner or operator of each storage tank in which any VOC is placed, stored, or held was required to be in compliance with this division on or before March 1, 2009, and shall continue to comply with this division, except as follows.

(1) The affected owner or operator shall comply with §§115.112(e), 115.115(a)(3)(B), (5), and (6), 115.116, and 115.118(a)(6) of this title as soon as practicable, but no later than March 1, 2013.

(A) If compliance with §115.112(e) of this title would require emptying and degassing of the storage tank, compliance is not required until the next time the storage tank is emptied and degassed but no later than December 1, 2021.

(B) The owner or operator of a storage tank with a storage capacity less than 210,000 gallons storing crude oil and condensate prior to custody transfer shall comply with these requirements no later than March 1, 2013, regardless if compliance with these requirements would require emptying and degassing of the storage tank.

(C) As soon as practicable but no later than 15 months after the commission publishes notice in the *Texas Register* that the Dallas-Fort Worth area, except Wise County, has been reclassified as a severe nonattainment area for the 1997 Eight-Hour Ozone National Ambient Air Quality Standard the owner or operator of a storage tank storing crude oil or condensate prior to custody transfer or at a pipeline breakout station is required to be in compliance with the control requirements in §115.112(e)(4)(B)(ii) and (5)(B)(ii) of this title except as specified in §115.111(a)(11) of this title (relating to Exemptions).

(2) The owner or operator is no longer required to comply with §115.112(a) of this title beginning March 1, 2013.

(3) The affected owner or operator in Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Parker, Rockwall, and Tarrant Counties shall comply with §§115.112(e)(7), 115.114(a)(5), and 115.118(a)(6)(D) and (E) of this title as soon as practicable, but no later than January 1, 2017.

(c) In Hardin, Jefferson, and Orange Counties, the owner or operator of each storage tank in which any VOC is placed, stored, or held was required to be in compliance with this division by March 7, 1997, and shall continue to comply with this division, except that compliance with §115.115(a)(3)(B), (5), and (6), and §115.116 of this title is required as soon as practicable, but no later than March 1, 2013.

(d) In El Paso County, the owner or operator of each storage tank in which any VOC is placed, stored, or held was required to be in compliance with this division by January 1, 1996, and shall continue to comply with this division, except that compliance with §115.115(a)(3)(B), (5), and (6), and §115.116 of this title is required as soon as practicable, but no later than March 1, 2013.

(e) In Aransas, Bexar, Calhoun, Gregg, Matagorda, Nueces, San Patricio, Travis, and Victoria Counties, the owner or operator of each storage tank in which any VOC is placed, stored, or held was required to be in compliance with this division by July 31, 1993, and shall continue to comply with this division, except that compliance with §115.116(b) of this title is required as soon as practicable, but no later than March 1, 2013.

(f) In Wise County, the owner or operator of each storage tank in which any VOC is placed, stored, or held shall comply with this division as soon as practicable, but no later than January 1, 2017.

(g) The owner or operator of each storage tank in which any VOC is placed, stored, or held that becomes subject to this division on or after the date specified in subsections (a) - (f) of this section, shall comply with the requirements in this division no later than 60 days after becoming subject.

~~[(h) Upon the date the commission publishes notice in the *Texas Register* that the Wise County nonattainment designation for the 2008 Eight-Hour Ozone National Ambient Air Quality Standard is no longer legally effective, the owner or operator of each storage tank in Wise County is not required to comply with any of the requirements in this division.]~~

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

Filed with the Office of the Secretary of State on September 23, 2016.

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Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
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CHAPTER 290. PUBLIC DRINKING WATER

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) proposes to amend §§290.38, 290.42, 290.46, 290.47, 290.102 - 290.104, 290.106 - 290.119, 290.121, 290.122, 290.272, and 290.275.

Background and Summary of the Factual Basis for the Proposed Rules

Under 40 Code of Federal Regulations (CFR) §142.10 and §142.12, TCEQ shall adopt rules at least as stringent as the federal rules to maintain primacy over the Public Water System Supervision Program in Texas. The Revised Total Coliform Rule (RTCR), a federal drinking water rule, was promulgated by the United States Environmental Protection Agency (EPA) on February 13, 2013. The RTCR increases public health protection through the reduction of potential pathways of entry for fecal contamination into the distribution system of public water systems. Greater public health protection is anticipated under the RTCR as it requires public water systems that are vulnerable to microbial contamination to identify and address problems.

The proposed amendments to Chapter 290, provide rule language that is no less stringent than the RTCR. The proposed amendments provide for consistency with other federal drinking water provisions, address the EPA's comments on the federal Ground Water Rule (GWR), and provide clarification on existing state rules. Regarding the GWR, the EPA conducted a primacy review of the TCEQ's adopted GWR rules. On March 10, 2014,

the EPA provided its GWR comments outlining additional state rule revisions needed. TCEQ proposes to amend Chapter 290 to ensure that the state rules are no less stringent than with the federal GWR in response to the EPA's primacy review comments.

The RTCR's implementation date for public water systems is April 1, 2016. Due to an open section conflict with an ongoing rulemaking, the Office of Water requested an extension from the EPA on this rule's implementation and the request was approved by EPA on March 4, 2015. States with an approved extension shall submit complete and final program revision packages to the EPA by February 13, 2017.

Section by Section Discussion

In addition to the proposed revisions associated with this rulemaking, the proposed rulemaking also includes various stylistic, non-substantive changes to update rule language to current *Texas Register* style and format requirements. Such changes included appropriate and consistent use of acronyms, section references, rule structure, and certain terminology. Where the proposal of new subsections, paragraphs, subparagraphs, etc. are proposed, subsequent relettering or renumbering are modified accordingly. These changes are non-substantive and generally not specifically discussed in this preamble.

The terms "system" and "water system" were amended to "public water system" where appropriate and will not be specifically discussed in each section.

§290.38, Definitions

The commission proposes to add §290.38(31) and (32), defining "Grantee" and "Grantor," to clarify the proposed amendment of §290.46(p)(1). Subsequent definitions are renumbered accordingly due to the addition of "Grantee" and "Grantor." Under the current §290.46(p)(1), notice of the change of ownership is required before the change in owner actually occurs, so the terms of "prospective owner" and "current owner" are unambiguous. Under the proposed §290.46(p)(1), notice of the change of ownership is required no later than 30 days after the change in ownership occurs, which will occur at an indefinite point in time. For purposes of enforcement and clarity, the terms "grantee" and "grantor" are substituted for "prospective owner" and "current owner" in proposed §290.46(p)(1).

The commission proposes to add §290.38(82) to clarify that the use of the word "System" has the same meaning as "Public water system," as described in §290.38(71). The commission proposes a similar addition with §290.38(88) to clarify that the use of the word "Water system" has the same meaning as "Public water system," as described in §290.38(71). Subsequent definitions are renumbered accordingly.

§290.42, Water Treatment

The commission proposes to amend §290.42(b)(1) and (e)(2) to clarify the association between §290.42(b)(1) and (e)(2) with the requirements of §290.110, concerning the disinfection, treatment, and monitoring requirements for public water systems that utilize a groundwater source.

The commission proposes to amend §290.42(d)(15)(D) to require surface water treatment plants that utilize chlorine dioxide to provide testing equipment for measuring chlorine dioxide and chlorite levels.

The commission proposes to add §290.42(g)(6) and (6)(A) and (B) to address the utilization of membrane filtration for virus removal that achieves at least 4-log removal of viruses to comply with the groundwater rule requirements under §290.109 and §290.116.

§290.46, Minimum Acceptable Operating Practices for Public Drinking Water Systems

The commission proposes to add §290.46(f)(3)(D)(x) and (xi) and amend (f)(3)(E)(ix) and (x) to require public water systems to maintain and update operating records concerning assessment forms, corrective actions, seasonal operating procedures, Sample Siting Plans, and membrane integrity testing results as required by the RTCR and GWR.

The commission proposes to amend §290.46(n)(3) to clarify the recordkeeping requirements for public water systems concerning well completion data as required by §290.41(c)(3)(A).

The commission proposes to amend §290.46(p)(1) to require the new owner or grantee of a public water system to notify the executive director of the change in ownership within 30 days after the effective date of the change in ownership and include any other information necessary to identify the transaction. In addition, the commission proposes adding definitions of "Grantee" and "Grantor" as discussed in §290.38 of this preamble. Finally, the commission proposes to remove the reference to 30 TAC Chapter 291 (Utility Regulations).

The commission proposes to amend §290.46(q) to clarify the subject matter of the subsection, which is special precautions, protective measures, and boil water notices. The amendment also adds the abbreviation *E. coli* and adds the language "or other approved fecal indicator" to be consistent with the federal GWR requirements as described in 40 CFR §141.402. The amendment adds a description of what special precautions, protective measures, and boil water notices are and when they shall be instituted by public water systems.

The commission proposes to amend §290.46(q)(1) to clarify when and how a public water system shall issue and rescind boil water notices. The commission proposes to add language to specify boil water notice delivery requirements by cross-referencing §290.122 and referencing the format specified in §290.47(c)(1) and (2).

The commission proposes to amend §290.46(q)(2) to clarify when a boil water notice shall be issued by a public water system in the event distribution system pressure is lost.

The commission proposes to add §290.46(q)(3) to specify that a public water system shall issue a boil water notice to customers for a violation of the acute maximum contaminant level (MCL) for *Escherichia coli (E. coli)* or other approved fecal indicator. The boil water notice shall be in accordance with rule requirements as described in §290.122(a)(1)(A) and to be consistent with the RTCR.

The commission proposes to amend §290.46(q)(4) to specify when a public system shall issue a boil water notice to customers for exceeding certain combined filter effluent turbidity levels at a water treatment plant in accordance with the rule requirements as described in §290.122(a)(1)(B) and to be consistent with the RTCR. The commission proposes adding §290.46(q)(4)(A) - (D) to summarize the conditions triggering a boil water notice for turbidity.

The commission proposes to add §290.46(q)(5) to clarify the circumstances when discretionary action by the executive director may be warranted concerning special precautions, protective measures, and boil water notices. The proposed rule requires

the executive director to provide written notification to the public water system when exercising this discretionary action.

The commission proposes to add §290.46(q)(5)(A) and (A)(i) - (iii) to clarify the circumstances that may warrant the exercise of discretionary action by the executive director. Under proposed §290.46(q)(5)(A)(i), such circumstances include a public water system failing to provide required compliance information to the executive director and the failure results in the inability of the executive director to determine compliance with disinfection and treatment technique requirements for public water systems. Under proposed §290.46(q)(5)(A)(ii), such circumstances include prevention or correction of a potential or actual health hazard as defined in this chapter. Under proposed §290.46(q)(5)(A)(iii), the circumstances include a public water system which has failed to maintain adequate disinfectant residuals.

The commission proposes to add §290.46(q)(5)(B) to require that the executive directive provide written notification to a public water system when requiring the public water system to institute special precautions, protective measures, or issue boil water notices when the executive director exercises his discretionary action under this subsection. The proposed rule also establishes a time frame in which the public water system is required to implement the requirements.

The commission proposes to add §290.46(q)(5)(C) to establish that a public water system is required to provide any required information to the executive director when requested to document that the public water system has met the requirements for special precautions, protective measures, and boil water notices required under §290.46(q)(5).

The commission proposes to add §290.46(q)(6), which summarizes what actions are required to rescind a boil water notice. The proposed language clarifies that the executive director may provide written notification to the public water system once the public water system has provided compliance documentation to him. The proposed language establishes that the boil water notice shall remain in effect until the public water system establishes that it has met the applicable requirements. The applicable requirements are set forth in proposed §290.46(q)(6)(A) - (E), which incorporate requirements located in existing §290.46(q) and adds new language.

The commission proposes to add §290.46(q)(6)(A), with the requirements to rescind a boil water notice for a public water system which experienced distribution system pressure issues.

The commission proposes to add §290.46(q)(6)(B), with the requirements to rescind a boil water notice for a public water system which experienced disinfectant residuals issues.

The commission proposes to add §290.46(q)(6)(C), with the requirements to rescind a boil water notice for a public water system which experienced turbidity issues.

The commission proposes to add §290.46(q)(6)(D), with the requirements to rescind a boil water notice for a public water system which failed to provide required compliance information to the executive director.

The commission proposes adding §290.46(q)(6)(E), with the water sampling and microbiological analysis requirements to rescind a boil water notice for a public water system which has met all other required actions to rescind a boil water notice. The commission proposes adding language requiring public water systems to collect representative water samples for microbiological analysis which meet specific laboratory labeling and analytical requirements and that the water sample laboratory analysis results are negative for coliform organisms before a public water system may rescind a boil water notice.

The commission proposes to add §290.46(q)(6)(F), which incorporates rule requirements located in current §290.46(q)(1) and adds new language requiring a public water system to issue a notice rescinding a boil water notice within a specific time frame once the public water system has met the applicable requirements in proposed §290.46(q)(6)(A) - (E). The commission proposes adding language requiring a public water system to provide a copy of the rescind notice and associated microbial sample results to the executive director within a specific time frame, and to issue the rescind notice to customers in accordance with existing rule requirements in §290.122(f).

§290.47, Appendices

The commission proposes to amend existing §290.47(c) and add §290.41(c)(1) and Figure: 30 TAC §290.47(c)(1) to revise the mandatory boil water notice language that "community" public water systems are required to provide to customers and to add language which establishes that the mandatory boil water notice language is specific to "community" public water systems.

The commission proposes to add §290.47(c)(2) and Figure: 30 TAC §290.47(c)(2) to establish the mandatory boil water notice language that "noncommunity" public water systems are required to provide to customers, individuals, or employees.

The commission proposes to add §290.47(c)(3) and Figure: 30 TAC §290.47(c)(3) to establish the mandatory language to rescind a boil water notice that all public water systems are required to provide to customers, individuals, or employees.

§290.102, General Applicability

The commission proposes to amend §290.102(b)(1) to revise variances and exemptions as described in 40 CFR §141.4 by removing the total coliform MCL reference and adding *E. coli* to the list, which establishes that the executive director may not grant variances or exemptions from the MCL for *E. coli* and that the total coliform MCL is no longer applicable, which is consistent with 40 CFR §141.4 and the RTCR.

The commission proposes to add §290.102(g) to clarify compliance monitoring reporting requirements for public water systems to be consistent with 40 CFR §141.31 and be consistent with the amended rule requirements as described in §§290.106 - 290.109 and 290.113 - 290.115.

§290.103, Definitions

The commission proposes to amend §290.103(3) to clarify the definition of the term "Compliance cycle" to be consistent with 40 CFR §141.23(j), which requires all public water systems to monitor for inorganic chemicals at the time designated by the executive director during each compliance period during each nine-year compliance cycle, and be consistent with the amended rule in §290.106(c)(7)(A), which specifies nitrite monitoring requirements for public water systems.

The commission proposes to amend §290.103(4) to clarify the definition of the term "Compliance period" to be consistent with 40 CFR §§141.23, 141.24, and 141.26, which specifies monitoring requirements for public water systems concerning inorganic chemicals, organic chemicals, and radionuclides; and requires public water systems to monitor for inorganic chemicals, organic chemicals, and radionuclides at the time designated by the exec-

utive director during each compliance period during each nine-year compliance cycle.

The commission proposes to amend §290.103(6) to clarify the definition of the term "Consecutive system" by adding the words "raw water or" prior to the existing "finished water" to be consistent with the applicability requirements as described in 40 CFR §141.400, which applies to all public water systems that use groundwater except that it does not apply to public water systems that combine all of their groundwater with surface water or with ground water under the direct influence of surface water prior to treatment. In addition to public water systems that provide "Finished water," as defined in proposed §290.103(19), existing §290.103(18), to customers from a groundwater source, the amended language will require public water systems that provide "Raw water," as defined in proposed §290.103(33), existing §290.103(30), to other public water systems that provide "Finished water" to customers will be subject to the GWR requirements as described in 40 CFR §141.400.

The commission proposes to add §290.103(9) to define the term "Domestic or other non-distribution system plumbing problem" as described in 40 CFR §141.2 to be consistent with the RTCR.

The commission proposes to add §290.103(26) to define the term "Level 1 assessment" as described in 40 CFR §141.2 to be consistent with the RTCR.

The commission proposes to add §290.103(27) to define the term "Level 2 assessment" as described in 40 CFR §141.2 to be consistent with the RTCR.

The commission proposes to add §290.103(35) to define the term "Sanitary defect" as described in 40 CFR §141.2 to be consistent with the RTCR.

The commission proposes to add §290.103(36) to define the term "Seasonal public water system" as described in 40 CFR §141.2 to be consistent with the RTCR.

§290.104, Summary of Maximum Contaminant Levels, Maximum Residual Disinfectant Levels, Treatment Techniques, and Action Levels

The commission proposes to amend §290.104(e) to clarify the MCL for microbiological contaminants as described in 40 CFR §141.52, which is based on the presence or absence of *E. coli,* to be consistent with the RTCR.

§290.106, Inorganic Contaminants

The commission proposes to amend §290.106(c)(3) to correct a typographical error concerning the initial monitoring frequency for inorganic compounds (IOC) except asbestos. The commission proposes to amend the second use of the word "nitrate" in the existing paragraph from "nitrate" to "nitrite" to correct this typographical error.

The commission proposes to amend §290.106(c)(7)(A) to clarify the monitoring requirements for nitrite for public water systems and to be consistent with 40 CFR §141.23(j) which requires all public water systems to monitor for inorganic chemicals at the time designated by the executive director during each compliance period during each

nine-year compliance cycle.

The commission proposes to amend §290.106(e) to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director and to be consistent with 40 CFR §141.31.

§290.107, Organic Contaminants

The commission proposes to amend §290.107(e) to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director and to be consistent with 40 CFR §141.31.

§290.108, Radionuclides Other than Radon

The commission proposes to amend §290.108(e) to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director and to be consistent with 40 CFR §141.31.

§290.109, Microbial Contaminants

The commission proposes to amend §290.109(b)(1) to clarify the applicability requirements relating to the MCL for microbial contaminants and for public water systems, consistent with the RTCR as described in 40 CFR §141.851.

The commission proposes to add §290.109(b)(1)(A) - (E) to clarify the applicability requirements relating to the MCL for *E. coli* for public water systems, consistent with the RTCR as described in 40 CFR §141.851.

The commission proposes §290.109(c), which establishes that public water systems shall comply with the requirements to conduct and complete assessments after exceeding any of the treatment technique triggers, as described in proposed (c)(1) and (2). The commission proposes to add this language to be consistent with the RTCR. Subsequent subsections are relettered accordingly.

The commission proposes to add §290.109(c)(1)(A) - (C) to establish the Level 1 treatment technique triggers and assessment requirements for microbial contaminants for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to add §290.109(c)(2)(A) and (B) to establish the Level 2 treatment technique triggers and assessment requirements for microbial contaminants for public water systems to be consistent with the RTCR as described in 40 CFR §141.859. The commission proposes to add language which establishes the requirements for public water systems concerning the submission of documentation to the executive director to determine if a Level 2 assessment is required when a second Level 1 assessment trigger has occurred within a rolling 12-month period.

The commission proposes to add §290.109(c)(3)(A)(i) and (ii) to establish the Level 1 and Level 2 treatment technique assessment requirements for microbial contaminants for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

Additionally, the commission proposes to add language to establish the Level 1 and Level 2 assessment assessor qualifications for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to add §290.109(c)(3)(B)(i) - (vii) to establish the Level 1 and Level 2 assessment requirements and evaluation criteria for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to add §290.109(c)(3)(C)(i) - (iii) to establish the Level 1 assessment requirements regarding completion deadlines, consultations with the executive director, and

corrective actions for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to add §290.109(c)(3)(D)(i) - (iii) to establish the Level 2 assessment requirements, regarding completion deadlines, consultations with the executive director, and corrective actions, for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to add §290.109(c)(3)(E) and (F) to establish and further clarify the Level 1 and Level 2 assessment requirements, regarding the correction of sanitary defects identified during Level 1 and Level 2 assessments and consultations with the executive director, for public water systems to be consistent with the RTCR as described in 40 CFR §141.859. Subsequent subsections are relettered accordingly.

The commission proposes to amend existing §290.109(c), proposed as §290.109(d), to establish microbial sampling location and Sample Siting Plan requirements for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to amend existing §290.109(c)(1)(A), proposed as §290.109(d)(1)(A) and (B), to establish microbial sampling location and Sample Siting Plan requirements for public water systems to be consistent with the RTCR as described in 40 CFR §141.859.

The commission proposes to amend existing §290.109(c)(2)(A)(i) and (ii), proposed as §290.109(d)(2)(A)(i) and (ii), to clarify the methods in which public water system population data is established and reported to the executive director to determine microbial sampling frequency for public water systems to be consistent with the RTCR as described in 40 CFR §§141.853 - 141.857, and Texas Health and Safety Code (THSC), §341.033(d).

The commission proposes to amend existing §290.109(c)(2)(C), proposed as §290.109(d)(2)(C), to correct a typographical error concerning the use of the words "uses only" which are repeated consecutively in the subparagraph. This revision will remove the second occurrence of these words.

The commission proposes to remove existing §290.109(c)(2)(F), replaced with proposed §290.109(d)(2)(F), to clarify and establish the routine microbial sampling frequency for public water systems to be consistent with the RTCR. This amended language establishes that public water systems that collect fewer than five routine distribution coliform samples per month will not be required to conduct increased routine microbial monitoring during the month following a month in which the public water system has one or more total coliform-positive samples.

The commission proposes to add §290.109(d)(2)(F) and (G) to clarify and establish the routine microbial sampling frequency for public water systems to be consistent with the RTCR. This language establishes that all public water systems shall collect at least the minimum number of required routine microbial samples even if the public water system has had an *E. coli* MCL violation or has exceeded the coliform treatment technique triggers. This language establishes that public water systems may conduct more microbial compliance monitoring than is required to investigate potential problems. This language establishes that if a public water system chooses to take more than the minimum number of required routine samples, the results of all samples shall be used in calculating whether the coliform treatment technique triggers have been exceeded. This language establishes that the routine sample sites shall be included in the public water system's Sample Siting Plan and requires that the samples be collected in accordance with the Sample Siting Plan.

The commission proposes to amend existing §290.109(c)(3)(A), proposed as §290.109(d)(3)(A), to clarify the 24-hour repeat microbial sampling limit for public water systems to be consistent with the RTCR as described in 40 CFR §141.858. The language specifies that the executive director may extend the 24-hour limit for public water systems on a case-by-case basis under extenuating circumstances. The amended language specifies that all public water systems shall collect no fewer than three repeat samples for each total coliform-positive sample found.

The commission proposes to amend existing §290.109(c)(3)(A)(i) and (ii), proposed as §290.109(d)(3)(A), to clarify and establish the repeat microbial sampling requirements for public water systems which collect only one routine distribution coliform sample per month to be consistent with the RTCR as described in 40 CFR §141.858. The amended language specifies that these public water systems will no longer be required to collect four repeat samples for each coliform-positive sample found and that all public water systems shall collect no fewer than three repeat samples for each total coliform-positive sample found.

The commission proposes to amend existing §290.109(c)(3)(B), proposed as §290.109(d)(3)(B), to clarify the time frame in which repeat microbial sampling is required for public water systems to establish that all repeat samples shall be collected on the same day, except for public water systems with a single service connection may collect daily repeat samples over a three-day period until the required number of repeat samples have been collected. This language is consistent with the RTCR as described in 40 CFR §141.858.

The commission proposes to amend existing §290.109(c)(3)(C), proposed as §290.109(d)(3)(C), to clarify the location in which repeat microbial samples are required to be collected for public water systems to establish that when a positive routine sample is collected at the end of the distribution system or one service connection away from the end of the distribution system, one repeat sample shall be collected at that point and all other samples shall be collected within five connections upstream of that point. This language is consistent with the RTCR as described in 40 CFR §141.853.

The commission proposes to amend existing §290.109(c)(3)(C)(i) - (iii), proposed as §290.109(d)(3)(C)(i) - (iii), which establishes that public water systems may propose alternative repeat microbial sampling locations to the executive director that are representative of a pathway for contamination of the distribution system. The proposed language specifies that the executive director may approve alternative microbial sampling locations for public water systems that elect to propose this repeat sample selection criteria option as an alternative to the repeat microbial sampling requirements as described in proposed §290.109(d)(3)(C). The language specifies that if a public water system proposes this option, they shall do so in a written standard operating procedure (SOP) included in its Sample Siting Plan as described in proposed §290.109(d)(6). The proposed language establishes that the executive director may approve public water systems that use a groundwater source and serve 1,000 or fewer people to specify alternative microbial sampling locations in a written SOP. The language specifies that the executive director may approve a written SOP for public water systems that have only one groundwater well and serve 1,000 or fewer people which allows the public

water system to collect one of its repeat samples at the location required for triggered source monitoring under the GWR and to use this sample to comply with both the repeat monitoring and triggered source monitoring requirements. This language is consistent with the RTCR as described in 40 CFR §141.853.

The commission proposes to amend existing §290.109(c)(3)(D), proposed as §290.109(d)(3)(D)(i) - (iii), to clarify the required 24-hour repeat microbial sampling limit for public water systems by adding language which specifies that the executive director may extend the 24-hour microbial sampling limit for public water systems under extenuating circumstances. The commission proposes to add language to establish the number of repeat microbial samples public water systems are required to collect based on the presence or absence of coliform bacteria, and exceeding coliform treatment technique triggers to be consistent with the RTCR as described in 40 CFR §141.858.

The commission proposes to amend existing §290.109(c)(4), proposed as §290.109(d)(4), to clarify the triggered source monitoring requirements for public water systems to be consistent with the GWR as described in 40 CFR §141.402. The commission proposes to add language to establish that the executive director may approve public water systems to collect a triggered source monitoring sample at an alternate location prior to any treatment if the sample is representative of the water quality of that well.

The commission proposes to amend existing §290.109(c)(4)(A), proposed as §290.109(d)(4)(A), by adding the language "or other approved fecal indicator" to be consistent with the GWR requirements as described in 40 CFR §141.402.

The commission proposes to amend existing §290.109(c)(4)(A)(i), proposed as §290.109(d)(4)(A)(i), to revise the reference for the definition of "4-log treatment" in §290.103.

The commission proposes to remove existing §290.109(c)(4)(B)(iii), replaced with proposed §290.109(d)(4)(B)(iii) and add proposed §290.109(d)(4)(B)(iv) and (v), to establish that a public water system that uses a groundwater source, has only one well, and serves 1,000 people or fewer may use one of the three required repeat samples collected from a raw groundwater source to meet both the repeat microbial monitoring requirements as required under the RTCR and the triggered raw source monitoring requirements as required under the GWR. The commission proposes to add language which establishes that if one of the required repeat samples is used to meet both of the RTCR and GWR requirements and the sample is found to be *E. coli*-positive, the public water system will have achieved an *E. coli* MCL violation which requires corrective action at the groundwater source where the *E. coli*-positive sample taken. The commission proposes to add language which establishes that if the executive director does not require corrective action, then the public water system will be required to conduct additional microbial monitoring at the groundwater source where the *E. coli*-positive sample was detected. The commission also proposes to add language which establishes that public water systems will be able to conduct reduced microbial monitoring for groundwater sources under certain conditions.

The commission proposes to amend existing §290.109(c)(4)(C)(i) and (ii), proposed as §290.109(d)(4)(C)(i) and (ii), by adding the language "or other approved fecal indicator" to be consistent with the GWR requirements as described in 40 CFR §141.402.

The commission proposes to add §290.109(d)(4)(C)(iii) to establish public notification and triggered source monitoring requirements for public water systems that wholesale groundwater to other public water systems. The language specifies that if a wholesale groundwater system receives an *E. coli*-positive raw source sample result, the wholesale groundwater system shall notify all consecutive public water systems served by that groundwater source of the *E. coli*-positive result within 24 hours of being notified of the result, and the wholesale groundwater system shall conduct triggered source monitoring in accordance with proposed §290.109(d)(4)(B)(iv). The commission proposes to add this language to be consistent with the RTCR and the GWR requirements as described in 40 CFR §141.402.

The commission proposes to amend existing §290.109(c)(4)(E), proposed as §290.109(d)(4)(E), to clarify public notification requirements for public water systems that use groundwater sources and their consecutive public water systems. The language specifies that if a groundwater system receives a fecal indicator positive raw source sample result, the groundwater system shall notify all consecutive public water systems served by that groundwater source of the fecal indicator positive result within 24 hours of being notified of the result. The commission proposes to add this language to be consistent with the GWR requirements as described in 40 CFR §141.402.

The commission proposes to amend existing §290.109(c)(5), proposed as §290.109(d)(5), to establish that public water systems will be required to ensure that if a routine or repeat microbial sample result is total coliform-positive, the total coliform-positive sample medium will be analyzed to determine if *E. coli* are present; and if *E. coli* are present in the sample, the public water system will be required to notify the executive director of the *E. coli* result by the end of the day. The commission proposes to add this language to be consistent with the RTCR as described in 40 CFR §141.858.

The commission proposes to amend existing §290.109(d)(1)(B), proposed as §290.109(e)(1)(B), to clarify that unless a total coliform-positive sample has been invalidated by the executive director, public water systems are required to collect the minimum number of required samples even if the system has had an *E. coli* MCL violation or has exceeded the coliform treatment technique triggers, and public water systems are required to continue to collect additional sets of repeat samples until either total coliforms are not detected in one complete set of repeat samples or it has been determined that a coliform treatment technique trigger has been exceeded as a result of a repeat sample being total coliform-positive. The commission proposes to add this language to be consistent with the RTCR as described in 40 CFR §141.853 and §141.858.

The commission proposes to amend existing §290.109(d)(1)(C), proposed as §290.109(e)(1)(C), to clarify that public water systems shall collect all repeat microbial samples as required and use all valid repeat samples to assist in determining compliance with the *E. coli* MCL and whether a coliform treatment technique trigger has been exceeded.

The commission proposes to amend existing §290.109(d)(2)(A) and (B), proposed as §290.109(e)(2)(A) and (B), by adding the language "or other approved fecal indicator" to be consistent with the GWR requirements as described in 40 CFR §141.402.

The commission proposes to add §290.109(d)(6) and (6)(A) - (E) to require public water systems to develop a Sample Siting Plan which identifies microbial routine and repeat sampling sites, a sample schedule that is representative of water throughout the distribution system, all groundwater sources, and any associated sampling points necessary to meet the RTCR and GWR requirements. The commission proposes to add language which establishes that the Sample Siting Plan is subject to review and revision by the executive director and shall be included in the public water system's monitoring plan to be consistent with the RTCR. The commission proposes to add language to require public water systems to develop Sample Siting Plans in a format specified by the executive director and that the Sample Siting Plans are subject to review and revision by the executive director to be consistent with the RTCR. The commission proposes to add the language, "in a format specified by the executive director," to provide review consistency in determining that Sample Siting Plans identify microbial routine and repeat sampling sites and a sample schedule that are representative of water throughout the distribution system to be consistent with the RTCR. The commission proposes to add language to require public water systems to collect routine and repeat microbial samples and any other samples necessary to meet the requirements of the RTCR and GWR according to their written Sample Siting Plan and that these sample site locations shall be reflected in their Sample Siting Plan to be consistent with the RTCR. The commission proposes to add language that requires public water system's to include any SOP for proposed repeat microbial monitoring as described in §290.109(d)(3) in their Sample Siting Plan to be consistent with the RTCR. The commission proposes to add language to establish that the executive director may review, revise, and approve any proposed SOP as required by the executive director to be consistent with the RTCR. The commission proposes to add language to require public water systems to include a distribution system map, which is required under existing rule requirements as described in §290.46(n)(2), with their Sample Siting Plan. The commission proposes to add language, in addition to the existing rule requirements as described in §290.46(n)(2), which requires public water systems to include the location of all routine microbial sample sites, water main sizes, entry point source locations, water storage facilities, and any pressure plane boundaries in their distribution system map. The commission proposes to add this language to provide review consistency and assist in determining that Sample Siting Plans identify routine microbial sample site locations that are representative of water throughout the distribution system to be consistent with the RTCR. The commission proposes to add language which requires public water systems to update their written Sample Siting Plan as necessary, or as requested by the executive director, to identify the most current microbial routine and repeat sampling sites and a sample collection schedule to be consistent with the RTCR. The commission proposes to add language which requires public water systems to maintain a copy of their Sample Siting Plan on file at the public water system for inspection purposes and to submit a copy of their Sample Siting Plan to the executive director upon request to be consistent with existing recordkeeping rule requirements.

The commission proposes to amend existing §290.109(e), proposed as §290.109(f), to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director to be consistent with 40 CFR §141.31.

The commission proposes to remove existing §290.109(f)(1) - (3), proposed as §290.109(g)(1) and (2), to clarify the MCL compliance determination criteria for public water systems regarding microbial contaminants to be consistent with the RTCR as described in 40 CFR §141.63.

The commission proposes to add §290.109(g)(1)(A) - (D) to establish the *E. coli* MCL violation compliance determination criteria for public water systems regarding microbial contaminants to be consistent with the RTCR as described in 40 CFR §141.63.

The commission proposes to add §290.109(g)(1)(E)(i)- (v), to identify for public water systems the best technology, treatment techniques, or other means available for achieving compliance with the MCL for *E. coli* to be consistent with the RTCR as described in 40 CFR §141.63.The commission also proposes to add §290.109(g)(1)(E)(vi) to establish that the executive director may require additional best technology, treatment techniques, or other means available for achieving compliance with the MCL for *E. coli.*

The commission proposes to add §290.109(g)(2) to establish *E. coli* MCL violation scenarios for public water systems regarding repeat samples collected for triggered source monitoring to be consistent with the RTCR as described in 40 CFR §141.853.

The commission proposes to amend existing §290.109(f)(5), proposed as §290.109(g)(4) and add (5), to establish microbial monitoring violations for public water systems to be consistent with the RTCR as described in 40 CFR §141.860.

The commission proposes to remove existing §290.109(f)(9) replaced with proposed §290.109(g)(9), to establish for public water systems that the results of all routine and repeat distribution coliform samples not invalidated by the executive director shall be included in determining compliance with the *E. coli* MCL and whether a coliform treatment technique trigger has been exceeded to be consistent with the RTCR as described in 40 CFR §141.21(b)(7) and §141.858(a)(5).

The commission proposes to amend existing §290.109(f)(10), proposed as §290.109(g)(10), to establish for public water systems that the results of all routine and repeat distribution coliform samples invalidated by the executive director shall not be included in determining compliance with the *E. coli* MCL and whether a coliform treatment technique trigger has been exceeded to be consistent with the RTCR as described in 40 CFR §141.21(c) and §141.853(c).

The commission proposes to add §290.109(g)(12) to establish the start-up procedures, certification requirements, and reporting violations for seasonal public water systems as defined in §290.103(36) to be consistent with the RTCR as described in 40 CFR §141.854 and §141.861. The commission proposes to add language that requires all seasonal public water systems to demonstrate completion of an executive director-approved start-up procedure and certification prior to serving water to the public.

The commission proposes to add §290.109(g)(13) to establish the treatment technique violation requirements for seasonal public water systems to be consistent with the RTCR as described in 40 CFR §141.860.

The commission proposes to add §290.109(g)(14) to establish the treatment technique violation for public water systems when a system exceeds a treatment technique trigger and then fails to conduct the required assessment or corrective actions within the

specified timeframe to be consistent with the RTCR as described in 40 CFR §141.860.

The commission proposes to add §290.109(g)(15) to establish the assessment, corrective actions, and reporting requirements for public water systems to be consistent with the TCR as described in 40 CFR §141.859.

The commission proposes to amend existing §290.109(g)(2) and (3), proposed as §290.109(h)(2) and (3), by adding the language "or other approved fecal indicator" to be consistent with the GWR requirements as described in 40 CFR §141.402.

The commission proposes to add §290.109(h)(5) to establish the reporting requirements for public water systems regarding an *E. coli* MCL violation to be consistent with the GWR requirements as described in 40 CFR §141.860.

The commission proposes to add §290.109(h)(7) to establish the reporting requirements for public water systems regarding an *E. coli* MCL violation to be consistent with the GWR requirements as described in 40 CFR §141.860.

§290.110, Disinfectant Residuals

The commission proposes to amend §290.110(c)(4)(D) to clarify the residual disinfectant concentration monitoring requirements for public water systems during microbial monitoring activities and in accordance with existing residual disinfectant concentration monitoring requirements to be consistent with the RTCR as described in 40 CFR §§141.74, 141.132, 141.854, and 141.858.

The commission proposes to amend §290.110(d)(2) and remove the requirements in subsection (d)(2)(A) - (C), to clarify the monitoring requirements for public water systems using chlorine dioxide and to establish executive approval requirements for certain monitoring equipment for testing chlorine dioxide.

The commission proposes to amend §290.110(f)(8) to revise a grammatical reference and establish that public water systems shall consult with the executive director upon increasing residual disinfectant levels in the distribution system in order to maintain compliance with the Maximum Residual Disinfectant Levels (MRDL).

The commission proposes to amend §290.110(g)(3) and remove the requirements in subsection (g)(3)(A) and (B) to clarify that a public water system shall provide notice to customers in accordance with §290.122 when the public water system does not demonstrate an adequate residual disinfectant concentration in more than 5.0% of the samples collected each month for two consecutive months.

§290.111, Surface Water Treatment

The commission proposes to amend §290.111(d)(4)(D) and remove the requirements in subsection (d)(4)(D)(i) and (ii) to clarify the required analytical methods used for measuring the chlorine dioxide residual and analytical methods that require written permission of the executive director.

The commission proposes to amend §290.111(e)(4) to clarify when public water systems are required to conduct a special investigation concerning the removal/inactivation of pathogens during the surface water treatment process.

The commission proposes to add §290.111(e)(4)(A)(iv) and (C) to establish criteria for public water systems concerning when they may be required to participate in a special investigation conducted by the executive director.

The commission proposes to amend §290.111(e)(5)(A) and remove the requirements in subsection (e)(5)(A)(i) - (iii) to clarify the required analytical methods used for measuring turbidity.

The commission proposes to add §290.111(e)(5)(E)(i) - (iii) to establish and clarify the precision and accuracy requirements for turbidity monitoring equipment and associated data recording devices used to measure and record combined filter and individual filter effluent turbidity levels.

The commission proposes to add §290.111(f)(3)(F)(i) - (iii) to establish and clarify the precision and accuracy requirements for turbidity monitoring equipment and associated data recording devices used to measure and record combined filter and individual filter effluent turbidity levels.

The commission proposes to add §290.111(f)(4)(A) - (C) to establish criteria for public water systems concerning when they may be required to participate in a special investigation conducted by the executive director.

The commission proposes to amend §290.111(i)(3) and add §290.111(i)(3)(A) - (E) to establish the acute treatment technique violation conditions and public notice and boil water notice requirements when a public water system fails to meet specific treatment, turbidity level, monitoring, and/or reporting requirements.

The commission proposes to amend §290.111(i)(4) and add §290.111(i)(4)(A) - (D) to establish the acute treatment technique violation conditions and public notice requirements when a public water system fails to meet specific treatment, turbidity level, monitoring, and/or reporting requirements.

§290.112, Total Organic Carbon (TOC)

The commission proposes to amend §290.112(f)(3)(A) to clarify the formula and method for calculating and determining the actual monthly TOC percent removal in a TOC sample set.

The commission proposes to amend §290.112(f)(3)(D) and (E) to clarify the terminology of the annual average TOC removal ratio and the method for calculating and determining the annual average TOC removal ratio.

§290.113, Stage 1 Disinfection Byproducts (TTHM and HAA5)

The commission proposes to amend §290.113(e) to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director to be consistent with 40 CFR §141.31.

§290.114, Other Disinfection Byproducts (Chlorite and Bromate)

The commission proposes to amend §290.114(a)(3)(A) and remove the requirements in §290.111(a)(3)(A)(i) and (ii) to clarify that public water systems are required to use facilities that are approved by the executive director for the analysis of chlorite concentrations in water entering the distribution system.

The commission proposes to amend §290.114(a)(4)(B) to clarify the reporting requirements for public water systems regarding the submission of any required chlorite test, measurement, or analysis to the executive director to be consistent with 40 CFR §141.31.

The commission proposes to amend §290.114(b)(4) to clarify to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director to be consistent with 40 CFR §141.31.

§290.115, Stage 2 Disinfection Byproducts (TTHM and HAA5)

The commission proposes to amend §290.115(e)(1) to clarify to clarify the reporting requirements for public water systems regarding the submission of laboratory analyses and reports to the executive director to be consistent with 40 CFR §141.31.

§290.116, Groundwater Corrective Actions and Treatment Techniques

The commission proposes to amend §290.116(a) to clarify the applicability requirements for public water systems to be consistent with the GWR and RTCR as described in 40 CFR §141.859. This amended language specifies the treatment technique and corrective action requirements for public water systems that use groundwater sources to be consistent with the GWR and the treatment technique and corrective action requirements for these public water systems when they have exceeded a treatment technique trigger under the RTCR as described in §141.859.

The commission proposes to amend §290.116(a)(1) and (2) to establish that public water systems that use groundwater sources shall receive prior written approval from the executive director before the public water system discontinues the use of 4-log treatment for their groundwater sources to be consistent with the GWR.

The commission proposes to amend §290.116(b)(5) to clarify the corrective action plan and approval requirements for public water systems that are required to complete the corrective action to be consistent with the GWR.

The commission proposes to amend §290.116(c) by removing the words "or in lieu of the" and adding the words "instead of conducting" to clarify the microbial inactivation and removal requirements for public water systems that treat groundwater sources in response to a fecal indicator positive source sample or significant deficiency, instead of conducting raw groundwater source monitoring, shall meet minimum requirements demonstrating at least 4-log treatment of viruses to be consistent with the GWR.

The commission proposes to amend §290.116(c)(2) and add the requirements in §290.116(c)(2)(A) and (B) to include and establish the monitoring and operating requirements for membrane treatment systems and to specify the approval process for monitoring and recording the performance of these alternative treatment technologies to be consistent with the GWR.

The commission proposes to add §290.116(c)(3)(F) to establish that membrane treatment system integrity monitoring shall be conducted in accordance with executive director specified requirements to be consistent with the GWR.

The commission proposes to amend §290.116(c)(4) to clarify the recordkeeping applicability requirements for public water systems to be consistent with the GWR.

The commission proposes to amend §290.116(d) by removing the words "in lieu of the" and "to conduct" and adding the words "instead of conducting" to clarify that public water systems that treat groundwater sources in response to a fecal indicator positive source sample or significant deficiency, instead of conducting raw groundwater source monitoring, shall report to the executive director to be consistent with the GWR.

The commission proposes to add §290.116(d)(6) to establish the reporting requirements for public water systems that are required to conduct integrity monitoring for membrane treatment systems for groundwater sources.

The commission proposes to amend §290.116(e)(4) and (5) to clarify the compliance monitoring and reporting requirements for public water systems that use membrane systems to treat groundwater sources.

The commission proposes to amend §290.116(f)(1) to clarify and establish the public notification requirements for community public water systems that use groundwater sources when the public water system receives notice from the executive director of a significant deficiency or notification of a fecal indicator positive groundwater source sample to be consistent with the GWR. This amended language requires these public water systems to provide public notice to customers on an annual basis until the significant deficiency is corrected or the fecal contamination in the groundwater source is corrected as determined by the executive director.

§290.117, Regulation of Lead and Copper

The commission proposes to amend §290.117(c)(2)(D)(i) - (vi) to add the word "reduced" to clarify the reduced nine-year tap sampling requirements for public water system's regarding lead and copper monitoring to be consistent with the federal Lead and Copper Rule Minor Revisions (LCRMR) as described in 40 CFR §141.85. This amended language removes the word "waiver" and replaces it with "schedule" for consistency with amended rule language. This amended language will provide clarification concerning the executive director's authority to modify reduced nine-year tap sampling schedules.

The commission proposes to amend §290.117(c)(2)(D)(vii) by removing the executive director's approval of waivers regarding the lead and copper nine-year tap sampling requirements for public water systems that received such waivers. This amended language is consistent with a new provision under the LCRMR and supersedes pre-existing waivers that were granted for lead and copper tap monitoring. This amended language will provide clarification for public water systems with state-approved waivers that the waivers are no longer valid in accordance with the LCRMR provision. The public water systems that were granted waivers will be eligible for reduced nine-year monitoring if the public water system meets the federal criteria outlined in the LCRMR and will be required to re-apply for reduced monitoring every nine years.

The commission proposes to amend §290.117(e) to remove and clarify an incorrect table reference and to clarify the applicability of Water Quality Monitoring Parameters (WQP) within subsection (e).

The commission proposes to amend §290.117(e)(1) by adding the words "take two samples" to clarify the sampling requirements for public water system's relating to monitoring for water quality parameters to be consistent with the LCRMR as described in 40 CFR §141.87(a)(2). This amended language requires public water systems to also take two samples at all raw water WQP sites in addition to entry points and distribution WQP sites in accordance with the table referenced in Figure: 30 TAC §290.117(e)(1). The requirement to monitor at raw water WQP sites was added to be consistent with the March 2016 EPA *Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to add §290.117(e)(1)(C) to establish the raw water monitoring requirements for WQP sample sites to be consistent with the March 2016 EPA *Optimal Corrosion Con-*

trol Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems guidance document.

The commission proposes to amend §290.117(e)(2) to establish the initial and routine raw water monitoring requirements for WQP sample sites to be consistent with the March 2016 *EPA Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to amend Figure: 30 TAC §290.117(e)(2) to include raw water monitoring WQP sample sites in the title and to include total dissolved solids, sodium, sulfate, chloride, hardness, manganese, and iron as additional WQP monitoring parameters to be consistent with the March 2016 EPA *Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to amend §290.117(e)(2)(A) to establish the initial and routine raw water monitoring requirements for WQP sample site locations as referenced in Figure: 30 TAC §290.117(e)(1) to be consistent with the March 2016 EPA *Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to amend §290.117(e)(2)(B) to establish the frequency for initial and routine WQP monitoring on a quarterly basis to reflect seasonal variability in water quality conditions to be consistent with the March 2016 EPA *Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to amend §290.117(e)(3) to establish the entry point and distribution WQP monitoring requirements for public water systems after the installation of corrosion control treatment as referenced in Figure: 30 TAC §290.117(e)(3). This amended language clarifies the Figure: 30 TAC §290.117(e)(3) table reference.

The commission proposes to amend Figure: 30 TAC §290.117(e)(3) to amend the title and to include calcium, total dissolved solids, temperature, sodium, sulfate, chloride, hardness, manganese, and iron as additional WQP monitoring parameters and remove the requirement to measure calcium if calcium carbonate stabilization is used as part of corrosion control to be consistent with the March 2016 EPA *Optimal Corrosion Control Treatment Evaluation Technical Recommendations for Primacy Agencies and Public Water Systems* guidance document.

The commission proposes to amend §290.117(e)(4) to clarify the Figure: 30 TAC §290.117(e)(4) table reference.

The commission proposes to amend §290.117(f)(1)(C) to clarify the reference to corrosion control treatment methods as described in §290.117(f)(1)(B) and to make grammatical revisions.

The commission proposes to amend §290.117(i)(4)(B)(i) - (iii) to add the word "reduced" to clarify the reduced nine-year tap sampling requirements for public water system's regarding lead and copper monitoring to be consistent with the LCRMR as described in 40 CFR §141.85. This amended language removes the word "waiver" and replaces it with "schedule" for consistency with amended rule language.

The commission proposes to amend §290.117(k)(2)(B)(i) and (ii) and remove §290.117(k)(2)(B)(iii), to establish that community public water systems serving 3,300 or fewer people are allowed to limit certain aspects of their public education programs by distributing required public education materials to facilities and organizations served by the public water system that are most likely to be visited regularly by pregnant women and children. This amended language allows community public water systems serving 3,300 or fewer people the option to distribute notices to every household served by the public water system instead of delivering notices by media release. This amended language requires community public water systems serving 3,300 or fewer people to implement at least one of nine possible options to deliver public education materials to customers.

§290.118, Secondary Constituent Levels

The commission proposes to amend §290.118(g)(1) to clarify terminology for public water systems regarding secondary constituent levels to be consistent with existing rule language.

§290.119, Analytical Procedures

The commission proposes to amend §290.119(b)(1) to reference and include the acceptable federal analytical methods as described in 40 CFR §141.852. This language will specify that public water systems are required to conduct total coliform and *E. coli* analyses in accordance with the analytical methods or alternative methods as described in 40 CFR §141.852 to be consistent with the RTCR.

§290.121, Monitoring Plans

The commission proposes to add §290.121(b)(3) to require public water systems to include a list of all repeat microbial sample sites which are associated to their originating routine microbial sample sites in a Sample Siting Plan to be consistent with the RTCR as described in 40 CFR §141.853. The RTCR requires public water systems to include routine and repeat microbial sample sites in a Sample Siting Plan. The amended language specifies that the Sample Siting Plan shall be included in the public water system's monitoring plan. This requirement is included in the amended rule language regarding Sample Siting Plans as described in §290.109.

§290.122, Public Notification

The commission proposes to amend §290.122(a) to establish the Tier 1 public notice category and to describe that a Tier 1 public notice is associated to acute violations or situations with significant potential to have serious adverse effects on human health as a result of short-term exposure and which require a Tier 1 public notice. The commission proposes to amend this language to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to amend §290.122(a)(1)(A) to establish that a Tier 1 public notice is required for a violation of the *E. coli* MCL as described in §290.109(g)(1)(A) - (D) and that the acute MCL for microbial contaminants is no longer applicable to be consistent with the RTCR as described in 40 CFR §141.63 and §141.860.

The commission proposes to add §290.122(a)(1)(B)(v) and (vi) to establish the Tier 1 public notice requirements when a public water system fails to meet specific treatment, turbidity level, monitoring, and/or reporting requirements as described in §290.111(i)(3) and (4).

The commission proposes to amend §290.122(a)(2) to clarify and establish the methods in which public water systems are

required to issue a Tier 1 public notice to customers to be consistent with 40 CFR Part 141, Subpart Q. The commission proposes to amend this language to specify that public water systems shall issue the initial Tier 1 public notice to customers for an acute violation or situation in one or more manners that are reasonably calculated to reach persons served by the public water system within the required time period. The commission proposes to amend language to specify that public water systems are no longer required to issue a Tier 1 public notice by using two of the approved methods described in rule and are now allowed to issue a Tier 1 public notice by using one or more of the approved methods described in rule to be consistent with 40 CFR §141.202.

The commission proposes to amend §290.122(a)(2)(A) to clarify the Tier 1 public notice and/or boil water notice requirements when a public water system fails to meet specific treatment, turbidity level, monitoring, and/or reporting requirements as referenced in §290.122(a)(1)(B)(vi) and described in §290.111(i)(4).

The commission proposes to remove §290.122(a)(4) to establish that public water systems are not required to issue a public notice to customers when the public water system has corrected a Tier 1 acute violation or situation to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to amend §290.122(b) to establish the Tier 2 public notice category and to describe that a Tier 2 public notice is associated to other MCL, MRDL, or treatment technique violations and for variance and exemption violations which are violations and situations with potential to have serious adverse effects on human health and which require a Tier 2 public notice. The commission proposes to amend this language to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to amend §290.122(b)(2) to provide consistency with revised terminology concerning Tier 2 public notices to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to remove §290.122(b)(4) to establish that public water systems are not required to issue a public notice to customers when the public water system has corrected a Tier 2 violation to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to amend §290.122(c) and (c)(1) to establish the Tier 3 public notice category and to describe that a Tier 3 public notice is associated with other violations, situations, variances, and exemptions as defined and which require a Tier 3 public notice. The commission proposes to amend this language to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to add §290.122(c)(1)(F) - (K) to require a community and nontransient, noncommunity public water system to provide notification to its customers of the availability of unregulated contaminant monitoring results. These systems will also be required to issue a Tier 3 public notice to customers in the event the public water system fails to notify customers of the availability of unregulated contaminant monitoring results to be consistent with 40 CFR §141.204 and §141.207. The commission proposes to add language to establish that a public water system is required to issue a Tier 3 public notice for failure to maintain any assessment form and documentation of corrective actions completed as a result of those assessments to be consistent with 40 CFR §141.204 and §141.861. The commission proposes to add language to establish that a public water system is required to issue a Tier 3 public notice for failure to maintain a record of any repeat sample taken that meets the criteria for an extension of the 24-hour period for collecting repeat samples to be consistent with 40 CFR §141.204 and §141.861. The commission proposes to add language that may require public water systems to issue a Tier 1 public notice instead of a Tier 3 public notice for other violations or situations deemed by the executive director to pose an acute risk to human health or with significant potential to have serious adverse effects on human health as a result of short-term exposure to be consistent with 40 CFR §141.202. The commission proposes to add language that may require public water systems to issue a Tier 2 public notice instead of a Tier 3 public notice for other violations or situations, at the discretion of the executive director, which take into account potential health impacts and persistence of the violation and failure to comply with the terms and conditions of any variance or exemption to be consistent with 40 CFR §141.203.

The commission proposes to amend §290.122(c)(2) to clarify and establish the methods in which public water systems are required to issue the initial and repeat Tier 3 public notices to customers to be consistent with 40 CFR §141.204. The commission proposes to add language to specify that public water systems shall issue the initial Tier 3 public notice to customers not later than one year after the public water system learns of the violation or situation or begins operating under a variance or exemption. The commission proposes to add language to specify that public water systems shall issue the repeat Tier 3 public notice to customers annually for as long as the violation, variance, exemption, or other situation persists. The commission proposes to add language to specify that if the public notice is posted, the notice shall remain in place for as long as the violation, variance, exemption, or other situation persists, but in no case less than seven days even if the violation or situation is resolved. The commission proposes to amend language to specify that public water systems are no longer required to issue a Tier 3 public notice within three months of the violation or the granting of a variance or exemption and may now issue a Tier 3 public notice on an annual basis unless otherwise specified by rule to be consistent with 40 CFR §141.204.

The commission proposes to add §290.122(c)(2)(C)(i) - (iii) to establish the criteria that allows community public water systems to use their annual Consumer Confidence Report (CCR) for delivering the initial Tier 3 public notice and all required repeat Tier 3 public notices to be consistent with 40 CFR §141.204.

The commission proposes to amend §290.122(c)(3)(A) to establish the criteria that allows community public water systems to use their annual CCR for delivering repeat Tier 3 public notices to be consistent with 40 CFR §141.204.

The commission proposes to amend §290.122(c)(4) to establish that public water systems are not required to issue a public notice to customers when the public water system has corrected a Tier 3 violation to be consistent with 40 CFR Part 141, Subpart Q.

The commission proposes to amend §290.122(f) to clarify the reporting methods for public water systems regarding the proof of public notification delivery.

The commission proposes to amend §290.122(g) to clarify the public notification requirements for public water systems that sell or provide drinking water to other public water systems (i.e., consecutive systems) and to clarify that consecutive systems are responsible for and shall provide public notice to the persons it serves to be consistent with 40 CFR §141.201(c)(1).

§290.272, Content of the Report

The commission proposes to add §290.272(b)(1)(A) and (B) to establish the content requirements for CCR regarding Level 1 and Level 2 assessments to be consistent with the RTCR, as described in 40 CFR §141.153.

The commission proposes to amend §290.272(c)(4)(D) and (D)(i) to establish the content requirements for CCR regarding contaminants subject to an MCL, except turbidity, total coliform, fecal coliform, and *E. coli* to be consistent with the RTCR.

The commission proposes to amend §290.272(c)(4)(G) and (H) to establish the content requirements for CCR regarding *E. coli* reporting to be consistent with the RTCR.

The commission proposes to add §290.272(d)(4) to establish the content requirements for CCR regarding community and nontransient, noncommunity public water systems that exceed the secondary constituent level for fluoride but are below the MCL.

The commission proposes to add §290.272(g)(9) - (11) to establish the content requirements for CCR regarding Level 1 or Level 2 assessments, associated corrective actions, monitoring and reporting, and the *E. coli* MCL to be consistent with the RTCR.

The commission proposes to add §290.272(h) to establish the content requirements for CCR regarding when a public water system detects *E. coli* and has not violated the *E. coli* MCL to be consistent with the RTCR, as described in 40 CFR §141.153.

§290.275, Appendices A - D

The commission proposes to amend Figure: 30 TAC §290.275(3) to establish the mandatory health effects language required for CCR regarding coliforms and *E. coli* bacteria to be consistent with the RTCR.

Fiscal Note: Costs to State and Local Government

Jeffrey Horvath, Analyst in the Chief Financial Officer Division, determined that for the first five-year period the proposed rules are in effect, fiscal implications, which may be significant, are anticipated for the agency and for other units of state or local government as a result of the administration or enforcement of the proposed rules.

These rules are proposed in order to conform agency rules to the RTCR promulgated by the EPA. Under federal regulations, TCEQ shall adopt rules at least as stringent as the federal rules in order to maintain primacy over the federal Public Water System Supervision Program in Texas. This rulemaking also proposes to address EPA's comments on TCEQ's adopted GWR; and to provide consistency with other federal provisions, including: the Lead and Copper Rule; the Total Organic Carbon Rule; public notice requirements; disinfection and analytical requirements; and other federal monitoring and reporting requirements.

In addition, this rulemaking proposes to provide clarification and streamline existing commission rules regarding: state monitoring and ownership reporting requirements; boil water notice reporting and requirements for special precautions, protective measures, boil water notices, and special investigation requirements for elevated turbidity levels and for failure to provide compliance data; disinfection operating reports; and water well recordkeeping requirements.

Public water systems owned by local governments (cities, counties, water districts, river authorities, and utility districts) will be affected by the proposed rules. In particular, public water systems will be affected by the proposed changes that correspond with the RTCR. Agency staff estimates that there are approximately 3,013 local governmental entities that own public water systems in Texas.

Under the proposed rules, local governmental entities that own public water systems will be required to revise their existing Sample Siting Plans for the collection of total coliform samples. These public water systems will also be required to conduct Level 1 and Level 2 assessments of their system if they trigger certain requirements and will be required to conduct any corrective actions associated with those Level 1 and Level 2 assessments. Corrective actions associated with Level 1 and Level 2 assessments could range from minor to major activities associated with maintenance, treatment, and distribution system infrastructure improvements. Finally, if applicable, public water systems will be required to perform seasonal start-up procedures and provide certification to the executive director that the required seasonal start-up activities have been completed.

Costs to perform these activities are difficult to estimate and would vary due to the difference and variability in size, type, and configuration of each public water system's distribution system. The additional activities may require local governmental entities who own public water systems to hire consultants to develop: 1) Sample Siting Plan revisions; 2) Level 1 or Level 2 assessments; 3) corrective actions; or 4) seasonal start-up procedures. Costs associated with Level 1 and Level 2 assessments could be significant for activities concerning maintenance, treatment, and distribution system infrastructure improvements. The EPA has indicated that the overall net increase in costs for most of the public water systems serving greater than 4,100 people will be driven primarily by the requirements to conduct assessments and to conduct necessary corrective actions when sanitary defects are identified. Public water systems will be required to update their water distribution map to include the location of microbial sampling sites, water main sizes, entry point source locations, water storage facilities, any pressure plane boundaries, and include their water distribution map with their Sample Siting Plan.

Under the proposed agency rules separate from the RTCR rules, public water systems may be required to issue boil water notices to customers at the discretion of the executive director in addition to pre-existing requirements. Public water systems will also be required to provide boil water rescind notifications to customers. These requirements are not expected to result in significant fiscal implications for the agency or public water systems.

Some cost savings may be anticipated for some local governmental entities that own public water systems serving 4,900 or fewer customers. Under the RTCR, these systems will only be required to take three repeat samples instead of five after receiving an initial routine sample result that is positive for the presence of coliform. In addition, these public water systems will no longer be required to collect five microbial samples the month following a month in which the public water system received a total coliform-positive sample result. Sample collection and analysis cost an average of $25 - $40 per sample and the cost savings vary depending on the type and size of the public water system.

Public water systems may also realize a cost savings due to the proposed conformity with federal rules as they concern public notice requirements. Specifically, public water systems would not be required to issue a Tier 1 public notice using two of the approved methods, but instead would be allowed to issue a Tier 1 public notice using one or more of the approved methods. In addition, public water systems would not be required to issue a

Tier 3 public notice within three months and would be allowed to issue a Tier 3 public notice on an annual basis.

Other minor cost savings may be expected for those public water systems allowed to issue public notice to customers for certain violations on an annual basis rather than within 90 days. Community public water systems will be allowed to issue required notices in their annual CCR, and all other public water systems will be required to issue notices by posting or other means. Cost savings will vary due to the differences in size and type of the public water system.

TCEQ will be responsible for providing a thorough review and approval of the reports generated from the RTCR Level 1 and Level 2 assessments of the distribution systems of public water systems. Staff will have to track and review the completion of the RTCR required corrective actions associated with distribution systems assessments and verify compliance. Staff will also review, on a continuing basis, revisions to the RTCR Sample Siting Plans of approximately 6,900 public water systems. Some of these reviews will also require evaluations of the distribution systems. Staff will also provide consultation to public water systems on addressing any distribution system deficiencies identified during the RTCR distribution system assessments. Staff will also review qualifications for personnel proposed by public water systems to perform the RTCR Level 1 and Level 2 assessments and determine if they meet regulatory criteria. Finally, staff will review and evaluate on annual basis the certification of the RTCR start-up procedures for public water systems that operate on seasonal basis.

At this time the agency does not have sufficient staff resources to implement the proposed rules. The agency may request additional funding in the next legislative session or reallocate resources to fund the proposed changes. Fourteen full-time equivalent employees (FTEs) will be required.

The 14 FTEs will be required to conduct daily compliance reviews and provide technical and regulatory assistance with the RTCR Sample Siting Plans, seasonal start-up procedures, distribution system assessments, corrective actions to address distribution system deficiencies, provide specialized compliance assistance, technical and regulatory training for and maintenance of approved assessment providers, and training activities. The FTEs will be required to monitor and track required plan reviews and exception requests for public water systems that have triggered Level 1 and Level 2 assessments. The FTEs will be required to provide coordination and outreach between the EPA, Office of Water, and Office of Compliance and Enforcement concerning these activities and any associated enforcement actions.

The FTEs will be required to conduct enhanced investigations of community distribution systems at a minimum of once every five years in addition to the currently required Comprehensive Compliance Investigations conducted at public water systems once every three years. An enhanced evaluation of the distribution system would include, but not be limited to, a review of the RTCR, nitrification, and lead/copper monitoring plans, as well as review of the sample analysis and sampling locations, monthly operating reports, etc. Investigations will be conducted based on findings of previous investigations, compliance with distribution requirements, sampling results, complaints, and regional staff knowledge. Total estimated costs for the 14 FTEs would be $780,889 for the first year the proposed rules are in effect and $722,089 each year thereafter.

Additional costs include: RTCR Compliance Training Outreach Events at a cost of $75,000 in the first year; an increase in financial, managerial, and technical compliance support at $250,000 per year, and additional operator training for technical and regulatory compliance through the Texas Optimization Program which provides technical assistance, training, and optimization strategies for public water systems at approximately $150,000 per year. This totals to $475,000 the first year and $400,000 for each subsequent year.

The total agency costs to implement the proposed RTCR including FTEs, compliance training and outreach events are estimated to be $1,255,889 in the first year and $1,122,089 in subsequent years. The agency would fund any new costs from its Water Resources Account 0153.

Public Benefits and Costs

Mr. Horvath also determined that for each year of the first five years the proposed rules are in effect, the public benefit anticipated from the changes in the proposed rules would be compliance with federal law and the protection of public health by ensuring the integrity of public drinking water distribution systems through monitoring for the presence of microbial contamination.

Fiscal implications are anticipated for businesses and individuals as a result of the administration and enforcement of the proposed rules, particularly for those businesses or individuals that own or operate a public water system.

The proposed rules would impact approximately 3,706 businesses that own or operate public water systems. In particular, public water systems will be affected by the proposed changes that correspond with the RTCR.

Under the proposed rules, businesses that own public water systems will be required to revise their existing Sample Siting Plans for the collection of total coliform samples. These public water systems will also be required to conduct Level 1 and Level 2 assessments of their system if they trigger certain requirements and will be required to conduct any corrective actions associated with those Level 1 and Level 2 assessments. Corrective actions associated with Level 1 and Level 2 assessments could range from minor to major activities associated with maintenance, treatment, and distribution system infrastructure improvements. Finally, if applicable, they will be required to perform seasonal start-up procedures and provide certification to the executive director that the required seasonal start-up activities have been completed.

Costs to perform these activities are difficult to estimate and would vary due to the difference and variability in size, type, and configuration of each public water system's distribution system. The additional activities may require businesses that own public water systems to hire consultants to develop: 1) Sample Siting Plan revisions; 2) Level 1 or Level 2 assessments; 3) corrective actions; or 4) seasonal start-up procedures. Costs associated with Level 1 and Level 2 assessments could be significant for activities concerning maintenance, treatment, and distribution system infrastructure improvements. The EPA has indicated that the overall net increase in costs for most of the public water systems serving greater than 4,100 people will be driven primarily by the requirements to conduct assessments and to conduct necessary corrective actions when sanitary defects are identified. Public water systems will be required to update their water distribution map to include the location of microbial sampling sites, water main sizes, entry point source locations, water storage fa-

cilities, any pressure plane boundaries, and include their water distribution map with their Sample Siting Plan.

Public water systems may also realize a cost savings due to the proposed conformity with federal rules as they concern public notice requirements. Specifically, public water systems would not be required to issue a Tier 1 public notice using two of the approved methods, but instead would be allowed to issue a Tier 1 public notice using one or more of the approved methods. In addition, public water systems would not be required to issue a Tier 3 public notice within three months and would be allowed to issue a Tier 3 public notice on an annual basis.

Minor cost savings may be expected for those public water systems allowed to issue public notice to customers for certain violations on an annual basis rather than within 90 days. Community public water systems will be allowed to issue required notices in their annual CCR, and all other public water systems will be required to issue notices by posting or other means. Cost savings will vary due to the differences in size and type of the public water system.

Under the proposed agency rules separate from the RTCR rules, public water systems may be required to issue boil water notices to customers at the discretion of the executive director in addition to pre-existing requirements. Public water systems will also be required to provide boil water rescind notifications to customers. These requirements are not expected to result in significant fiscal implications for public water systems.

Businesses or individuals may see their water rates increase due to the increased costs for public water system activities associated with compliance with this rulemaking. Overall, rate increases are not anticipated to be significant.

Small Business and Micro-Business Assessment

Adverse fiscal implications are anticipated for small or micro-businesses as a result of the proposed rules. There are approximately 3,600 small businesses and approximately 1,000 micro-businesses that are public water systems and may be affected by the proposed rules.

Costs will generally be the same for small water systems as they are for larger ones. However, smaller public water systems will not be required to collect as many samples as larger public water systems and will generally have less complex Sample Siting Plans and less complex distribution systems, decreasing the time to conduct Level 1 and Level 2 assessments and address any subsequent corrective actions. Smaller seasonal public water systems may have less time involved in conducting start-up activities. EPA estimates that transient, noncommunity public water systems serving 100 or fewer people will experience the largest increase as a result of this rulemaking. These systems are estimated to incur a net annualized present value increase of approximately $86 per system under the RTCR.

Small Business Regulatory Flexibility Analysis

The commission reviewed this proposed rulemaking and determined that a small business regulatory flexibility analysis is not required because the proposed rulemaking is necessary in order to comply with federal law and is, therefore, consistent with protecting the health, safety, or environmental and economic welfare of the state.

Local Employment Impact Statement

The commission reviewed this proposed rulemaking and determined that a local employment impact statement is not required because the proposed rulemaking does not adversely affect a local economy in a material way for the first five years that the proposed rulemaking is in effect.

Draft Regulatory Impact Analysis Determination

The commission reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225 and determined that the rulemaking is not subject to Texas Government Code, §2001.0225. A "major environmental rule" means a rule with a specific intent to protect the environment or reduce risks to human health from environmental exposure, and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

First, the proposed rulemaking does not meet the statutory definition of a "major environmental rule" because its specific intent is not to protect the environment or reduce risks to human health from environmental exposure. The specific intent of the proposed rulemaking is to incorporate changes in the federal drinking water regulations in order to maintain the state's primary enforcement responsibility with regard to drinking water. This is accomplished by enacting state rules no less stringent than the federal regulations and adopting adequate procedures for implementation and enforcement of these rules, while providing alternative approaches to compliance based in part on stakeholder input and taking into account special considerations related to the state's particular source water conditions. The federal regulations in the RTCR that would be implemented through the proposed rulemaking are designed to increase public human health protection through the reduction of potential pathways of entry for fecal contamination into the distribution systems of public drinking water systems, which should reduce the potential risk from all waterborne pathogens including bacteria, viruses, parasitic protozoa, and their associated illnesses. In addition, the proposed rulemaking addresses specific comments from the EPA regarding state implementation of the GWR, ensuring that the state rules are no less stringent than the GWR. Finally, the proposed rulemaking clarifies state implantation of the Lead and Copper Rule, the Total Organic Carbon Rule, and incorporate other federal analytical and reporting requirements for public drinking water systems.

Second, the proposed rulemaking does not meet the statutory definition of a "major environmental rule" because the proposed rules would not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. It is not anticipated that the cost of complying with the proposed rules will be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the proposed amendments will not adversely affect in a material way the economy, a sector of the economy, competition, or jobs.

Finally, the proposed rulemaking does not meet any of the four applicability requirements for a "major environmental rule" listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 only applies to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general

powers of the agency instead of under a specific state law. This proposed rulemaking does not meet any of the preceding four applicability requirements because this rulemaking: does not exceed any standard set by federal law for public water systems and is proposed to be consistent with and no less stringent than federal rules; does not exceed any express requirement of state law under THSC, Chapter 341, Subchapter C; does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government, but rather is proposed to be consistent with applicable federal rules in order to allow the state to maintain its authority to implement the federal Safe Drinking Water Act, pursuant to agreements between the commission and the EPA; and is not proposed solely under the general powers of the agency, but specifically under THSC, §341.031, which allows the commission to adopt and enforce rules to implement the federal Safe Drinking Water Act, as well as the other general powers of the commission.

The commission invites public comment regarding this Draft Regulatory Impact Analysis Determination. Written comments on the Draft Regulatory Impact Analysis Determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission evaluated this proposed rulemaking and performed a preliminary assessment of whether these proposed rules constitute a taking under Texas Government Code, Chapter 2007.

The commission proposes these rules for the specific purpose of maintaining the state's primary enforcement responsibility by incorporating federal drinking water regulations related to: 1) increasing public health protection through the reduction of potential pathways of entry for fecal contaminants into distribution systems of public drinking water systems in response to the RTCR, published by the EPA in the February 13, 2013, issue of the *Federal Register;* and 2) responding to comments from the EPA on state implementation of the GWR to ensure that the state rules are no less stringent than the federal. The proposed rules also clarify state rules governing lead and copper, TOC, and other state drinking water analytical and reporting requirements governed by federal requirements and/or addressed in federal guidance documents. In addition, the proposed rules clarify requirements for special precautions, protective measures, boil water notices, and special investigation requirements for elevated turbidity levels and for failure to provide compliance data. Finally, the proposed rules correct typographical errors, formatting, internal cross-references, and citation changes.

The commission's analysis indicates that Texas Government Code, Chapter 2007, does not apply to these proposed rules based upon exceptions to applicability in Texas Government Code, §2007.003(b). First, the proposed rulemaking is an action that is reasonably taken to fulfill an obligation mandated by federal law, Texas Government Code, §2007.003(b)(4). In order to maintain primacy over public drinking water, the state shall enact rules no less stringent than the federal drinking water regulations as required by 40 CFR §142.10. Second, the proposed rulemaking is an action that is taken in response to a real and substantial threat to public health and safety; that is designed to significantly advance the public health and safety purpose; and that does not impose a greater burden than is necessary to achieve the public health and safety purpose, Texas Government Code. §2007.003(b)(13). Though health and safety purpose is incidental to the rulemaking's goal of maintaining state primacy over drinking water regulation, fecal contamination in the distribution systems of public drinking water systems constitutes a real and substantial threat to public health and safety and requires appropriate governmental regulation. Reducing potential pathways for fecal contamination in drinking water distribution systems should reduce the potential risk from all waterborne pathogens including bacteria, viruses, parasitic protozoa, and their associated illnesses. The proposed rules significantly advance the public health and safety purpose by ensuring appropriate governmental regulation of these items, and do so in a way that does not impose a greater burden than is necessary to achieve the public health and safety purpose.

Further, the commission determined that promulgation and enforcement of these proposed rules would be neither a statutory nor a constitutional taking of private real property. Specifically, there are no burdens imposed on private real property under the rule because the proposed rules neither relate to, nor have any impact on, the use or enjoyment of private real property, and there would be no reduction in property value as a result of these rules. The rules require public water systems to comply with drinking water standards protective of human health and the environment, and the rules bring those standards into concurrence with the corresponding federal regulations. Therefore, the proposed rules would not constitute a taking under Texas Government Code, Chapter 2007.

Consistency with the Coastal Management Program

The commission reviewed the proposed rules and found that they are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the proposed rules are not subject to the Texas Coastal Management Program.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Announcement of Hearing

The commission will hold a public hearing on this proposal in Austin on November 7, 2016, at 2:00 p.m., in Austin, at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services at (512) 239-1802 or 1-800-RELAY-TX (TDD). Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Sherry Davis, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-4808. Electronic comments may be submitted at: *http://www1.tceq.texas.gov/rules/ecomments/.* File size restrictions may apply to comments being submitted via the eComments system. All comments should reference

Rule Project Number 2015-035-290-OW. The comment period closes on November 22, 2016. Copies of the proposed rulemaking can be obtained from the commission's website at *http://www.tceq.texas.gov/rules/propose_adopt.html.* For further information, please contact James Beauchamp, Office of Water, (512) 239-6174.

SUBCHAPTER D. RULES AND REGULATIONS FOR PUBLIC WATER SYSTEMS

30 TAC §§290.38, 290.42, 290.46, 290.47

Statutory Authority

These amendments are proposed under the Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; TWC, §5.105, which establishes the commission's authority to set policy by rule; Texas Health and Safety Code (THSC), §341.031, which allows the commission to adopt rules to implement the federal Safe Drinking Water Act, 42 United States Code, §§300f - 300j-26; and THSC, §341.0315, which requires public water systems to comply with commission rules adopted to ensure the supply of safe drinking water.

§290.38. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise. If a word or term used in this chapter is not contained in the following list, its definition shall be as shown in 40 Code of Federal Regulations (CFR) §141.2. Other technical terms used shall have the meanings or definitions listed in the latest edition of *The Water Dictionary: A Comprehensive Reference of Water Terminology,* prepared by the American Water Works Association.

(1) Affected utility--A retail public utility (§291.3 of this title (relating to Definitions of Terms)), exempt utility (§291.103(d)(1) of this title (relating to Certificates Not Required)), or provider or conveyor of potable or raw water service that furnishes water service to more than one customer:

(A) in a county with a population of 3.3 million or more; or

(B) in a county with a population of 550,000 or more adjacent to a county with a population of 3.3 million or more.

(2) Air gap--The unobstructed vertical distance through the free atmosphere between the lowest opening from any pipe or faucet conveying water to a tank, fixture, receptor, sink, or other assembly and the flood level rim of the receptacle. The vertical, physical separation must be at least twice the diameter of the water supply outlet, but never less than 1.0 inch.

(3) American National Standards Institute (ANSI) standards--The standards of the American National Standards Institute, Inc.

(4) American Society of Mechanical Engineers (ASME) standards--The standards of the ASME.

(5) American Water Works Association (AWWA) standards--The latest edition of the applicable standards as approved and published by the AWWA.

(6) Approved laboratory--A laboratory approved by the executive director to analyze water samples to determine their compliance with certain maximum or minimum allowable constituent levels.

(7) ASTM International standards--The standards of ASTM International (formerly known as the American Society for Testing and Materials).

(8) Auxiliary power--Either mechanical power or electric generators which can enable the system to provide water under pressure to the distribution system in the event of a local power failure. With the approval of the executive director, dual primary electric service may be considered as auxiliary power in areas which are not subject to large scale power outages due to natural disasters.

(9) Bag filter--Pressure-driven separation device that removes particulate matter larger than 1 micrometer using an engineered porous filtration media. They are typically constructed of a non-rigid, fabric filtration media housed in a pressure vessel in which the direction of flow is from the inside of the bag to the outside.

(10) Baseline performance--In reference to a membrane treatment facility, the detailed assessment of observed operational conditions at the time the membrane facility is placed in service for the purpose of tracking changes over time and determining when maintenance or service is required. Examples of parameters where baseline performance data is collected include: net driving pressure, normalized permeate flow, salt rejection, and salt passage.

(11) Cartridge filter--Pressure-driven separation device that removes particulate matter larger than 1 micrometer using an engineered porous filtration media. They are typically constructed as rigid or semi-rigid, self-supporting filter elements housed in pressure vessels in which flow is from the outside of the cartridge to the inside.

(12) Certified laboratory--A laboratory certified by the commission to analyze water samples to determine their compliance with maximum allowable constituent levels. After June 30, 2008, laboratories must be accredited, not certified, in order to perform sample analyses previously performed by certified laboratories.

(13) Challenge test--A study conducted to determine the removal efficiency (log removal value) of a device for a particular organism, particulate, or surrogate.

(14) Chemical disinfectant--Any oxidant, including but not limited to chlorine, chlorine dioxide, chloramines, and ozone added to the water in any part of the treatment or distribution process, that is intended to kill or inactivate pathogenic microorganisms.

(15) Community water system--A public water system which has a potential to serve at least 15 residential service connections on a year-round basis or serves at least 25 residents on a year-round basis.

(16) Connection--A single family residential unit or each commercial or industrial establishment to which drinking water is supplied from the system. As an example, the number of service connections in an apartment complex would be equal to the number of individual apartment units. When enough data is not available to accurately determine the number of connections to be served or being served, the population served divided by three will be used as the number of connections for calculating system capacity requirements. Conversely, if only the number of connections is known, the connection total multiplied by three will be the number used for population served. For the purposes of this definition, a dwelling or business which is connected to a system that delivers water by a constructed conveyance other than a pipe shall not be considered a connection if:

(A) the water is used exclusively for purposes other than those defined as human consumption (see human consumption);

(B) the executive director determines that alternative water to achieve the equivalent level of public health protection

provided by the drinking water standards is provided for residential or similar human consumption, including, but not limited to, drinking and cooking; or

(C) the executive director determines that the water provided for residential or similar human consumption is centrally treated or is treated at the point of entry by a provider, a pass through entity, or the user to achieve the equivalent level of protection provided by the drinking water standards.

(17) Contamination--The presence of any foreign substance (organic, inorganic, radiological, or biological) in water which tends to degrade its quality so as to constitute a health hazard or impair the usefulness of the water.

(18) Cross-connection--A physical connection between a public water system and either another supply of unknown or questionable quality, any source which may contain contaminating or polluting substances, or any source of water treated to a lesser degree in the treatment process.

(19) Direct integrity test--A physical test applied to a membrane unit in order to identify and isolate integrity breaches/leaks that could result in contamination of the filtrate.

(20) Disinfectant--A chemical or a treatment which is intended to kill or inactivate pathogenic microorganisms in water.

(21) Disinfection--A process which inactivates pathogenic organisms in the water by chemical oxidants or equivalent agents.

(22) Distribution system--A system of pipes that conveys potable water from a treatment plant to the consumers. The term includes pump stations, ground and elevated storage tanks, potable water mains, and potable water service lines and all associated valves, fittings, and meters, but excludes potable water customer service lines.

(23) Drinking water--All water distributed by any agency or individual, public or private, for the purpose of human consumption or which may be used in the preparation of foods or beverages or for the cleaning of any utensil or article used in the course of preparation or consumption of food or beverages for human beings. The term "drinking water" [~~"Drinking Water"~~] shall also include all water supplied for human consumption or used by any institution catering to the public.

(24) Drinking water standards--The commission rules covering drinking water standards in Subchapter F of this chapter (relating to Drinking Water Standards Governing Drinking Water Quality and Reporting Requirements for Public Water Systems).

(25) Elevated storage capacity--That portion of water which can be stored at least 80 feet above the highest service connection in the pressure plane served by the storage tank.

(26) Emergency operations--The operation of an affected utility during an extended power outage at a minimum water pressure of 35 pounds per square inch.

(27) Emergency power--Either mechanical power or electric generators which can enable the system to provide water under pressure to the distribution system in the event of a local power failure. With the approval of the executive director, dual primary electric service may be considered as emergency power in areas which are not subject to large scale power outages due to natural disasters.

(28) Extended power outage--A power outage lasting for more than 24 hours.

(29) Filtrate--The water produced from a filtration process; typically used to describe the water produced by filter processes such as membranes.

(30) Flux--The throughput of a pressure-driven membrane filtration system expressed as flow per unit of membrane area. For example, gallons per square foot per day or liters per hour per square meter.

(31) Grantee--For purposes of this chapter, any person receiving an ownership interest in a public water system, whether by sale, transfer, descent, probate, or otherwise.

(32) Grantor--For purposes of this chapter, any person who conveys an ownership interest in a public water system, whether by sale, transfer, descent, probate, or otherwise.

(33) [~~(31)~~] Groundwater--Any water that is located beneath the surface of the ground and is not under the direct influence of surface water.

(34) [~~(32)~~] Groundwater under the direct influence of surface water--Any water beneath the surface of the ground with:

(A) significant occurrence of insects or other macroorganisms, algae, or large-diameter pathogens such as *Giardia lamblia* or *Cryptosporidium;*

(B) significant and relatively rapid shifts in water characteristics such as turbidity, temperature, conductivity, or pH which closely correlate to climatological or surface water conditions; or

(C) site-specific characteristics including measurements of water quality parameters, well construction details, existing geological attributes, and other features that are similar to groundwater sources that have been identified by the executive director as being under the direct influence of surface water.

(35) [~~(33)~~] Health hazard--A cross-connection, potential contamination hazard, or other situation involving any substance that can cause death, illness, spread of disease, or has a high probability of causing such effects if introduced into the potable drinking water supply.

(36) [~~(34)~~] Human consumption--Uses by humans in which water can be ingested into or absorbed by the human body. Examples of these uses include, but are not limited to drinking, cooking, brushing teeth, bathing, washing hands, washing dishes, and preparing foods.

(37) [~~(35)~~] Indirect integrity monitoring--The monitoring of some aspect of filtrate water quality, such as turbidity, that is indicative of the removal of particulate matter.

(38) [~~(36)~~] Innovative/alternate treatment--Any treatment process that does not have specific design requirements in §290.42(a) - (f) of this title (relating to Water Treatment).

(39) [~~(37)~~] Interconnection--A physical connection between two public water supply systems.

(40) [~~(38)~~] International Fire Code (IFC)--The standards of the International Code Council.

(41) [~~(39)~~] Intruder-resistant fence--A fence six feet or greater in height, constructed of wood, concrete, masonry, or metal with three strands of barbed wire extending outward from the top of the fence at a 45 degree angle with the smooth side of the fence on the outside wall. In lieu of the barbed wire, the fence must be eight feet in height. The fence must be in good repair and close enough to surface grade to prevent intruder passage.

(42) [~~(40)~~] L/d ratio--The dimensionless value that is obtained by dividing the length (depth) of a granular media filter bed by the weighted effective diameter "d" of the filter media. The weighted effective diameter of the media is calculated based on the percentage of the total bed depth contributed by each media layer.

(43) [~~(41)~~] Licensed professional engineer--An engineer who maintains a current license through the Texas Board of Professional Engineers in accordance with its requirements for professional practice.

(44) [~~(42)~~] Log removal value (LRV)--Removal efficiency for a target organism, particulate, or surrogate expressed as $\log_{10}$ (i.e., $\log_{10}$ (feed concentration) - $\log_{10}$ (filtrate concentration)).

(45) [~~(43)~~] Maximum daily demand--In the absence of verified historical data or in cases where a public water system has imposed mandatory water use restrictions within the past 36 months, maximum daily demand means 2.4 times the average daily demand of the system.

(46) [~~(44)~~] Maximum contaminant level (MCL)--The MCL for a specific contaminant is defined in the section relating to that contaminant.

(47) [~~(45)~~] Membrane filtration--A pressure or vacuum driven separation process in which particulate matter larger than one micrometer is rejected by an engineered barrier, primarily through a size-exclusion mechanism, and which has a measurable removal efficiency of a target organism that can be verified through the application of a direct integrity test; includes the following common membrane classifications microfiltration (MF), ultrafiltration (UF), nanofiltration (NF), and reverse osmosis (RO), as well as any "membrane cartridge filtration" (MCF) device that satisfies this definition.

(48) [~~(46)~~] Membrane $LRV_{C\text{-}Test}$--The number that reflects the removal efficiency of the membrane filtration process demonstrated during challenge testing. The value is based on the entire set of log removal values (LRVs) obtained during challenge testing, with one representative LRV established per module tested.

(49) [~~(47)~~] Membrane module--The smallest component of a membrane unit in which a specific membrane surface area is housed in a device with a filtrate outlet structure.

(50) [~~(48)~~] Membrane sensitivity--The maximum log removal value that can be reliably verified by a direct integrity test.

(51) [~~(49)~~] Membrane unit--A group of membrane modules that share common valving, which allows the unit to be isolated from the rest of the system for the purpose of integrity testing or other maintenance.

(52) [~~(50)~~] Milligrams per liter (mg/L)--A measure of concentration, equivalent to and replacing parts per million in the case of dilute solutions.

(53) [~~(51)~~] Monthly reports of water works operations--The daily record of data relating to the operation of the system facilities compiled in a monthly report.

(54) [~~(52)~~] National Fire Protection Association (NFPA) standards--The standards of the NFPA.

(55) [~~(53)~~] NSF International--The organization and the standards, certifications, and listings developed by NSF International (formerly known as the National Sanitation Foundation) related to drinking water.

(56) [~~(54)~~] Noncommunity water system--Any public water system which is not a community system.

(57) [~~(55)~~] Nonhealth hazard--A cross-connection, potential contamination hazard, or other situation involving any substance that generally will not be a health hazard, but will constitute a nuisance, or be aesthetically objectionable, if introduced into the public water supply.

(58) [~~(56)~~] Nontransient, noncommunity water system--A public water system that is not a community water system and regularly serves at least 25 of the same persons at least six months out of the year.

(59) [~~(57)~~] Pass--In reference to a reverse osmosis or nanofiltration membrane system, stages of pressure vessels in series in which the permeate from one stage is further processed in a following stage.

(60) [~~(58)~~] Peak hourly demand--In the absence of verified historical data, peak hourly demand means 1.25 times the maximum daily demand (prorated to an hourly rate) if a public water supply meets the commission's minimum requirements for elevated storage capacity and 1.85 times the maximum daily demand (prorated to an hourly rate) if the system uses pressure tanks or fails to meet the commission's minimum elevated storage capacity requirement.

(61) [~~(59)~~] Plumbing inspector--Any person employed by a political subdivision for the purpose of inspecting plumbing work and installations in connection with health and safety laws and ordinances, who has no financial or advisory interest in any plumbing company, and who has successfully fulfilled the examinations and requirements of the Texas State Board of Plumbing Examiners.

(62) [~~(60)~~] Plumbing ordinance--A set of rules governing plumbing practices which is at least as stringent and comprehensive as one of the following nationally recognized codes:

(A) the International Plumbing Code; or

(B) the Uniform Plumbing Code.

(63) [~~(61)~~] Potable water customer service line--The sections of potable water pipe between the customer's meter and the customer's point of use.

(64) [~~(62)~~] Potable water service line--The section of pipe between the potable water main and [~~to~~] the customer's side of the water meter. In cases where no customer water meter exists, it is the section of pipe that is under the ownership and control of the public water system.

(65) [~~(63)~~] Potable water main--A pipe or enclosed constructed conveyance operated by a public water system which is used for the transmission or distribution of drinking water to a potable water service line.

(66) [~~(64)~~] Potential contamination hazard--A condition which, by its location, piping or configuration, has a reasonable probability of being used incorrectly, through carelessness, ignorance, or negligence, to create or cause to be created a backflow condition by which contamination can be introduced into the water supply. Examples of potential contamination hazards are:

(A) bypass arrangements;

(B) jumper connections;

(C) removable sections or spools; and

(D) swivel or changeover assemblies.

(67) [~~(65)~~] Process control duties--Activities that directly affect the potability of public drinking water, including: making decisions regarding the day-to-day operations and maintenance of public water system production and distribution; maintaining system pressures; determining the adequacy of disinfection and disinfection proce-

dures; taking routine microbiological samples; taking chlorine residuals and microbiological samples after repairs or installation of lines or appurtenances; and operating chemical feed systems, filtration, disinfection, or pressure maintenance equipment; or performing other duties approved by the executive director.

(68) [~~(66)~~] psi--Pounds per square inch.

(69) [~~(67)~~] Public drinking water program--Agency staff designated by the executive director to administer the Safe Drinking Water Act and state statutes related to the regulation of public drinking water. Any report required to be submitted in this chapter to the executive director must be submitted to the Texas Commission on Environmental Quality, Water Supply Division, MC 155, P.O. Box 13087, Austin, Texas 78711-3087.

(70) [~~(68)~~] Public health engineering practices--Requirements in this chapter [~~subchapter~~] or guidelines promulgated by the executive director.

(71) [~~(69)~~] Public water system--A system for the provision to the public of water for human consumption through pipes or other constructed conveyances, which includes all uses described under the definition for drinking water. Such a system must have at least 15 service connections or serve at least 25 individuals at least 60 days out of the year. This term includes: any collection, treatment, storage, and distribution facilities under the control of the operator of such system and used primarily in connection with such system, and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Two or more systems with each having a potential to serve less than 15 connections or less than 25 individuals but owned by the same person, firm, or corporation and located on adjacent land will be considered a public water system when the total potential service connections in the combined systems are 15 or greater or if the total number of individuals served by the combined systems total 25 or greater at least 60 days out of the year. Without excluding other meanings of the terms "individual" or "served," an individual shall be deemed to be served by a water system if he lives in, uses as his place of employment, or works in a place to which drinking water is supplied from the system.

(72) [~~(70)~~] Quality Control Release Value (QCRV)--A minimum quality standard of a non-destructive performance test established by the manufacturer for membrane module production that ensures that the module will attain the targeted log removal value demonstrated during challenge testing.

(73) [~~(71)~~] Reactor Validation Testing--A process by which a full-scale ultraviolet (UV) reactor's disinfection performance is determined relative to operating parameters that can be monitored. These parameters include flow rate, UV intensity as measured by a UV sensor and the UV lamp status.

(74) [~~(72)~~] Resolution--The size of the smallest integrity breach that contributes to a response from a direct integrity test in membranes used to treat surface water or groundwater under the direct influence of surface water.

(75) [~~(73)~~] Sanitary control easement--A legally binding document securing all land, within 150 feet of a public water supply well location, from pollution hazards. This document must fully describe the location of the well and surrounding lands and must be filed in the county records to be legally binding. For an example, see commission Form 20698.

(76) [~~(74)~~] Sanitary survey--An onsite review of a public water system's adequacy for producing and distributing safe drinking water by evaluating the following elements: water source; treatment; distribution system; finished water storage; pump, pump facilities, and controls; monitoring, reporting, and data verification; system management, operation and maintenance; and operator compliance.

(77) [~~(75)~~] Sensitivity--The maximum log removal value (LRV) that can be reliably verified by a direct integrity test in membranes used to treat surface water or groundwater under the direct influence of surface water; also applies to some continuous indirect integrity monitoring methods.

(78) [~~(76)~~] Service line--A pipe connecting the utility service provider's main and the water meter, or for wastewater, connecting the main and the point at which the customer's service line is connected, generally at the customer's property line.

(79) [~~(77)~~] Service pump--Any pump that takes treated water from storage and discharges to the distribution system.

(80) [~~(78)~~] Significant deficiency--Significant deficiencies cause, or have the potential to cause, the introduction of contamination into water delivered to customers. This may include defects in design, operation, or maintenance of the source, treatment, storage, or distribution systems.

(81) [~~(79)~~] Stage--In reference to a reverse osmosis or nanofiltration membrane system, a set of pressure vessels installed in parallel.

(82) System--Public water system as defined in this section unless otherwise modified (i.e., distribution system).

(83) [~~(80)~~] Transfer pump--Any pump which conveys water from one point to another within the treatment process or which conveys water to storage facilities prior to distribution.

(84) [~~(81)~~] Transient, noncommunity water system--A public water system that is not a community water system and serves at least 25 persons at least 60 days out of the year, yet by its characteristics, does not meet the definition of a nontransient, noncommunity water system.

(85) [~~(82)~~] Vessel--In reference to a reverse osmosis or nanofiltration membrane system, a cylindrical housing unit where membrane modules are placed in a series to form one unit.

(86) [~~(83)~~] Wastewater lateral--Any pipe or constructed conveyance carrying wastewater, running laterally down a street, alley, or easement, and receiving flow only from the abutting properties.

(87) [~~(84)~~] Wastewater main--Any pipe or constructed conveyance which receives flow from one or more wastewater laterals.

(88) Water system--Public water system as defined in this section unless otherwise modified (i.e., distribution system).

§290.42. Water Treatment.

(a) Capacity and location.

(1) Based on current acceptable design standards, the total capacity of the public water system's treatment facilities must always be greater than its anticipated maximum daily demand.

(2) The water treatment plant and all pumping units shall be located in well-drained areas not subject to flooding and away from seepage areas or where the groundwater water table is near the surface.

(A) Water treatment plants shall not be located within 500 feet of a sewage treatment plant or lands irrigated with sewage effluent. A minimum distance of 150 feet must be maintained between any septic tank drainfield line and any underground treatment or storage unit. Any sanitary sewers located within 50 feet of any underground treatment or storage unit shall be constructed of ductile iron or

polyvinyl chloride (PVC) pipe with a minimum pressure rating of 150 pounds per square inch (psi) and have watertight joints.

(B) Plant site selection shall also take into consideration the need for disposition of all plant wastes in accordance with all applicable regulations and state statutes, including both liquid and solid wastes, or by-product material from operation and/or maintenance.

(3) Each water treatment plant shall be located at a site that is accessible by an all-weather road.

(b) Groundwater.

(1) Disinfection facilities shall be provided for all groundwater supplies for the purpose of microbiological control and distribution protection and shall be in conformity with applicable disinfection requirements in subsection (e) of this section and in a manner consistent with the requirements of §290.110 of this title (relating to Disinfectant Residuals).

(2) Treatment facilities shall be provided for groundwater if the water does not meet the drinking water standards. The facilities provided shall be in conformance with established and proven methods.

(A) Filters provided for turbidity and microbiological quality control shall be preceded by coagulant addition and shall conform to the requirements of subsection (d)(11) of this section. Filtration rates for iron and manganese removal, regardless of the media or type of filter, shall be based on a maximum rate of five gallons per minute per square foot (gpm/sq ft).

(B) The removal of iron and manganese may not be required if it can be demonstrated that these metals can be sequestered so that the discoloration problems they cause do not exist in the distribution system.

(C) All processes involving exposure of the water to atmospheric contamination shall provide for subsequent disinfection of the water ahead of ground storage tanks. Likewise, all exposure of water to atmospheric contamination shall be accomplished in a manner such that insects, birds, and other foreign materials will be excluded from the water. Aerators and all other such openings shall be screened with 16-mesh or finer corrosion-resistant screen.

(D) If reverse osmosis or nanofiltration membrane systems are used, the design shall conform to the requirements in paragraph (9) of this subsection.

(3) Any proposed change in the extent of water treatment required will be determined on the basis of geological data, well construction features, nearby sources of contamination, and on qualitative and quantitative microbiological and chemical analyses.

(4) Appropriate laboratory facilities shall be provided for controls as well as to check the effectiveness of disinfection or any other treatment processes employed.

(5) All plant piping shall be constructed to minimize leakage.

(6) All groundwater systems shall provide sampling taps for raw water, treated water, and at a point representing water entering the distribution system at every entry point.

(7) Air release devices shall be installed in such a manner as to preclude the possibility of submergence or possible entrance of contaminants. In this respect, all openings to the atmosphere shall be covered with 16-mesh or finer corrosion-resistant screening material or an equivalent acceptable to the executive director.

(8) The executive director may require 4-log removal or inactivation of viruses based on raw water sampling results required by §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques).

(9) Reverse osmosis or nanofiltration membrane systems used for the treatment of primary and secondary contaminants defined in Subchapter F of this chapter (relating to Drinking Water Standards Governing Drinking Water Quality and Reporting Requirements for Public Water Systems), must meet the design criteria in subparagraphs (A) - (L) of this paragraph.

(A) The design for all reverse osmosis and nanofiltration membrane systems must be in accordance with the findings of the engineering report. Variations from the engineering report must be explained and shall not compromise public health. Minimum engineering report requirements are found in §290.39(e)(1) and (6) of this title (relating to General Provisions).

(B) The reverse osmosis and nanofiltration membrane systems must be designed to ensure adequate cleaning of the membrane system.

(C) The reverse osmosis or nanofiltration membrane systems must be designed to operate at flux rates which assure effective filtration at all times based on at least one of the following:

(i) manufacturer's computer models for new and end-of-life membranes;

(ii) site-specific pilot study;

(iii) comparable design data from an alternative site; or

(iv) the manufacturer's allowable operating parameters, if the membrane unit's capacity is rated less than 300 gallons per minute [~~(gpm)~~].

(D) Pretreatment shall be provided such that the feed water quality to the membrane units shall meet the minimum allowable requirements of the membrane manufacturer. Pretreatment processes shall be sized correctly for the flow of the plant, and the components and chemicals used for pretreatment in contact with the water must conform to American National Standards Institute/NSF International (ANSI/NSF) Standard 60 for Drinking Water Treatment Chemicals or ANSI/NSF Standard 61 for Drinking Water System Components. Other pretreatment processes will be reviewed on an individual basis in accordance the innovative/alternate treatment requirements specified in subsection (g) of this section. Acceptable pretreatment techniques include:

(i) bags, cartridge filters, or screens for particulate removal;

(ii) chemical addition that will not adversely affect the reverse osmosis or nanofiltration membrane;

(iii) filters for iron and manganese removal in accordance with paragraph (2)(A) of this subsection;

(iv) aeration or degasification; and

(v) ion exchange softening.

(E) The treatment plant must include post-treatment facilities for corrosivity control, re-mineralization and the removal of dissolved gases, such as carbon dioxide and hydrogen sulfide, if necessary to meet the system's water quality goals. The treatment must be sized correctly for the flow of the plant, and the components and chemicals used for treatment must conform to ANSI/NSF Standard 60 for Drinking Water Treatment Chemicals or ANSI/NSF Standard 61 for Drinking Water System Components.

(F) Pipes and pipe galleries shall meet the minimum requirements specified in subsection (d)(12) and (13) of this section.

(G) Each reverse osmosis or nanofiltration membrane unit shall be equipped to measure conductivity or total dissolved solids in the feed and the permeate water.

(H) Chemical storage and chemical feed facilities shall comply with subsection (f) of this section.

(I) Provide cross-connection protection for common piping used for cleaning and normal production modes.

(J) Provide flow meters on the pipes for feed, permeate, and concentrate water. Additional metering devices shall be provided as appropriate to monitor the flow rate through specific treatment processes. Metering devices shall be located to facilitate use and to assist in the determination of chemical dosages, the accumulation of water production data, and the operation of plant facilities.

(K) The water system must provide pressure measuring and recording devices before and after each membrane stage.

(L) The water system must provide equipment to monitor the temperature of the water. The temperature of the water must be measured using a thermometer or thermocouple with a minimum accuracy of plus or minus 0.5 degrees Celsius.

(c) Springs and other water sources.

(1) Water obtained from springs, infiltration galleries, wells in fissured areas, wells in carbonate rock formations, or wells that do not penetrate impermeable strata or any other source subject to surface or near surface contamination of recent origin shall be evaluated for the provision of treatment facilities. Minimum treatment shall consist of coagulation with direct filtration and adequate disinfection. In all cases, the treatment process shall be designed to achieve at least a 2-log removal of *Cryptosporidium* oocysts, a 3-log removal or inactivation of *Giardia* cysts, and a 4-log removal or inactivation of viruses before the water is supplied to any consumer. The executive director may require additional levels of treatment in cases of poor source water quality. Based on raw water monitoring results, the executive director may require additional levels of treatment for *Cryptosporidium* treatment as specified in §290.111 of this title (relating to Surface Water Treatment).

(A) Filters provided for turbidity and microbiological quality control shall conform to the requirements of subsection (d)(11) of this section.

(B) All processes involving exposure of the water to atmospheric contamination shall provide for subsequent disinfection of the water ahead of ground storage tanks. Likewise, all exposure of water to atmospheric contamination shall be accomplished in a manner such that insects, birds, and other foreign materials will be excluded from the water. Aerators and all other such openings shall be screened with 16-mesh or finer corrosion-resistant screen.

(2) Any proposed change in the extent of water treatment required will be determined on the basis of geological data, well construction features, nearby sources of contamination, and qualitative and quantitative microbiological and chemical analyses.

(3) Appropriate laboratory facilities shall be provided for controls as well as for checking the effectiveness of disinfection or any other treatment processes employed.

(4) All plant piping shall be constructed to minimize leakage. No cross-connection or interconnection shall be permitted to exist between a conduit carrying potable water and another conduit carrying raw water or water in a prior stage of treatment.

(5) All systems using springs and other water sources shall provide sampling taps for raw water, treated water, and at a point representing water entering the distribution system at every entry point.

(6) Return of the decanted water or sludge to the treatment process shall be adequately controlled so that there will be a minimum of interference with the treatment process and shall conform to the applicable requirements of subsection (d)(3) of this section. Systems that do not comply with the provisions of subsection (d)(3) of this section commit a treatment technique violation and must notify their customers in accordance with the requirements of §290.122(b) of this title (relating to Public Notification).

(7) Air release devices on treated waterlines shall be installed in such a manner as to preclude the possibility of submergence or possible entrance of contaminants. In this respect, all openings to the atmosphere shall be covered with 16-mesh or finer corrosion-resistant screening material or an equivalent acceptable to the executive director.

(8) Reverse osmosis and nanofiltration membrane systems not provided for microbiological quality control shall conform to the requirements of subsection (b) of this section.

(d) Surface water.

(1) All water secured from surface sources shall be given complete treatment at a plant which provides facilities for pretreatment disinfection, taste and odor control, continuous coagulation, sedimentation, filtration, covered clearwell storage, and terminal disinfection of the water with chlorine or suitable chlorine compounds. In all cases, the treatment process shall be designed to achieve at least a 2-log removal of *Cryptosporidium* oocysts, a 3-log removal or inactivation of *Giardia* cysts, and a 4-log removal or inactivation of viruses before the water is supplied to any consumer. The executive director may require additional levels of treatment in cases of poor source water quality. Based on raw water monitoring results, the executive director may require additional levels of treatment for *Cryptosporidium* treatment as specified in §290.111 of this title.

(2) All plant piping shall be constructed so as to be thoroughly tight against leakage. No cross-connection or interconnection shall be permitted to exist in a filtration plant between a conduit carrying filtered or post-chlorinated water and another conduit carrying raw water or water in any prior stage of treatment.

(A) Vacuum breakers must be provided on each hose bibb within the plant facility.

(B) No conduit or basin containing raw water or any water in a prior stage of treatment shall be located directly above, or be permitted to have a single common partition wall with another conduit or basin containing finished water.

(C) Make-up water supply lines to chemical feeder solution mixing chambers shall be provided with an air gap or other acceptable backflow prevention device.

(D) Filters shall be located so that common walls will not exist between them and aerators, mixing and sedimentation basins or clearwells. This rule is not strictly applicable, however, to partitions open to view and readily accessible for inspection and repair.

(E) Filter-to-waste connections, if included, shall be provided with an air gap connection to waste.

(F) Air release devices on treated waterlines shall be installed in such a manner as to preclude the possibility of submergence or possible entrance of contaminants. In this respect, all openings to the atmosphere shall be covered with 16-mesh or finer corrosion-re-

sistant screening material or an equivalent acceptable to the executive director.

(3) Return of the decanted water or solids to the treatment process shall be adequately controlled so that there will be a minimum of interference with the treatment process. Systems that do not comply with the provisions of this paragraph commit a treatment technique violation and must notify their customers in accordance with the requirements of §290.122(b) of this title.

(A) Unless the executive director has approved an alternate recycling location, spent backwash water and the liquids from sludge settling lagoons, spent backwash water tanks, sludge thickeners, and similar dewatering facilities shall be returned to the raw waterline upstream of the raw water sample tap and coagulant feed point. The blended recycled liquids shall pass through all of the major unit processes at the plant.

(B) Recycle facilities shall be designed to minimize the magnitude and impact of hydraulic surges that occur during the recycling process.

(C) Solids produced by dewatering facilities such as sludge lagoons, sludge thickeners, centrifuges, mechanical presses, and similar devices shall not be returned to the treatment plant without the prior approval of the executive director.

(4) Reservoirs for pretreatment or selective quality control shall be provided where complete treatment facilities fail to operate satisfactorily at times of maximum turbidities or other abnormal raw water quality conditions exist. Recreational activities at such reservoirs shall be prohibited.

(5) Flow-measuring devices shall be provided to measure the raw water supplied to the plant, the recycled decant water, the treated water used to backwash the filters, and the treated water discharged from the plant. Additional metering devices shall be provided as appropriate to monitor the flow rate through specific treatment processes. Metering devices shall be located to facilitate use and to assist in the determination of chemical dosages, the accumulation of water production data, and the operation of plant facilities.

(6) Chemical storage facilities shall comply with applicable requirements in subsection (f)(1) of this section.

(7) Chemical feed facilities shall comply with the applicable requirements in subsection (f)(2) of this section.

(8) Flash mixing equipment shall be provided.

(A) Plants with a design capacity greater than 3.0 million gallons per day (MGD) must provide at least one hydraulic mixing unit or at least two sets of mechanical flash mixing equipment designed to operate in parallel. Public water systems with other surface water treatment plants, interconnections with other systems, or wells that can meet the system's average daily demand are exempt from the requirement for redundant mechanical flash mixing equipment.

(B) Flash mixing equipment shall have sufficient flexibility to ensure adequate dispersion and mixing of coagulants and other chemicals under varying raw water characteristics and raw water flow rates.

(9) Flocculation equipment shall be provided.

(A) Plants with a design capacity greater than 3.0 MGD must provide at least two sets of flocculation equipment which are designed to operate in parallel. Public water systems with other surface water treatment plants, interconnections with other systems, or wells that can meet the system's average daily demand are exempt from the requirement for redundant flocculation equipment.

(B) Flocculation facilities shall be designed to provide adequate time and mixing intensity to produce a settleable floc under varying raw water characteristics and raw water flow rates.

(i) Flocculation facilities for straight-flow and up-flow sedimentation basins shall provide a minimum theoretical detention time of at least 20 minutes when operated at their design capacity. Flocculation facilities constructed prior to October 1, 2000, are exempt from this requirement if the settled water turbidity of each sedimentation basin remains below 10.0 nephelometric turbidity units and the treatment plant meets with turbidity requirements of §290.111 of this title.

(ii) The mixing intensity in multiple-stage flocculators shall decrease as the coagulated water passes from one stage to the next.

(C) Coagulated water or water from flocculators shall flow to sedimentation basins in such a manner as to prevent destruction of floc. Piping, flumes, and troughs shall be designed to provide a flow velocity of 0.5 to 1.5 feet per second. Gates, ports, and valves shall be designed at a maximum flow velocity of 4.0 feet per second in the transfer of water between units.

(10) Clarification facilities shall be provided.

(A) Plants with a design capacity greater than 3.0 MGD must provide at least two sedimentation basins or clarification units which are designed to operate in parallel. Public water systems with other surface water treatment plants, interconnections with other systems, or wells that can meet the system's average daily demand are exempt from the requirement for redundant sedimentation basins or clarification units.

(B) The inlet and outlet of clarification facilities shall be designed to prevent short-circuiting of flow or the destruction of floc.

(C) Clarification facilities shall be designed to remove flocculated particles effectively.

(i) When operated at their design capacity, basins for straight-flow or up-flow sedimentation of coagulated waters shall provide either a theoretical detention time of at least six hours in the flocculation and sedimentation chambers or a maximum surface overflow rate of 0.6 gpm/sq ft of surface area in the sedimentation chamber.

(ii) When operated at their design capacity, basins for straight-flow or up-flow sedimentation of softened waters shall provide either a theoretical detention time of at least 4.5 hours in the flocculation and sedimentation chambers or a maximum surface overflow rate of 1.0 gpm/sq ft of surface area in the sedimentation chamber.

(iii) When operated at their design capacity, sludge-blanket and solids-recirculation clarifiers shall provide either a theoretical detention time of at least two hours in the flocculation and sedimentation chambers or a maximum surface overflow rate of 1.0 gpm/sq ft in the settling chamber.

(iv) A side wall water depth of at least 12 feet shall be provided in clarification basins that are not equipped with mechanical sludge removal facilities.

(v) The effective length of a straight-flow sedimentation basin shall be at least twice its effective width.

(D) Clarification facilities shall be designed to prevent the accumulation of settled solids.

(i) At treatment plants with a single clarification basin, facilities shall be provided to drain the basin within six hours. In the event that the plant site topography is such that gravity draining

cannot be realized, a permanently installed electric-powered pump station shall be provided to dewater the basin. Public water systems with other potable water sources that can meet the system's average daily demand are exempt from this requirement.

(ii) Facilities for sludge removal shall be provided by mechanical means or by hopper-bottomed basins with valves capable of complete draining of the units.

(11) Gravity or pressure type filters shall be provided.

(A) The use of pressure filters shall be limited to installations with a treatment capacity of less than 0.50 MGD.

(B) Filtration facilities shall be designed to operate at filtration rates which assure effective filtration at all times.

(i) The design capacity of gravity rapid sand filters shall not exceed a maximum filtration rate of 2.0 gpm/sq ft. At the beginning of filter runs for declining rate filters, a maximum filtration rate of 3.0 gpm/sq ft is allowed.

(ii) Where high-rate gravity filters are used, the design capacity shall not exceed a maximum filtration rate of 5.0 gpm/sq ft. At the beginning of filter runs for declining rate filters, a maximum filtration rate of 6.5 gpm/sq ft is allowed.

(iii) The design capacity of pressure filters shall not exceed a maximum filtration rate of 2.0 gpm/sq ft with the largest filter off-line.

(iv) Except as provided in clause (vi) of this subparagraph, any surface water treatment plant that provides, or is being designed to provide, less than 7.5 MGD must be able to meet either the maximum daily demand or the minimum required 0.6 gpm per connection, whichever is larger, with all filters on-line.

(v) Any surface water treatment plant that provides, or is being designed to provide, 7.5 MGD or more must be able to meet either the maximum daily demand or the minimum required 0.6 gpm per connection, whichever is larger, with the largest filter off-line.

(vi) Any surface water treatment plant that uses pressure filters must be able to meet either the maximum daily demand or the minimum required 0.6 gpm per connection, whichever is larger, with the largest filter off-line.

(C) The depth and condition of the media and support material shall be sufficient to provide effective filtration.

(i) The filtering material shall conform to American Water Works Association (AWWA) standards and be free from clay, dirt, organic matter, and other impurities.

(ii) The grain size distribution of the filtering material shall be as prescribed by AWWA standards.

(iii) The depth of filter sand, anthracite, granular activated carbon, or other filtering materials shall be 24 inches or greater and provide an L/d ratio, as defined in §290.38 of this title (relating to Definitions), of at least 1,000.

(I) Rapid sand filters typically contain a minimum of eight inches of fine sand with an effective size of 0.35 to 0.45 millimeter (mm), eight inches of medium sand with an effective size of 0.45 to 0.55 mm, and eight inches of coarse sand with an effective size of 0.55 to 0.65 mm. The uniformity coefficient of each size range should not exceed 1.6.

(II) High-rate dual media filters typically contain a minimum of 12 inches of sand with an effective size of 0.45 to 0.55 mm and 24 inches of anthracite with an effective size of 0.9 to 1.1 mm. The uniformity coefficient of each material should not exceed 1.6.

(III) High-rate multi-media filters typically contain a minimum of three inches of garnet media with an effective size of 0.2 to 0.3 mm, nine inches of sand with an effective size of 0.5 to 0.6 mm, and 24 inches of anthracite with an effective size of 0.9 to 1.1 mm. The uniformity coefficient of each size range should not exceed 1.6.

(IV) High-rate mono-media anthracite or granular activated carbon filters typically contain a minimum of 48 inches of anthracite or granular activated carbon with an effective size of 1.0 to 1.2 mm. The uniformity coefficient of each size range should not exceed 1.6.

(iv) Under the filtering material, at least 12 inches of support gravel shall be placed varying in size from 1/16 inch to 2.5 inches. The gravel may be arranged in three to five layers such that each layer contains material about twice the size of the material above it. Other support material may be approved on an individual basis.

(D) The filter shall be provided with facilities to regulate the filtration rate.

(i) With the exception of declining rate filters, each filter unit shall be equipped with a manually adjustable rate-of-flow controller with rate-of-flow indication or flow control valves with indicators.

(ii) Each declining rate filter shall be equipped with a rate-of-flow limiting device or an adjustable flow control valve with a rate-of-flow indicator.

(iii) The effluent line of each filter installed after January 1, 1996, must be equipped with a slow opening valve or another means of automatically preventing flow surges when the filter begins operation.

(E) The filters shall be provided with facilities to monitor the performance of the filter. Monitoring devices shall be designed to provide the ability to measure and record turbidity as required by §290.111 of this title.

(i) Each filter shall be equipped with a sampling tap so that the effluent turbidity of the filter can be individually monitored.

(ii) Each filter operated by a public water system that serves fewer than 10,000 people shall be equipped with an on-line turbidimeter and recorder which will allow the operator to measure and record the turbidity at 15-minute intervals. The executive director may allow combined filter effluent monitoring in lieu of individual filter effluent monitoring under the following conditions:

(I) The public water system has only two filters that were installed prior to October 1, 2000, and were never equipped with individual on-line turbidimeters and recorders; and

(II) The plant is equipped with an on-line turbidimeter and recorder which will allow the operator to measure and record the turbidity level of the combined filter effluent at a location prior to clearwell storage at 15-minute intervals.

(iii) Each filter operated by a public water system that serves at least 10,000 people shall be equipped with an on-line turbidimeter and recorder which will allow the operator to measure and record the turbidity at 15-minute intervals.

(iv) Each filter installed after October 1, 2000, shall be equipped with an on-line turbidimeter and recorder which will allow the operator to determine the turbidity at 15-minute intervals.

(v) Each filter unit that is not equipped with an on-line turbidimeter and recorder shall be equipped with a device to indicate loss of head through the filter. In lieu of loss-of-head indicators, declining rate filter units may be equipped with rate-of-flow indicators.

(F) Filters shall be designed to ensure adequate cleaning during the backwash cycle.

(i) Only filtered water shall be used to backwash the filters. This water may be supplied by elevated wash water tanks, by the effluent of other filters, or by pumps which take suction from the clearwell and are provided for backwashing filters only. For installations having a treatment capacity no greater than 150,000 gallons per day, water for backwashing may be secured directly from the distribution system if proper controls and rate-of-flow limiters are provided.

(ii) The rate of filter backwashing shall be regulated by a rate-of-flow controller or flow control valve.

(iii) The rate of flow of backwash water shall not be less than 20 inches vertical rise per minute (12.5 gpm/sq ft) and usually not more than 35 inches vertical rise per minute (21.8 gpm/sq ft).

(iv) The backwash facilities shall be capable of expanding the filtering bed during the backwash cycle.

(I) For facilities equipped with air scour, the backwash facilities shall be capable of expanding the filtering bed at least 15% during the backwash cycle.

(II) For mixed-media filters without air scour, the backwash facilities shall be capable of expanding the filtering bed at least 25% during the backwash cycle.

(III) For mono-media sand filters without air scour, the backwash facilities shall be capable of expanding the filtering bed at least 40% during the backwash cycle.

(v) The filter freeboard in inches shall exceed the wash rate in inches of vertical rise per minute.

(vi) When used, surface filter wash systems shall be installed with an atmospheric vacuum breaker or a reduced pressure principle backflow assembly in the supply line. If an atmospheric vacuum breaker is used, it shall be installed in a section of the supply line through which all the water passes and which is located above the overflow level of the filter.

(vii) Gravity filters installed after January 1, 1996, shall be equipped with air scour backwash or surface wash facilities.

(G) Each filter installed after October 1, 2000, shall be equipped with facilities that allow the filter to be completely drained without removing other filters from service.

(12) Pipe galleries shall provide ample working room, good lighting, and good drainage provided by sloping floors, gutters, and sumps. Adequate ventilation to prevent condensation and to provide humidity control is also required.

(13) The identification of influent, effluent, waste backwash, and chemical feed lines shall be accomplished by the use of labels or various colors of paint. Where labels are used, they shall be placed along the pipe at no greater than five-foot intervals. Color coding must be by solid color or banding. If bands are used, they shall be placed along the pipe at no greater than five-foot intervals.

(A) A plant that is built or repainted after October 1, 2000, must use the following color code. The color code to be used in labeling pipes is as follows:
Figure: 30 TAC §290.42(d)(13)(A) (No change.)

(B) A plant that was repainted before October 1, 2000, may use an alternate color code. The alternate color code must provide clear visual distinction between process streams.

(C) The system must maintain clear, current documentation of its color code in a location easily accessed by all personnel.

(14) All surface water treatment plants shall provide sampling taps for raw, settled, individual filter effluent, and clearwell discharge. Additional sampling taps shall be provided as appropriate to monitor specific treatment processes.

(15) An adequately equipped laboratory shall be available locally so that daily microbiological and chemical tests can be conducted.

(A) For plants serving 25,000 persons or more, the local laboratory used to conduct the required daily microbiological analyses must be accredited by the executive director to conduct coliform analyses.

(B) For plants serving populations of less than 25,000, the facilities for making microbiological tests may be omitted if the required microbiological samples can be submitted to a laboratory accredited by the executive director on a timely basis.

(C) All surface water treatment plants shall be provided with equipment for making at least the following determinations:

(i) pH;

(ii) temperature;

(iii) disinfectant residual;

(iv) alkalinity;

(v) turbidity;

(vi) jar tests for determining the optimum coagulant dose; and

(vii) other tests deemed necessary to monitor specific water quality problems or to evaluate specific water treatment processes.

(D) Each surface water treatment plant that uses chlorine dioxide shall provide testing equipment for measuring chlorine dioxide and chlorite levels [~~An amperometric titrator with platinum-platinum electrodes shall be provided at all surface water treatment plants that use chlorine dioxide~~].

(E) Each surface water treatment plant that uses sludge-blanket clarifiers shall be equipped with facilities to monitor the depth of the sludge blanket.

(F) Each surface water treatment plant that uses solids-recirculation clarifiers shall be equipped with facilities to monitor the solids concentration in the slurry.

(16) Each surface water treatment plant shall be provided with a computer and software for recording performance data, maintaining records, and submitting reports to the executive director. The executive director may allow a water system to locate the computer at a site other than the water treatment plant only if performance data can be reliably transmitted to the remote location on a real-time basis, the plant operator has access to the computer at all times, and performance data is readily accessible to agency staff during routine and special investigations.

(17) Reverse osmosis and nanofiltration membrane systems not provided for microbiological quality control shall conform to the requirements of subsection (b)(9) of this section.

(e) Disinfection.

(1) All water obtained from surface sources or groundwater sources that are under the direct influence of surface water must be disinfected in a manner consistent with the requirements of §290.110 of this title [~~(relating to Disinfectant Residuals)~~].

(2) All groundwater must be disinfected prior to distribution and in a manner consistent with the requirements of §290.110 of this title. The point of application must be ahead of the water storage tank(s) if storage is provided prior to distribution. Permission to use alternate disinfectant application points must be obtained in writing from the executive director.

(3) Disinfection equipment shall be selected and installed so that continuous and effective disinfection can be secured under all conditions.

(A) Disinfection equipment shall have a capacity at least 50% greater than the highest expected dosage to be applied at any time. It shall be capable of satisfactory operation under every prevailing hydraulic condition.

(B) Automatic proportioning of the disinfectant dosage to the flow rate of the water being treated shall be provided at plants where the treatment rate varies automatically and at all plants where the treatment rate varies more than 50% above or below the average flow. Manual control shall be permissible only if an operator is always on hand to make adjustments promptly.

(C) All disinfecting equipment in surface water treatment plants shall include at least one functional standby unit of each capacity for ensuring uninterrupted operation. Common standby units are permissible but, generally, more than one standby unit must be provided because of the differences in feed rates or the physical state in which the disinfectants are being fed (solid, liquid, or gas).

(D) Facilities shall be provided for determining the amount of disinfectant used daily and the amount of disinfectant remaining for use.

(E) When used, solutions of calcium hypochlorite shall be prepared in a separate mixing tank and allowed to settle so that only a clear supernatant liquid is transferred to the hypochlorinator container.

(F) Provisions shall be made for both pretreatment disinfection and post-disinfection in all surface water treatment plants. Additional application points shall be installed if they are required to adequately control the quality of the treated water.

(G) The use of disinfectants other than free chlorine and chloramines will be considered on a case-by-case basis under the exception guidelines of §290.39(l) of this title. If water containing chloramines and water containing free chlorine are blended, then a case-by-case review under §290.39(l) of this title will be required.

(4) Systems that use chlorine gas must ensure that the risks associated with its use are limited as follows.

(A) When chlorine gas is used, a full-face self-contained breathing apparatus or supplied air respirator that meets Occupational Safety and Health Administration (OSHA) standards for construction and operation, and a small bottle of fresh ammonia solution (or approved equal) for testing for chlorine leakage shall be readily accessible outside the chlorinator room and immediately available to the operator in the event of an emergency.

(B) Housing for gas chlorination equipment and cylinders of chlorine shall be in separate buildings or separate rooms with impervious walls or partitions separating all mechanical and electrical equipment from the chlorine facilities. Housing shall be located above ground level as a measure of safety. Equipment and cylinders may be installed on the outside of the buildings when protected from adverse weather conditions and vandalism.

(C) Adequate ventilation, which includes both high level and floor level screened vents, shall be provided for all enclosures in which gas chlorine is being stored or fed. Enclosures containing more than one operating 150-pound cylinder of chlorine shall also provide forced air ventilation which includes: screened and louvered floor level and high level vents; a fan which is located at and draws air in through the top vent and discharges to the outside atmosphere through the floor level vent; and a fan switch located outside the enclosure. Alternately, systems may install negative pressure ventilation as long as the facilities also have gas containment and treatment as prescribed by the current International Fire Code (IFC).

(5) Hypochlorination solution containers and pumps must be housed in a secure enclosure to protect them from adverse weather conditions and vandalism. The solution container top must be completely covered to prevent the entrance of dust, insects, and other contaminants.

(6) Where anhydrous ammonia feed equipment is utilized, it must be housed in a separate enclosure equipped with both high and low level ventilation to the outside atmosphere. The enclosure must be provided with forced air ventilation which includes: screened and louvered floor level and high level vents; a fan which is located at and draws air in through the floor vent and discharges through the top vent; and a fan switch located outside the enclosure. Alternately, systems may install negative pressure ventilation as long as the facilities also have gas containment and treatment as prescribed by the current IFC.

(7) Chloramine disinfection shall be performed in a manner which assures that the proper chlorine to ammonia (as nitrogen) ratio is achieved in order to maintain a monochloramine residual and limit nitrification.

(A) The order of chlorine and ammonia injection must be accomplished in a manner which allows inactivation of viruses and oxidation of cyanide.

(i) When chlorine is injected upstream of any other disinfectant, the ammonia injection point must be downstream of the chlorine injection point.

(ii) When chlorine and ammonia are added to distribution water that has a chloramine residual, ammonia should be added first.

(iii) When chlorine and ammonia are added to distribution water that has a free chlorine residual, chlorine should be added first.

(B) Mixing shall be provided to disperse chemicals.

(C) Sampling taps must be provided at locations that allow for chlorine and ammonia to be added to the water to form monochloramine as the primary chloramine species. These locations must be listed in the system's monitoring plan as described in §290.121 of this title (relating to Monitoring Plans). Sample taps must be provided as follows:

(i) upstream of the chlorine or ammonia chemical injection point, whichever is furthest upstream;

(ii) between the addition of the chloramine chemicals at chloramination facilities submitted for plan review after December 31, 2015. For these facilities, an installation without this sample tap may be approved if an acceptable technical reason is described in the plan review documents. Technical reasons, such as disinfection

byproduct control, must be supported by bench scale sampling results. Other technical reasons, such as membrane integrity, must be supported by documentation; and

(iii) at a point after mixing to be able to measure fully-formed monochloramine levels.

(D) When using chloramines, the feed and storage must be designed as described in subsection (f) of this section, regardless of water source.

(E) When using chloramines, the public water systems shall provide equipment for making at least the following determinations for purposes of complying with the requirements in §290.110 of this title:

(i) free ammonia (as nitrogen);

(ii) monochloramine;

(iii) total chlorine;

(iv) free chlorine; and

(v) nitrite and nitrate (both as nitrogen). The public water systems must either obtain equipment for measuring nitrite and nitrate or identify an accredited laboratory that can perform nitrite and nitrate analysis and can provide results to the public water systems within 48 hours of sample delivery.

(f) Water treatment plant chemical storage and feed facilities.

(1) Chemical storage facilities shall be designed to ensure a reliable supply of chemicals to the feeders, minimize the possibility and impact of accidental spills, and facilitate good housekeeping.

(A) Bulk storage facilities at the plant shall be adequate to store at least a 15-day supply of all chemicals needed to comply with minimum treatment technique and maximum contaminant level (MCL) requirements. The capacity of these bulk storage facilities shall be based on the design capacity of the treatment plant. However, the executive director may require a larger stock of chemicals based on local resupply ability.

(B) Day tanks shall be provided to minimize the possibility of severely overfeeding liquid chemicals from bulk storage facilities. Day tanks will not be required if adequate process control instrumentation and procedures are employed to prevent chemical overfeed incidents.

(C) Every chemical bulk storage facility and day tank shall have a label that identifies the facility's or tank's contents and a device that indicates the amount of chemical remaining in the facility or tank.

(D) Dry chemicals shall be stored off the floor in a dry room that is located above ground and protected against flooding or wetting from floors, walls, and ceilings.

(E) Bulk storage facilities and day tanks must be designed to minimize the possibility of leaks and spills.

(i) The materials used to construct bulk storage and day tanks must be compatible with the chemicals being stored and resistant to corrosion.

(ii) Except as provided in this clause, adequate containment facilities shall be provided for all liquid chemical storage tanks.

(I) Containment facilities for a single container or for multiple interconnected containers must be large enough to hold the maximum amount of chemical that can be stored with a minimum freeboard of six vertical inches or to hold 110% of the total volume of the container(s), whichever is less.

(II) Common containment for multiple containers that are not interconnected must be large enough to hold the volume of the largest container with a minimum freeboard of six vertical inches or to hold 110% of the total volume of the container(s), whichever is less.

(III) The materials used to construct containment structures must be compatible with the chemicals stored in the tanks.

(IV) Incompatible chemicals shall not be stored within the same containment structure.

(V) No containment facilities are required for hypochlorite solution containers that have a capacity of 55 gallons or less.

(VI) On a site-specific basis, the executive director may approve the use of double-walled tanks in lieu of separate containment facilities.

(F) Chemical transfer pumps and control systems must be designed to minimize the possibility of leaks and spills.

(G) Piping, pumps, and valves used for chemical storage and transfer must be compatible with the chemical being fed.

(2) Chemical feed and metering facilities shall be designed so that chemicals shall be applied in a manner which will maximize reliability, facilitate maintenance, and ensure optimal finished water quality.

(A) Each chemical feeder that is needed to comply with a treatment technique or MCL requirement shall have a standby or reserve unit. Common standby feeders are permissible, but generally, more than one standby feeder must be provided due to the incompatibility of chemicals or the state in which they are being fed (solid, liquid, or gas).

(B) Chemical feed equipment shall be sized to provide proper dosage under all operating conditions.

(i) Devices designed for determining the chemical feed rate shall be provided for all chemical feeders.

(ii) The capacity of the chemical feeders shall be such that accurate control of the dosage can be achieved at the full range of feed rates expected to occur at the facility.

(iii) Chemical feeders shall be provided with tanks for chemical dissolution when applicable.

(C) Chemical feeders, valves, and piping must be compatible with the chemical being fed.

(D) Chemical feed systems shall be designed to minimize the possibility of leaks and spills and provide protection against backpressure and siphoning.

(E) If enclosed feed lines are used, they shall be designed and installed so as to prevent clogging and be easily maintained.

(F) Dry chemical feeders shall be located in a separate room that is provided with facilities for dust control.

(G) Coagulant feed systems shall be designed so that coagulants are applied to the water prior to or within the mixing basins or chambers so as to permit their complete mixing with the water.

(i) Coagulant feed points shall be located downstream of the raw water sampling tap.

(ii) Coagulants shall be applied continuously during treatment plant operation.

(H) Chlorine feed units, ammonia feed units, and storage facilities shall be separated by solid, sealed walls.

(I) Chemical application points shall be provided to achieve acceptable finished water quality, adequate taste and odor control, corrosion control, and disinfection.

(g) Other treatment processes. Innovative/alternate treatment processes will be considered on an individual basis, in accordance with §290.39(l) of this title. Where innovative/alternate treatment systems are proposed, the licensed professional engineer must provide pilot test data or data collected at similar full-scale operations demonstrating that the system will produce water that meets the requirements of Subchapter F of this chapter. Pilot test data must be representative of the actual operating conditions which can be expected over the course of the year. The executive director may require a pilot study protocol to be submitted for review and approval prior to conducting a pilot study to verify compliance with the requirements of §290.39(l) of this title and Subchapter F of this chapter. The executive director may require proof of a one-year manufacturer's performance warrantee or guarantee assuring that the plant will produce treated water which meets minimum state and federal standards for drinking water quality.

(1) Package-type treatment systems and their components shall be subject to all applicable design criteria in this section.

(2) Bag and cartridge filtration systems or modules installed or replaced after April 1, 2012, and used for microbiological treatment, can receive up to 3.0-log *Giardia* removal credit, up to 2.0-log *Cryptosporidium* removal credit for individual bag or cartridge filters, and up to 2.5-log *Cryptosporidium* removal credit for bag or cartridge filters operated in series only if the cartridges or bags meet the criteria in subparagraphs (A) - (C) of this paragraph.

(A) The filter system must treat the entire plant flow.

(B) To be eligible for this credit, systems must receive approval from the executive director based on the results of challenge testing that is conducted according to the criteria established by 40 Code of Federal Regulations (CFR) §141.719(a) and the executive director.

(i) A factor of safety equal to 1.0-log for individual bag or cartridge filters and 0.5-log for bag or cartridge filters in series must be applied to challenge testing results to determine removal credit.

(ii) Challenge testing must be performed on full-scale bag or cartridge filters, and the associated filter housing or pressure vessel, that are identical in material and construction to the filters and housings the system will use for removal of *Cryptosporidium* and *Giardia.*

(iii) Bag or cartridge filters must be challenge tested in the same configuration that the system will use, either as individual filters or as a series configuration of filters.

(iv) Systems may use results from challenge testing conducted prior to January 5, 2006, if prior testing was consistent with 40 CFR §141.719, submitted by the system's licensed professional engineer, and approved by the executive director.

(v) If a previously tested filter is modified in a manner that could change the removal efficiency of the filter product line, additional challenge testing to demonstrate the removal efficiency of the modified filter must be conducted and results submitted to the executive director for approval.

(C) Pilot studies must be conducted using filters that will meet the requirements of this section.

(3) Membrane filtration systems or modules installed or replaced after April 1, 2012, and used for microbiological treatment, can receive *Cryptosporidium* and *Giardia* removal credit for membrane filtration only if the systems or modules meet the criteria in subparagraphs (A) - (F) of this paragraph.

(A) The membrane module used by the system must undergo challenge testing to evaluate removal efficiency. Challenge testing must be conducted according to the criteria established by 40 CFR §141.719(b)(2) and the executive director.

(i) All membrane module challenge test protocols and results, the protocol for calculating the representative Log Removal Value (LRV) for each membrane module, the removal efficiency, calculated results of Membrane $LRV_{C\text{-}Test}$, and the non-destructive performance test with its Quality Control Release Value (QCRV) must be submitted to the executive director for review and approval prior to beginning a membrane filtration pilot study at a public water system.

(ii) Challenge testing must be conducted on either a full-scale membrane module identical in material and construction to the membrane modules to be used in the system's treatment facility, or a smaller-scale membrane module identical in material and similar in construction to the full-scale module if approved by the executive director.

(iii) Systems may use data from challenge testing conducted prior to January 5, 2006, if prior testing was consistent with 40 CFR §141.719, submitted by the system's licensed professional engineer, and approved by the executive director.

(iv) If a previously tested membrane is modified in a manner that could change the removal efficiency of the membrane product line or the applicability of the non-destructive performance test and associated QCRV, additional challenge testing to demonstrate the removal efficiency of the modified membrane and determine a new QCRV for the modified membrane must be conducted and results submitted to the executive director for approval.

(B) The membrane system must be designed to conduct and record the results of direct integrity testing in a manner that demonstrates a removal efficiency equal to or greater than the removal credit awarded to the membrane filtration system approved by the executive director and meets the requirements in clauses (i) and (ii) of this subparagraph.

(i) The design must provide for direct integrity testing of each membrane unit.

(ii) The design must provide direct integrity testing that has a resolution of 3 micrometers or less.

(iii) The design must provide direct integrity testing with sensitivity sufficient to verify the log removal credit approved by the executive director. Sensitivity is determined by the criteria in 40 CFR §141.719(b)(3)(iii).

(iv) The executive director may reduce the direct integrity testing requirements for membrane units.

(C) The membrane system must be designed to conduct and record continuous indirect integrity monitoring on each membrane unit. The turbidity of the water produced by each membrane unit must be measured using the Hach FilterTrak Method 10133. The executive director may approve the use of alternative technology to monitor the quality of the water produced by each membrane unit.

(D) The level of removal credit approved by the executive director shall not exceed the lower of:

(i) the removal efficiency demonstrated during challenge testing conducted under the conditions in subparagraph (A) of this paragraph, or

(ii) the maximum removal efficiency that can be verified through direct integrity testing used with the membrane filtration process under the conditions in subparagraph (B) of this paragraph.

(E) Pilot studies must be conducted using membrane modules that will meet the requirements of this section.

(F) Membrane systems must be designed so that membrane units' feed water, filtrate, backwash supply, waste, and chemical cleaning piping shall have cross-connection protection to prevent chemicals from all chemical cleaning processes from contaminating other membrane units in other modes of operation. This may be accomplished by the installation of a double block and bleed valving arrangement, a removable spool system, or other alternative methods approved by the executive director.

(4) Bag, cartridge, or membrane filtration systems or modules installed or replaced before April 1, 2012, and used for microbiological treatment, can receive up to a 2.0-log removal credit for *Cryptosporidium* and up to a 3.0-log removal credit for *Giardia* based on site-specific pilot study results, design, operation, and reporting requirements.

(5) Ultraviolet (UV) light reactors used for microbiological inactivation can receive *Cryptosporidium, Giardia,* and virus inactivation credit if the reactors meet the criteria in subparagraphs (A) - (C) of this paragraph.

(A) UV light reactors can receive inactivation credit only if they are located after filtration.

(B) In lieu of a pilot study, the UV light reactors must undergo validation testing to determine the operating conditions under which a UV reactor delivers the required UV dose. Validation testing must be conducted according to the criteria established by 40 CFR §141.720(d)(2) and the executive director.

(i) The validation study must include the following factors: UV absorbance of the water; lamp fouling and aging; measurement uncertainty of on-line sensors; UV dose distributions arising from the velocity profiles through the reactor; failure of UV lamps and other critical system components; inlet and outlet piping or channel configuration of the UV reactor; lamp and sensor locations; and other parameters determined by the executive director.

(ii) Validation testing must be conducted on a full-scale reactor that is essentially identical to the UV reactor(s) to be used by the system and using waters that are essentially identical in quality to the water to be treated by the UV reactor.

(C) The UV light reactor systems must be designed to monitor and record parameters to verify the UV reactors operation within the validated conditions approved by the executive director. The UV light reactor must be equipped with facilities to monitor and record UV intensity as measured by a UV sensor, flow rate, lamp status, and other parameters designated by the executive director.

(6) Membrane filtration used by groundwater systems to achieve at least 4-log removal of viruses to comply with the groundwater rule requirements under §290.109 of this title (relating to Microbial Contaminants) and §290.116 of this title, the public water system shall meet the following criteria.

(A) The membrane module must have an absolute molecular weight cut-off, or an alternate parameter that describes the exclusion characteristics of the membrane, that can reliably achieve at least 4-log removal of viruses.

(B) The membrane system must be designed to conduct and record the results of integrity testing in a manner that demonstrates a removal efficiency equal to or greater than the removal credit awarded to the membrane system approved by the executive director.

(h) Sanitary facilities for water works installations. Toilet and hand washing facilities provided in accordance with established standards of good public health engineering practices shall be available at all installations requiring frequent visits by operating personnel.

(i) Permits for waste discharges. Any discharge of wastewater and other plant wastes shall be in accordance with all applicable state and federal statutes and regulations. Permits for discharging wastes from water treatment processes shall be obtained from the commission, if necessary.

(j) Treatment chemicals and media. All chemicals and any additional or replacement process media used in treatment of water supplied by public water systems must conform to ANSI/NSF Standard 60 for Drinking Water Treatment Chemicals and ANSI/NSF Standard 61 for Drinking Water System Components. Conformance with these standards must be obtained by certification of the product by an organization accredited by ANSI.

(k) Safety.

(1) Safety equipment for all chemicals used in water treatment shall meet applicable standards established by the OSHA or Texas Hazard Communication Act, Texas Health and Safety Code, Chapter 502.

(2) Systems must comply with United States Environmental Protection Agency (EPA) requirements for Risk Management Plans.

(l) Plant operations manual. A thorough plant operations manual must be compiled and kept up-to-date for operator review and reference. This manual should be of sufficient detail to provide the operator with routine maintenance and repair procedures, with protocols to be utilized in the event of a natural or man-made catastrophe, as well as provide telephone numbers of water system personnel, system officials, and local/state/federal agencies to be contacted in the event of an emergency. If operating a reverse osmosis or nanofiltration membrane system, the manual must also include the system's configuration, baseline performance data, and any set point for membrane cleaning or replacement.

(m) Security. Each water treatment plant and all appurtenances thereof shall be enclosed by an intruder-resistant fence. The gates shall be locked during periods of darkness and when the plant is unattended. A locked building in the fence line may satisfy this requirement or serve as a gate.

(n) Corrosion control treatment. Systems must install any corrosion control or source water treatment required by §290.117(f) and (g) of this title (relating to Regulation of Lead and Copper), respectively. Such treatment must be designed and installed consistent with the requirements of this subchapter. The requirements of 40 CFR §141.82(i) and §141.83(b)(7) relating to EPA involvement in treatment determination are adopted by reference.

§290.46. Minimum Acceptable Operating Practices for Public Drinking Water Systems.

(a) General. When a public drinking water supply system is to be established, plans shall be submitted to the executive director for review and approval prior to the construction of the system. All public

water systems are to be constructed in conformance with the requirements of this subchapter and maintained and operated in accordance with the following minimum acceptable operating practices. Owners and operators shall allow entry to members of the commission and employees and agents of the commission onto any public or private property at any reasonable time for the purpose of inspecting and investigating conditions relating to public water systems in the state including the required elements of a sanitary survey as defined in §290.38 of this title (relating to Definitions). Members, employees, or agents acting under this authority shall observe the establishment's rules and regulations concerning safety, internal security, and fire protection, and if the property has management in residence, shall notify management or the person then in charge of his presence and shall exhibit proper credentials.

(b) Microbiological. Submission of samples for microbiological analysis shall be as required by Subchapter F of this chapter (relating to Drinking Water Standards Governing Drinking Water Quality and Reporting Requirements for Public Water Systems). Microbiological samples may be required by the executive director for monitoring purposes in addition to the routine samples required by the drinking water standards. These samples shall be submitted to an accredited laboratory. (A list of the accredited laboratories can be obtained by contacting the executive director.) The samples shall be submitted to the executive director in a manner prescribed by the executive director.

(c) Chemical. Samples for chemical analysis shall be submitted as directed by the executive director.

(d) Disinfectant residuals and monitoring. A disinfectant residual must be continuously maintained during the treatment process and throughout the distribution system.

(1) Disinfection equipment shall be operated and monitored in a manner that will assure compliance with the requirements of §290.110 of this title (relating to Disinfectant Residuals).

(2) The disinfection equipment shall be operated to maintain the following minimum disinfectant residuals in each finished water storage tank and throughout the distribution system at all times:

(A) a free chlorine residual of 0.2 milligrams per liter (mg/L); or

(B) a chloramine residual of 0.5 mg/L (measured as total chlorine) for those systems that distribute chloraminated water.

(e) Operation by trained and licensed personnel. Except as provided in paragraph (1) of this subsection, the production, treatment, and distribution facilities at the public water system must be operated at all times under the direct supervision of a water works operator who holds an applicable, valid license issued by the executive director. Except as provided in paragraph (1) of this subsection, all public water systems must use a water works operator who holds an applicable, valid license issued by the executive director to meet the requirements of this subsection. The licensed operator of a public water system may be an employee, contractor, or volunteer.

(1) Transient, noncommunity public water systems are exempt from the requirements of this subsection if they use only groundwater or purchase treated water from another public water system.

(2) All public water systems that are subject to the provisions of this subsection shall meet the following requirements.

(A) Public water systems shall not allow new or repaired production, treatment, storage, pressure maintenance, or distribution facilities to be placed into service without the prior guidance and approval of a licensed water works operator.

(B) Public water systems shall ensure that their operators are trained regarding the use of all chemicals used in the water treatment plant. Training programs shall meet applicable standards established by the Occupational Safety and Health Administration or the Texas Hazard Communication Act, Texas Health and Safety Code, Chapter 502.

(C) Public water systems using chlorine dioxide shall place the operation of the chlorine dioxide facilities under the direct supervision of a licensed operator who has a Class "C" or higher license.

(D) Effective September 1, 2016, reverse osmosis or nanofiltration membrane systems must have operators that have successfully completed at least one executive director-approved training course or event specific to the operations and maintenance of reverse osmosis or nanofiltration membrane treatment.

(3) Systems that only purchase treated water shall meet the following requirements in addition to the requirements contained in paragraph (2) of this subsection.

(A) Purchased water systems serving no more than 250 connections must use an operator who holds a Class "D" or higher license.

(B) Purchased water systems serving more than 250 connections, but no more than 1,000 connections, must use an operator who holds a Class "C" or higher license.

(C) Purchased water systems serving more than 1,000 connections must use at least two operators who hold a Class "C" or higher license and who each work at least 16 hours per month at the public water system's treatment or distribution facilities.

(4) Systems that treat groundwater and do not treat surface water or groundwater that is under the direct influence of surface water shall meet the following requirements in addition to the requirements contained in paragraph (2) of this subsection.

(A) Groundwater systems serving no more than 250 connections must use an operator with a Class "D" or higher license.

(B) Groundwater systems serving more than 250 connections, but no more than 1,000 connections, must use an operator with a Class "C" or higher groundwater license.

(C) Groundwater systems serving more than 1,000 connections must use at least two operators who hold a Class "C" or higher groundwater license and who each work at least 16 hours per month at the public water system's production, treatment, or distribution facilities.

(5) Systems that treat groundwater that is under the direct influence of surface water must meet the following requirements in addition to the requirements contained in paragraph (2) of this subsection.

(A) Systems which serve no more than 1,000 connections and utilize cartridge or membrane filters must use an operator who holds a Class "C" or higher groundwater license and has completed a four-hour training course on monitoring and reporting requirements or who holds a Class "C" or higher surface water license and has completed the Groundwater Production course.

(B) Systems which serve more than 1,000 connections and utilize cartridge or membrane filters must use at least two operators who meet the requirements of subparagraph (A) of this paragraph and who each work at least 24 hours per month at the public water system's production, treatment, or distribution facilities.

(C) Systems which serve no more than 1,000 connections and utilize coagulant addition and direct filtration must use an operator who holds a Class "C" or higher surface water license and has completed the Groundwater Production course or who holds a Class "C" or higher groundwater license and has completed a Surface Water Production course. Effective January 1, 2007, the public water system must use at least one operator who has completed the Surface Water Production I course and the Surface Water Production II course.

(D) Systems which serve more than 1,000 connections and utilize coagulant addition and direct filtration must use at least two operators who meet the requirements of subparagraph (C) of this paragraph and who each work at least 24 hours per month at the public water system's production, treatment, or distribution facilities. Effective January 1, 2007, the public water system must use at least two operators who have completed the Surface Water Production I course and the Surface Water Production II course.

(E) Systems which utilize complete surface water treatment must comply with the requirements of paragraph (6) of this subsection.

(F) Each plant must have at least one Class "C" or higher operator on duty at the plant when it is in operation or the plant must be provided with continuous turbidity and disinfectant residual monitors with automatic plant shutdown and alarms to summon operators so as to ensure that the water produced continues to meet the commission's drinking water standards during periods when the plant is not staffed.

(6) Systems that treat surface water must meet the following requirements in addition to the requirements contained in paragraph (2) of this subsection.

(A) Surface water systems that serve no more than 1,000 connections must use at least one operator who holds a Class "B" or higher surface water license. Part-time operators may be used to meet the requirements of this subparagraph if the operator is completely familiar with the design and operation of the plant and spends at least four consecutive hours at the plant at least once every 14 days and the system also uses an operator who holds a Class "C" or higher surface water license. Effective January 1, 2007, the public water system must use at least one operator who has completed the Surface Water Production I course and the Surface Water Production II course.

(B) Surface water systems that serve more than 1,000 connections must use at least two operators; one of the required operators must hold a Class "B" or higher surface water license and the other required operator must hold a Class "C" or higher surface water license. Each of the required operators must work at least 32 hours per month at the public water system's production, treatment, or distribution facilities. Effective January 1, 2007, the public water system must use at least two operators who have completed the Surface Water Production I course and the Surface Water Production II course.

(C) Each surface water treatment plant must have at least one Class "C" or higher surface water operator on duty at the plant when it is in operation or the plant must be provided with continuous turbidity and disinfectant residual monitors with automatic plant shutdown and alarms to summon operators so as to ensure that the water produced continues to meet the commission's drinking water standards during periods when the plant is not staffed.

(D) Public water systems shall not allow Class "D" operators to adjust or modify the treatment processes at surface water treatment plant unless an operator who holds a Class "C" or higher surface license is present at the plant and has issued specific instructions regarding the proposed adjustment.

(f) Operating records and reports. All public water [~~Water~~] systems must maintain a record of water works operation and maintenance activities and submit periodic operating reports.

(1) The public water system's operating records must be organized, and copies must be kept on file or stored electronically.

(2) The public water system's operating records must be accessible for review during inspections and be available to the executive director upon request.

(3) All public water systems shall maintain a record of operations.

(A) The following records shall be retained for at least two years:

(i) the amount of chemicals used:

(I) Systems that treat surface water or groundwater under the direct influence of surface water shall maintain a record of the amount of each chemical used each day.

(II) Systems that serve 250 or more connections or serve 750 or more people shall maintain a record of the amount of each chemical used each day.

(III) Systems that serve fewer than 250 connections, serve fewer than 750 people, and use only groundwater or purchased treated water shall maintain a record of the amount of each chemical used each week;

(ii) the volume of water treated and distributed:

(I) Systems that treat surface water or groundwater under the direct influence of surface water shall maintain a record of the amount of water treated and distributed each day.

(II) Systems that serve 250 or more connections or serve 750 or more people shall maintain a record of the amount of water distributed each day.

(III) Systems that serve fewer than 250 connections, serve fewer than 750 people, and use only groundwater or purchase treated water shall maintain a record of the amount of water distributed each week.

(IV) Systems that serve 250 or more connections or serve 750 or more people and also add chemicals or provide pathogen or chemical removal shall maintain a record of the amount of water treated each day.

(V) Systems that serve fewer than 250 connections, serve fewer than 750 people, use only groundwater or purchase treated water, and also add chemicals or provide pathogen or chemical removal shall maintain a record of the amount of water treated each week;

(iii) the date, location, and nature of water quality, pressure, or outage complaints received by the system and the results of any subsequent complaint investigation;

(iv) the dates that dead-end mains were flushed;

(v) the dates that storage tanks and other facilities were cleaned;

(vi) the maintenance records for water system equipment and facilities. For systems using reverse osmosis or nanofiltration, maintain records of each clean-in-place process including the date, duration, and procedure used for each event;

(vii) for systems that do not employ full-time operators to meet the requirements of subsection (e) of this section, a daily record or a monthly summary of the work performed and the number of hours worked by each of the part-time operators used to meet the requirements of subsection (e) of this section; and

(viii) the owner or manager of a public water system that is operated by a volunteer to meet the requirements of subsection (e) of this section, shall maintain a record of each volunteer operator indicating the name of the volunteer, contact information for the volunteer, and the time period for which the volunteer is responsible for operating the public water system. These requirements apply to full-time and part-time licensed volunteer operators. Part-time licensed volunteer operators are excluded from the requirements of clause (vii) of this subparagraph.

(B) The following records shall be retained for at least three years:

(i) copies of notices of violation and any resulting corrective actions. The records of the actions taken to correct violations of primary drinking water regulations must be retained for at least three years after the last action taken with respect to the particular violation involved;

(ii) copies of any public notice issued by the water system;

(iii) the disinfectant residual monitoring results from the distribution system;

(iv) the calibration records for laboratory equipment, flow meters, rate-of-flow controllers, on-line turbidimeters, and on-line disinfectant residual analyzers;

(v) the records of backflow prevention device programs;

(vi) the raw surface water monitoring results and source water monitoring plans required by §290.111 of this title (relating to Surface Water Treatment) must be retained for three years after bin classification required by §290.111 of this title;

(vii) notification to the executive director that a system will provide 5.5-log *Cryptosporidium* treatment in lieu of raw surface water monitoring;

(viii) except for those specified in subparagraphs (C)(iv) and (E)(i) of this paragraph, the results of all surface water treatment monitoring that are used to demonstrate log inactivation or removal;

(ix) free and total chlorine, monochloramine, ammonia, nitrite, and nitrate monitoring results if chloramines are used in the water system; and

(x) the records of treatment effectiveness monitoring for systems using reverse osmosis or nanofiltration membranes. Treatment effectiveness monitoring includes the parameters for determining when maintenance is required. Examples of parameters to be monitored include conductivity (or total dissolved solids) on each membrane unit, pressure differential across a membrane vessel, flow, flux, and water temperature. At a minimum, systems using reverse osmosis or nanofiltration membranes must monitor the conductivity (or total dissolved solids) of the feed and permeate water once per day.

(C) The following records shall be retained for a period of five years after they are no longer in effect:

(i) the records concerning a variance or exemption granted to the system;

(ii) Concentration Time (CT) studies for surface water treatment plants;

(iii) the Recycling Practices Report form and other records pertaining to site-specific recycle practices for treatment plants that recycle; and

(iv) the turbidity monitoring results and exception reports for individual filters as required by §290.111 of this title.

(D) The following records shall be retained for at least five years:

(i) the results of microbiological analyses;

(ii) the results of inspections (as required in subsection (m)(1) of this section) for all water storage and pressure maintenance facilities;

(iii) the results of inspections (as required by subsection (m)(2) of this section) for all pressure filters;

(iv) documentation of compliance with state approved corrective action plan and schedules required to be completed by groundwater systems that must take corrective actions;

(v) documentation of the reason for an invalidated fecal indicator source sample and documentation of a total coliform-positive sample collected at a location with conditions that could cause such positive samples in a distribution system;

(vi) notification to wholesale system(s) of a distribution coliform-positive [~~coliform positive~~] sample for consecutive systems using groundwater;

(vii) Consumer Confidence Report compliance documentation;

(viii) records of the lowest daily residual disinfectant concentration and records of the date and duration of any failure to maintain the executive director-approved minimum specified disinfectant residual for a period of more than four hours for groundwater systems providing 4-log treatment; [~~and~~]

(ix) records of executive director-specified compliance requirements for membrane filtration, records of parameters specified by the executive director for approved alternative treatment and records of the date and duration of any failure to meet the membrane operating, membrane integrity, or alternative treatment operating requirements for more than four hours for groundwater systems. Membrane filtration can only be used if it is approved by the executive director and if it can be properly validated;[~~.~~]

(x) assessment forms and documentation of corrective actions completed as a result of those assessments and any other available summary documentation of the sanitary defects and corrective actions taken in accordance with §290.109 of this title (relating to Microbial Contaminants) for executive director review; and

(xi) seasonal public water systems shall maintain executive director-approved start-up procedures and certification documentation in accordance with §290.109 of this title for executive director review.

(E) The following records shall be retained for at least ten years:

(i) copies of Monthly Operating Reports and any supporting documentation including turbidity monitoring results of the combined filter effluent;

(ii) the results of chemical analyses;

(iii) any written reports, summaries, or communications relating to sanitary surveys of the system conducted by the system itself, by a private consultant, or by the executive director shall be kept for a period not less than ten years after completion of the survey involved;

(iv) copies of the Customer Service Inspection reports required by subsection (j) of this section;

(v) copy of any Initial Distribution System Evaluation (IDSE) plan, report, approval letters, and other compliance documentation required by §290.115 of this title (relating to Stage 2 Disinfection Byproducts (TTHM and HAA5));

(vi) state notification of any modifications to an IDSE report;

(vii) copy of any 40/30 certification required by §290.115 of this title;

(viii) documentation of corrective actions taken by groundwater systems in accordance with §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques);

(ix) any Sample Siting Plans required by §290.109(d)(6) of this title and monitoring plans required by §290.121(b) of this title (relating to Monitoring Plans); and

(x) records of the executive director-approved minimum specified disinfectant residual and executive director-approved membrane system integrity monitoring results for groundwater systems providing 4-log treatment, including wholesale, and consecutive [, ~~and mixed~~] systems, regulated under §290.116(c) of this title.

(F) A public water system shall maintain records relating to lead and copper requirements under §290.117 of this title (relating to Regulation of Lead and Copper) for no less than 12 years. Any system subject to the requirements of §290.117 of this title shall retain on its premises original records of all sampling data and analyses, reports, surveys, letters, evaluations, schedules, executive determinations, and any other information required by the executive director under §290.117 of this title. These records include, but are not limited to, the following items: tap water monitoring results including the location of each site and date of collection; certification of the volume and validity of first-draw-tap sample criteria via a copy of the laboratory analysis request form; where residents collected the sample; certification that the water system informed the resident of proper sampling procedures; the analytical results for lead and copper concentrations at each tap sample site; and designation of any substitute site not used in previous monitoring periods.

(G) A public water system shall maintain records relating to special studies and pilot projects, special monitoring, and other system-specific matters as directed by the executive director.

(4) Public water [~~Water~~] systems shall submit routine reports and any additional documentation that the executive director may require to determine compliance with the requirements of this chapter.

(A) The reports must be submitted to the Texas Commission on Environmental Quality, Water Supply Division, MC 155, P.O. Box 13087, Austin, Texas 78711-3087 by the tenth day of the month following the end of the reporting period.

(B) The reports must contain all the information required by the drinking water standards and the results of any special monitoring tests which have been required.

(C) The reports must be completed in ink, typed, or computer-printed and must be signed by the licensed water works operator.

(5) All public water systems that are affected utilities must maintain the following records for as long as they are applicable to the system:

(A) An emergency preparedness plan approved by the executive director and a copy of the approval letter.

(B) All required operating and maintenance records for auxiliary power equipment, including periodic testing of the auxiliary power equipment under load and any associated automatic switch over equipment.

(C) Copies of the manufacturer's specifications for all generators that are part of the approved emergency preparedness plan.

(g) Disinfection of new or repaired facilities. Disinfection by or under the direction of water system personnel must be performed when repairs are made to existing facilities and before new facilities are placed into service. Disinfection must be performed in accordance with American Water Works Association (AWWA) requirements and water samples must be submitted to a laboratory approved by the executive director. The sample results must indicate that the facility is free of microbiological contamination before it is placed into service. When it is necessary to return repaired mains to service as rapidly as possible, doses may be increased to 500 mg/L and the contact time reduced to 1/2 hour.

(h) Calcium hypochlorite. A supply of calcium hypochlorite disinfectant shall be kept on hand for use when making repairs, setting meters, and disinfecting new mains prior to placing them in service.

(i) Plumbing ordinance. Public water systems must adopt an adequate plumbing ordinance, regulations, or service agreement with provisions for proper enforcement to insure that neither cross-connections nor other unacceptable plumbing practices are permitted (See §290.47(b) of this title (relating to Appendices)). Should sanitary control of the distribution system not reside with the purveyor, the entity retaining sanitary control shall be responsible for establishing and enforcing adequate regulations in this regard. The use of pipes and pipe fittings that contain more than 0.25% lead or solders and flux that contain more than 0.2% lead is prohibited for installation or repair of any public water supply and for installation or repair of any plumbing in a residential or nonresidential facility providing water for human consumption and connected to a public drinking water supply system. This requirement may be waived for lead joints that are necessary for repairs to cast iron pipe.

(j) Customer service inspections. A customer service inspection certificate shall be completed prior to providing continuous water service to new construction, on any existing service either when the water purveyor has reason to believe that cross-connections or other potential contaminant hazards exist, or after any material improvement, correction, or addition to the private water distribution facilities. Any customer service inspection certificate form which varies from the format found in commission Form 20699 must be approved by the executive director prior to being placed in use.

(1) Individuals with the following credentials shall be recognized as capable of conducting a customer service inspection certification.

(A) Plumbing Inspectors and Water Supply Protection Specialists licensed by the Texas State Board of Plumbing Examiners (TSBPE).

(B) Customer service inspectors who have completed a commission-approved course, passed an examination administered by the executive director, and hold current professional license as a customer service inspector.

(2) As potential contaminant hazards are discovered, they shall be promptly eliminated to prevent possible contamination of the water supplied by the public water system. The existence of a health hazard, as identified in §290.47(f) of this title, shall be considered sufficient grounds for immediate termination of water service. Service can be restored only when the health hazard no longer exists, or until the health hazard has been isolated from the public water system in accordance with §290.44(h) of this title (relating to Water Distribution).

(3) These customer service inspection requirements are not considered acceptable substitutes for and shall not apply to the sanitary control requirements stated in §290.102(a)(5) of this title (relating to General Applicability).

(4) A customer service inspection is an examination of the private water distribution facilities for the purpose of providing or denying water service. This inspection is limited to the identification and prevention of cross-connections, potential contaminant hazards, and illegal lead materials. The customer service inspector has no authority or obligation beyond the scope of the commission's regulations. A customer service inspection is not a plumbing inspection as defined and regulated by the TSBPE. A customer service inspector is not permitted to perform plumbing inspections. State statutes and TSBPE adopted rules require that TSBPE licensed plumbing inspectors perform plumbing inspections of all new plumbing and alterations or additions to existing plumbing within the municipal limits of all cities, towns, and villages which have passed an ordinance adopting one of the plumbing codes recognized by TSBPE. Such entities may stipulate that the customer service inspection be performed by the plumbing inspector as a part of the more comprehensive plumbing inspection. Where such entities permit customer service inspectors to perform customer service inspections, the customer service inspector shall report any violations immediately to the local entity's plumbing inspection department.

(k) Interconnection. No physical connection between the distribution system of a public drinking water supply and that of any other water supply shall be permitted unless the other water supply is of a safe, sanitary quality and the interconnection is approved by the executive director.

(l) Flushing of mains. All dead-end mains must be flushed at monthly intervals. Dead-end lines and other mains shall be flushed as needed if water quality complaints are received from water customers or if disinfectant residuals fall below acceptable levels as specified in §290.110 of this title.

(m) Maintenance and housekeeping. The maintenance and housekeeping practices used by a public water system shall ensure the good working condition and general appearance of the system's facilities and equipment. The grounds and facilities shall be maintained in a manner so as to minimize the possibility of the harboring of rodents, insects, and other disease vectors, and in such a way as to prevent other conditions that might cause the contamination of the water.

(1) Each of the system's ground, elevated, and pressure tanks shall be inspected annually by water system personnel or a contracted inspection service.

(A) Ground and elevated storage tank inspections must determine that the vents are in place and properly screened, the roof hatches closed and locked, flap valves and gasketing provide adequate protection against insects, rodents, and other vermin, the interior and exterior coating systems are continuing to provide adequate protection to all metal surfaces, and the tank remains in a watertight condition.

(B) Pressure tank inspections must determine that the pressure release device and pressure gauge are working properly, the air-water ratio is being maintained at the proper level, the exterior coating systems are continuing to provide adequate protection to all metal surfaces, and the tank remains in watertight condition. Pressure tanks provided with an inspection port must have the interior surface inspected every five years.

(C) All tanks shall be inspected annually to determine that instrumentation and controls are working properly.

(2) When pressure filters are used, a visual inspection of the filter media and internal filter surfaces shall be conducted annually to ensure that the filter media is in good condition and the coating materials continue to provide adequate protection to internal surfaces.

(3) When cartridge filters are used, filter cartridges shall be changed at the frequency required by the manufacturer, or more frequently if needed.

(4) All water treatment units, storage and pressure maintenance facilities, distribution system lines, and related appurtenances shall be maintained in a watertight condition and be free of excessive solids.

(5) Basins used for water clarification shall be maintained free of excessive solids to prevent possible carryover of sludge and the formation of tastes and odors.

(6) Pumps, motors, valves, and other mechanical devices shall be maintained in good working condition.

(7) Reverse osmosis or nanofiltration membrane systems shall be cleaned, or replaced, in accordance with the allowable operating conditions of the manufacturer and shall be based on one or more of the following: increased salt passage, increased or decreased pressure differential, and/or change in normalized permeate flow.

(n) Engineering plans and maps. Plans, specifications, maps, and other pertinent information shall be maintained to facilitate the operation and maintenance of the system's facilities and equipment. The following records shall be maintained on file at the public water system and be available to the executive director upon request.

(1) Accurate and up-to-date detailed as-built plans or record drawings and specifications for each treatment plant, pump station, and storage tank shall be maintained at the public water system until the facility is decommissioned. As-built plans of individual projects may be used to fulfill this requirement if the plans are maintained in an organized manner.

(2) An accurate and up-to-date map of the distribution system shall be available so that valves and mains can be easily located during emergencies.

(3) Copies of well completion data as defined in §290.41(c)(3)(A) of this title (relating to Water Sources) [~~such as well material setting data, geological log, sealing information (pressure cementing and surface protection), disinfection information, microbiological sample results, and a chemical analysis report of a representative sample of water from the well~~] shall be kept on file for as long as the well remains in service.

(o) Filter backwashing at surface water treatment plants. Filters must be backwashed when a loss of head differential of six to ten feet is experienced between the influent and effluent loss of head gauges or when the turbidity level at the effluent of the filter reaches 1.0 nephelometric turbidity unit (NTU).

(p) Data on public water system ownership and management. The agency shall be provided with information regarding public water system ownership and management.

(1) When a public water system changes ownership, a written notice of the transaction must be provided to the executive director. The grantee shall notify the executive director of the change in ownership within 30 days after the effective date of the change in ownership by providing the name of the grantor, the effective date of the change in ownership, the physical and mailing address and phone number of the grantee, the public water system's drinking water supply identification number, and any other information necessary to identify the transaction [~~When applicable, notification shall be in accordance with Chapter 291 of this title (relating to Utility Regulations). Those systems not subject to Chapter 291 of this title shall notify the executive director of changes in ownership by providing the name of the current and prospective owner or responsible official, the proposed date of the transaction, and the address and phone number of the new owner or responsible official. The information listed in this paragraph and the system's public drinking water supply identification number, and any other information necessary to identify the transaction shall be provided to the executive director 120 days before the date of the transaction~~].

(2) On an annual basis, the owner of a public water system shall provide the executive director with a list of all the operators and operating companies that the public water system uses. The notice shall contain the name, contact information, work status, license number, and license class of each operator and the name and registration number of each operating company. Public water systems may report the list of operators and operating companies to the executive director by utilizing the Texas Commission on Environmental Quality (TCEQ) online "Operator Notice" form. If reporting cannot be accomplished utilizing the TCEQ online "Operator Notice" form, then a public water system may report the list of operators and operating companies on the written "Operator Notice" form to the executive director by mail, email or facsimile. (See §290.47(d) of this title).

(q) Special precautions, protective measures, and boil water notices. Special precautions, protective measures, and boil water notices shall [~~must~~] be instituted by the public water system [~~owner or responsible official~~] in the event of low distribution pressures (below 20 pounds per square inch (psi)), water outages, microbiological samples found to contain *Escherichia coli (E. coli)* (or other approved fecal indicator) [~~coliform organisms~~], failure to maintain adequate disinfectant [~~chlorine~~] residuals, elevated finished water turbidity levels, or other conditions which indicate that the potability of the drinking water supply has been compromised. Special precautions, protective measures, and boil water notices are corrective or protective actions which shall be instituted by the public water system to comply with the requirements of this subsection.

(1) Boil water notices and rescind notices. A public water system shall issue a boil water notice to customers throughout the distribution system or in the affected area(s) of the distribution system as soon as possible, but in no case later than 24 hours after the public water system has met any of the criteria described in paragraphs (2) - (5) of this subsection. Boil water notices shall be issued to customers by using one or more of the Tier 1 delivery methods as described in §290.122(a)(2) of this title (relating to Public Notification) and using the applicable boil water notice language and format specified in Figure: 30 TAC §290.47(c)(1) and (2) of this title [~~Boil water notifications must be issued to the customers within 24 hours using the prescribed notification format as specified in §290.47(c) of this title~~]. A copy of this notice shall be provided to the executive director within 24 hours or no later than the next business day after issuance by the public water system and shall be accompanied with a signed Certificate of Delivery. The boil water notice shall be multilingual where [~~Bilingual notification may be~~] appropriate based upon local demographics. Once the boil water notice [~~notification~~] is no longer in effect, the public water system shall notify customers throughout the distribution system or in the affected area(s) of the distribution system that the boil water notice has been rescinded using the language and format specified in Figure: 30 TAC §290.47(c)(3) of this title. A public water system shall not rescind a boil water notice and/or notify customers that the boil water notice has been rescinded until the public water system has met all of the applicable requirements as described in paragraph (6) of this subsection. [~~must be notified in a manner similar to the original notice.~~]

(2) Boil water notices for low distribution pressures. The flowchart found in §290.47(e) of this title shall be used to determine if a boil water notice shall [~~notification must~~] be issued by the public water system to customers in the event of a loss of distribution system pressure. [~~If a boil water notice is issued under this section, it shall remain in effect until water distribution pressures in excess of 20 psi can consistently be maintained, a minimum of 0.2 mg/L free chlorine residual or 0.5 mg/L chloramine residual (measured as total chlorine) is present throughout the system, and water samples collected for microbiological analysis are found negative for coliform organisms.~~]

(3) Boil water notices for *E. coli* (or other approved fecal indicator) maximum contaminant level (MCL) violations. A public water system shall issue a boil water notice to customers for a violation of the MCL for *E. coli* (or other approved fecal indicator) as described in §290.109(b)(1) of this title.

(4) [~~(3)~~] Boil water notices for turbidity requirements. A public water system shall issue a boil water notice to customers [~~notification shall be issued~~] if the combined filter effluent turbidity of the finished water, produced by a treatment plant that is treating surface water or groundwater under the direct influence of surface water, is above the turbidity level requirements as described in §290.122(a)(1)(B) of this title, specifically: [~~surface water treatment plant exceeds 5.0 NTU. The boil water notice shall remain in effect until the water entering the distribution system has a turbidity level below 1.0 NTU, the distribution system has been thoroughly flushed, a minimum of 0.2 mg/L free chlorine residual or 0.5 mg/L chloramine residual (measured as total chlorine) is present throughout the system, and water samples collected for microbiological analysis are found negative for coliform organisms.~~]

(A) a combined filter effluent turbidity level above 5.0 NTU;

(B) a combined filter effluent turbidity level above 1.0 NTU at a treatment plant using membrane filters;

(C) a combined filter effluent turbidity level above 1.0 NTU at a plant using other than membrane filters at the discretion of the executive director after consultation with the public water system; or

(D) failure of a public water system with treatment other than membrane filters to consult with the executive director within 24 hours after a combined filter effluent reading of 1.0 NTU.

(5) [~~(4)~~] Actions which may be required by the executive director. Special precautions, [~~Other~~] protective measures, and boil water notices may be required at the discretion of the executive director and shall be instituted by the public water system, upon written notification to the public water system, and shall remain in effect until the public water system meets the requirements of subparagraph (C) of this paragraph and paragraph (6) of this subsection.

(A) At the discretion of the executive director, and upon notification, a public water system shall institute special precautions, protective measures, and boil water notices as described under this subsection. Circumstances warranting the exercise of such discretion may include:

(i) the public water system has failed to provide required compliance information to the executive director as described in §290.110(e) and §290.111(h) of this title and the failure results in the inability of the executive director to determine compliance as described in §290.110(f) and §290.111(i) of this title;

(ii) special precautions, protective measures, and/or boil water notices are necessary to comply with the requirements of this title to prevent or correct a potential or actual health hazard, as described in §290.38 of this title, to public water system customers; or

(iii) the public water system has failed to maintain adequate disinfectant residuals as described in subsection (d) of this section and as described in §290.110 of title.

(B) The executive director will provide written notification to the public water system in the event a public water system is required to institute special precautions, protective measures, or issue boil water notices to customers at the discretion of the executive director. Upon receipt of written notification by the executive director, the public water system shall implement special precautions, protective measures, or issue boil water notices to customers within 24 hours or within the time period specified by the executive director.

(C) At the discretion of the executive director, the public water system shall provide any required information to the executive director to document that the public water system has met the requirements for special precautions, protective measures, and boil water notices as required under this paragraph.

(6) Required actions prior to rescinding a boil water notice. A public water system shall notify customers throughout the distribution system or in the affected area(s) of the distribution system that a boil water notice has been rescinded after the public water system has met the requirements of this paragraph. The executive director may provide written notification to the public water system once the public water system has provided required compliance documentation to the executive director. A boil water notice issued under the requirements of this subsection shall remain in effect until the public water system has provided required compliance documentation to the executive director which establishes that the public water system has met the following requirements, as applicable:

(A) water distribution system pressures in excess of 20 psi are consistently being maintained throughout the distribution system in accordance with the flowchart found in §290.47(e) of this title;

(B) affected area(s) of the distribution system have been thoroughly flushed until a minimum of 0.2 mg/L free chlorine residual or 0.5 mg/L chloramine residual (measured as total chlorine) is present and is consistently being maintained in each finished water storage tank and throughout the distribution system as described in subsection (d) of this section;

(C) finished water entering the distribution system, produced by a treatment plant that is treating surface water or groundwater under the direct influence of surface water, has a turbidity level that is consistently being maintained below 1.0 NTU;

(D) actions required by the executive director under paragraph (5) of this subsection have been met and the public water system is operating in accordance with §290.110(e) and (f) and §290.111(h) and (i) of this title as described in paragraph (5)(A)(i) of this subsection; and

(E) water samples for microbiological analysis, marked as "special" on the laboratory sample submission form, were collected from representative locations throughout the distribution system or in the affected area(s) of the distribution system within 24 hours or no later than the next business day once the public water system has met all other applicable requirements of this paragraph and the water samples collected for microbiological analysis are found negative for coliform organisms. The water samples described in this subparagraph shall be analyzed at laboratories in accordance with §290.119 of this title (relating to Analytical Procedures).

(F) A public water system shall notify customers throughout the distribution system or in the affected area(s) of the distribution system that a boil water notice has been rescinded within 24 hours or no later than the next business day, using the language and format specified in Figure: 30 TAC §290.47(c)(3) of this title, once the public water system has met the requirements of this paragraph. The public water system shall provide a copy of the "boil water notice rescinded" notice and a copy of the associated microbiological laboratory analysis results, as required by subparagraph (E) of this paragraph, to the executive director within ten days after the public water system has issued the rescind notice to customers in accordance with §290.122(f) of this title.

(r) Minimum pressures. All public water systems shall be operated to provide a minimum pressure of 35 psi throughout the distribution system under normal operating conditions. The system shall also be operated to maintain a minimum pressure of 20 psi during emergencies such as fire fighting. As soon as safe and practicable following the occurrence of a natural disaster, a public water system that is an affected utility shall maintain a minimum of 35 psi throughout the distribution system during an extended power outage.

(s) Testing equipment. Accurate testing equipment or some other means of monitoring the effectiveness of any chemical treatment or pathogen inactivation or removal processes must be used by the system.

(1) Flow-measuring devices and rate-of-flow controllers that are required by §290.42(b) and (d) of this title (relating to Water Treatment) shall be calibrated at least once every 12 months. Well meters required by §290.41(c)(3)(N) of this title [~~(relating to Water Sources)~~] shall be calibrated at least once every three years.

(2) Laboratory equipment used for compliance testing shall be properly calibrated.

(A) pH meters shall be properly calibrated.

(i) Benchtop pH meters shall be calibrated according to manufacturer [~~manufacturers~~] specifications at least once each day.

(ii) The calibration of benchtop pH meters shall be checked with at least one buffer each time a series of samples is run, and if necessary, recalibrated according to manufacturer [~~manufacturers~~] specifications.

(iii) On-line pH meters shall be calibrated according to manufacturer specifications at least once every 30 days.

(iv) The calibration of on-line pH meters shall be checked at least once each week with a primary standard or by comparing the results from the on-line unit with the results from a properly calibrated benchtop unit. If necessary, the on-line unit shall be recalibrated with primary standards.

(B) Turbidimeters shall be properly calibrated.

(i) Benchtop turbidimeters shall be calibrated with primary standards at least once every 90 days. Each time the turbidimeter is calibrated with primary standards, the secondary standards shall be restandardized.

(ii) The calibration of benchtop turbidimeters shall be checked with secondary standards each time a series of samples is tested, and if necessary, recalibrated with primary standards.

(iii) On-line turbidimeters shall be calibrated with primary standards at least once every 90 days.

(iv) The calibration of on-line turbidimeters shall be checked at least once each week with a primary standard, a secondary standard, or the manufacturer's proprietary calibration confirmation device or by comparing the results from the on-line unit with the results from a properly calibrated benchtop unit. If necessary, the on-line unit shall be recalibrated with primary standards.

(C) Chemical disinfectant residual analyzers shall be properly calibrated.

(i) The accuracy of manual disinfectant residual analyzers shall be verified at least once every 90 days using chlorine solutions of known concentrations.

(ii) The accuracy of continuous disinfectant residual analyzers shall be checked at least once every seven days with a chlorine solution of known concentration or by comparing the results from the on-line analyzer with the result of approved benchtop method in accordance with §290.119 of this title [~~(relating to Analytical Procedures)~~].

(iii) If a disinfectant residual analyzer produces a result which is not within 15% of the expected value, the cause of the discrepancy must be determined and corrected and, if necessary, the instrument must be recalibrated.

(D) Analyzers used to determine the effectiveness of chloramination in §290.110(c)(5) of this title shall be properly verified in accordance with the manufacturer's recommendations every 90 days. These analyzers include monochloramine, ammonia, nitrite, and nitrate equipment used by the public water system.

(E) Ultraviolet (UV) light disinfection analyzers shall be properly calibrated.

(i) The accuracy of duty UV sensors shall be verified with a reference UV sensor monthly, according to the UV sensor manufacturer.

(ii) The reference UV sensor shall be calibrated by the UV sensor manufacturer on a yearly basis, or sooner if needed.

(iii) If used, the UV Transmittance (UVT) analyzer shall be calibrated weekly according to the UVT analyzer manufacturer specifications.

(F) Systems must verify the performance of direct integrity testing equipment in a manner and schedule approved by the executive director.

(G) Conductivity (or total dissolved solids) monitors and pressure instruments used for reverse osmosis and nanofiltration membrane systems shall be calibrated at least once every 12 months.

(H) Any temperature monitoring devices used for reverse osmosis and nanofiltration shall be verified and calibrated in accordance with the manufacturer's specifications.

(t) System ownership. All community water systems shall post a legible sign at each of its production, treatment, and storage facilities. The sign shall be located in plain view of the public and shall provide the name of the water supply and an emergency telephone number where a responsible official can be contacted.

(u) Abandoned wells. Abandoned public water supply wells owned by the system must be plugged with cement according to 16 TAC Chapter 76 (relating to Water Well Drillers and Water Well Pump Installers). Wells that are not in use and are non-deteriorated as defined in those rules must be tested every five years or as required by the executive director to prove that they are in a non-deteriorated condition. The test results shall be sent to the executive director for review and approval. Deteriorated wells must be either plugged with cement or repaired to a non-deteriorated condition.

(v) Electrical wiring. All water system electrical wiring must be securely installed in compliance with a local or national electrical code.

(w) Security. All systems shall maintain internal procedures to notify the executive director by a toll-free reporting phone number immediately of the following events, if the event may negatively impact the production or delivery of safe and adequate drinking water:

(1) an unusual or unexplained unauthorized entry at property of the public water system;

(2) an act of terrorism against the public water system;

(3) an unauthorized attempt to probe for or gain access to proprietary information that supports the key activities of the public water system;

(4) a theft of property that supports the key activities of the public water system; or

(5) a natural disaster, accident, or act that results in damage to the public water system.

(x) Public safety standards. This subsection only applies to a municipality with a population of 1,000,000 or more, with a public utility within its corporate limits; a municipality with a population of more than 36,000 and less than 41,000 located in two counties, one of which is a county with a population of more than 1.8 million; a municipality, including any industrial district within the municipality or its extraterritorial jurisdiction (ETJ), with a population of more than 7,000 and less than 30,000 located in a county with a population of more than 155,000 and less than 180,000; or a municipality, including any industrial district within the municipality or its ETJ, with a population of more than 11,000 and less than 18,000 located in a county with a population of more than 125,000 and less than 230,000.

(1) In this subsection:

(A) "Regulatory authority" means, in accordance with the context in which it is found, either the commission or the governing body of a municipality.

(B) "Public utility" means any person, corporation, cooperative corporation, affected county, or any combination of these persons or entities, other than a municipal corporation, water supply or sewer service corporation, or a political subdivision of the state, except an affected county, or their lessees, trustees, and receivers, owning or operating for compensation in this state equipment or facilities for the transmission, storage, distribution, sale, or provision of potable water to the public or for the resale of potable water to the public for any use or for the collection, transportation, treatment, or disposal of sewage or other operation of a sewage disposal service for the public, other than equipment or facilities owned and operated for either purpose by a municipality or other political subdivision of this state or a water supply or sewer service corporation, but does not include any person or corporation not otherwise a public utility that furnishes the services or commodity only to itself or its employees or tenants as an incident of that employee service or tenancy when that service or commodity is not resold to or used by others.

(C) "Residential area" means:

(i) an area designated as a residential zoning district by a governing ordinance or code or an area in which the principal land use is for private residences;

(ii) a subdivision for which a plat is recorded in the real property records of the county and that contains or is bounded by public streets or parts of public streets that are abutted by residential property occupying at least 75% of the front footage along the block face; or

(iii) a subdivision a majority of the lots of which are subject to deed restrictions limiting the lots to residential use.

(D) "Industrial district" has the meaning assigned by Texas Local Government Code, §42.044, and includes an area that is designated by the governing body of a municipality as a zoned industrial area.

(2) When the regulatory authority is a municipality, it shall by ordinance adopt standards for installing fire hydrants in residential areas in the municipality. These standards must, at a minimum, follow current AWWA standards pertaining to fire hydrants and the requirements of §290.44(e)(6) of this title.

(3) When the regulatory authority is a municipality, it shall by ordinance adopt standards for maintaining sufficient water pressure for service to fire hydrants adequate to protect public safety in residential areas in the municipality. The standards specified in paragraph (4) of this subsection are the minimum acceptable standards.

(4) A public utility shall deliver water to any fire hydrant connected to the public utility's water system located in a residential area so that the flow at the fire hydrant is at least 250 gallons per minute for a minimum period of two hours while maintaining a minimum pressure of 20 psi throughout the distribution system during emergencies such as fire fighting. That flow is in addition to the public utility's maximum daily demand for purposes other than fire fighting.

(5) When the regulatory authority is a municipality, it shall adopt the standards required by this subsection within one year of the effective date of this subsection or within one year of the date this subsection first applies to the municipality, whichever occurs later.

(6) A public utility shall comply with the standards established by a municipality under both paragraphs (2) and (3) of this subsection within one year of the date the standards first apply to the public utility. If a municipality has failed to comply with the deadline required by paragraph (5) of this subsection, then a public utility shall comply with the standards specified in paragraphs (2) and (4) of this subsection within two years of the effective date of this subsection or within one year of the date this subsection first applies to the public utility, whichever occurs later.

(y) Fire hydrant flow standards.

(1) In this subsection:

(A) "Municipal utility" means a retail public utility, as defined by Texas Water Code (TWC), §13.002, that is owned by a municipality.

(B) "Residential area" means an area used principally for private residences that is improved with at least 100 single-family homes and has an average density of one home per half acre.

(C) "Utility" includes a "public utility" and "water supply or sewer service corporation" as defined by TWC, §13.002.

(2) The governing body of a municipality by ordinance may adopt standards set by the executive director requiring a utility to maintain a minimum sufficient water flow and pressure to fire hydrants in a residential area located in the municipality or the municipality's ETJ. The municipality must submit a signed copy of the ordinance to the executive director within 60 days of the adoption of an ordinance by its governing body.

(3) In addition to a utility's maximum daily demand, the utility must provide, for purposes of emergency fire suppression:

(A) a minimum sufficient water flow of at least 250 gallons per minute for at least two hours; and

(B) a minimum sufficient water pressure of at least 20 psi.

(4) If a municipality adopts standards for a minimum sufficient water flow and pressure to fire hydrants, the municipality must require a utility to maintain at least the minimum sufficient water flow and pressure described by paragraph (3) of this subsection in fire hydrants in a residential area located within the municipality or the municipality's ETJ. If the municipality adopts a fire flow standard exceeding the minimum standards set in paragraph (3) of this subsection, the standard adopted by the municipality must be based on:

(A) the density of connections;

(B) service demands; and

(C) other relevant factors.

(5) If the municipality owns a municipal utility, it may not require another utility located in the municipality or the municipality's ETJ to provide water flow and pressure in a fire hydrant greater than that provided by the municipal utility as determined by the executive director.

(6) If the municipality does not own a municipal utility, it may not require a utility located in the municipality or the municipality's ETJ to provide a minimum sufficient water flow and pressure greater than the standard established by paragraph (3) of this subsection.

(7) An ordinance under paragraph (2) of this subsection may not require a utility to build, retrofit, or improve infrastructure in existence at the time the ordinance is adopted.

(8) A municipality with a population of less than 1.9 million that adopts standards under paragraph (2) of this subsection or that seeks to use a utility's water for emergency fire suppression shall enter into a written memorandum of understanding with the utility.

(A) The memorandum of understanding must provide for:

(i) the necessary testing of fire hydrants; and

(ii) other relevant issues pertaining to the use of the water and maintenance of the fire hydrants to ensure compliance with this subsection.

(B) The municipality must submit a signed copy of the memorandum of understanding to the executive director within 60 days of the execution of the memorandum of understanding between its governing body and the utility.

(9) A municipality may notify the executive director of a utility's failure to comply with a standard adopted under paragraph (3) of this subsection.

(10) On receiving the notice described by paragraph (9) of this subsection, the executive director shall require a utility in violation of a standard adopted under this subsection to comply within a reasonable time established by the executive director.

(z) Nitrification Action Plan (NAP). Any water system distributing chloraminated water must create a NAP. The system must create a written NAP that:

(1) contains the system-specific plan for monitoring free ammonia, monochloramine, total chlorine, nitrite, and nitrate levels;

(2) contains system-specific action levels of the above monitored chemicals where action must be taken;

(3) contains specific corrective actions to be taken if the action levels are exceeded; and

(4) is maintained as part of the system's monitoring plan in §290.121 of this title.

§290.47. Appendices.

(a) Appendix A. Recognition as a Superior or Approved Public Water System.
Figure: 30 TAC §290.47(a) (No change.)

(b) Appendix B. Sample Retail Service Agreement.
Figure: 30 TAC §290.47(b) (No change.)

(c) Appendix C. Boil Water Notices [~~Notification~~].
[~~Figure: 30 TAC §290.47(c)~~]

(1) Appendix (c)(1): Boil Water Notice for Community Public Water Systems.
Figure: 30 TAC §290.47(c)(1)

(2) Appendix (c)(2): Boil Water Notice for Noncommunity Public Water Systems.
Figure: 30 TAC §290.47(c)(2)

(3) Appendix (c)(3): Boil Water Notice Rescinded.
Figure: 30 TAC §290.47(c)(3)

(d) Appendix D. Operator Notice.
Figure: 30 TAC §290.47(d) (No change.)

(e) Appendix E. Special Precautions.
Figure: 30 TAC §290.47(e) (No change.)

(f) Appendix F. Assessment of Hazards and Selection of Assemblies.
Figure: 30 TAC §290.47(f) (No change.)

(g) Appendix G. Emergency Preparedness Plan Template.
Figure: 30 TAC §290.47(g) (No change.)

(h) Appendix H. Sample Language for Notification Upon Changing from Free Chlorine to Chloramines.
Figure: 30 TAC §290.47(h) (No change.)

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

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Texas Commission on Environmental Quality
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SUBCHAPTER F. DRINKING WATER STANDARDS GOVERNING DRINKING WATER QUALITY AND REPORTING REQUIREMENTS FOR PUBLIC WATER SYSTEMS

30 TAC §§290.102 - 290.104, 290.106 - 290.119, 290.121, 290.122

Statutory Authority

These amendments are proposed under the Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; TWC, §5.105, which establishes the commission's authority to set policy by rule; and Texas Health and Safety Code (THSC), §341.031, which allows the commission to adopt rules to implement the federal Safe Drinking Water Act, 42 United States Code §§300f - 300j-26; and THSC, §341.0315, which requires public water systems to comply with commission rules adopted to ensure the supply of safe drinking water.

§290.102. General Applicability.

(a) General applicability. This subchapter shall apply to all public water systems as described in each section, unless the system:

(1) consists only of distribution and storage facilities (and does not have any production and treatment facilities);

(2) obtains all of its water from, but is not owned or operated by, a public water system to which such standards apply;

(3) does not sell water to any person;

(4) is not a carrier which conveys passengers in interstate commerce; and

(5) is subject to plumbing restrictions and inspections by the public water system which provides the water.

(b) Variances and exemptions. Variances and exemptions may be granted at the discretion of the executive director according to the Safe Drinking Water Act (SDWA), 42 United States Code (USC), §300g-4 and §300g-5, and according to National Primary Drinking Water Regulations Implementation, Subpart K, 40 Code of Federal Regulations (CFR) §§142.301 - 142.313. The executive director may not approve variances or exemptions from:

(1) the maximum contaminant level (MCL) for *Escherichia coli (E. coli),* [~~total coliforms,~~] nitrate, nitrite, or total nitrate and nitrite;

(2) the maximum residual disinfection level (MRDL) for chlorine dioxide; or

(3) the treatment technique requirements for filtration and disinfection.

(c) Extensions. An extension to the compliance deadline for an MCL or treatment technique that becomes effective on or after January 1, 2002, may be granted at the discretion of the executive director in accordance with the SDWA, 42 USC, §300g-1(b)(10).

(1) The executive director may extend the effective date of an MCL or treatment technique for up to two years if all of the following conditions apply:

(A) there are no acute violations associated with the new MCL or treatment technique for which the extension is being granted;

(B) the executive director determines that granting the extension will not result in an unreasonable risk to public health;

(C) the extension is granted only to public water systems that were in operation on the date that the MCL or treatment technique was promulgated by the United States Environmental Protection Agency (EPA);

(D) the executive director determines that capital improvements are needed to comply with the new MCL or treatment technique;

(E) the executive director approves a schedule identifying the capital improvements necessary to bring the system into compliance with the new MCL or treatment technique; and

(F) the EPA has not already incorporated a two-year extension into the effective date for the new MCL or treatment technique requirement.

(2) An application for an extension must be submitted to the executive director in writing by the owner or responsible party of the water system. The request must include a statement identifying the new MCL or treatment technique which is not being met and a general long range plan for meeting the new requirement.

(3) The executive director may issue an extension covering a group or class of systems with a common MCL or treatment technique which is not met without individual applications.

(d) Motion to overturn. Any person may file a motion to overturn the executive director's decision to grant or deny a variance, exemption, or extension under this section according to the procedures set out in §50.139 of this title (relating to Motion to Overturn Executive Director's Decision).

(e) Monitoring schedule. All monitoring required by this chapter shall be conducted in a manner and on a schedule approved by the executive director in concurrence with the requirements of the administrator of the EPA.

(f) Modified monitoring. When a public water system supplies water to one or more other public water systems, the executive director may modify the monitoring requirements imposed by this chapter to the extent that the interconnection of the systems justifies treating them as a single system for monitoring purposes. Any modified monitoring shall be conducted pursuant to a schedule specified by the executive director in concurrence with the requirements of the administrator of the EPA.

(g) The owner or operator of a public water system shall provide the executive director with a copy of the results of any test, measurement, or analysis required by this subchapter. The copies shall be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subchapter, whichever occurs first.

§290.103. Definitions.

The following definitions shall apply in the interpretation and enforcement of this subchapter. If a word or term used in this subchapter is not contained in the following list, its definition shall be as shown in §290.38 of this title (relating to Definitions) or in 40 Code of Federal Regulations (CFR) §141.2. Other technical terms used shall have the meanings or definitions listed in the latest edition of "Glossary, Water and Wastewater Control Engineering," prepared by a joint editorial board representing the American Public Health Association, American Society of Civil Engineers, American Water Works Association, and the Water Pollution Control Federation.

(1) Assessment source monitoring--Raw groundwater source monitoring required by the executive director based on groundwater source susceptibility to fecal contaminants.

(2) Combined distribution system (CDS)--The interconnected distribution system consisting of the distribution systems of wholesale systems and of the consecutive systems that receive finished water.

(A) The executive director may determine that the CDS does not include certain systems based on factors such as providing or receiving a relatively small amount of water or only on an emergency basis.

(B) A public water system may be determined to be in a different CDS for the purposes of compliance with regulations based on the Stage 2 Disinfection Byproducts Rule (DBP2) and the Long Term Stage 2 Enhanced Surface Water Treatment Rule (LT2).

(i) For the purposes of raw water monitoring under LT2, the CDS shall be based on the retail and wholesale population served by each surface water treatment plant or plant treating groundwater under the direct influence of surface water.

(ii) For the purposes of DBP2, the CDS shall be determined based on the retail population served within each individual system's distribution system.

(3) Compliance cycle--The nine-year (calendar year) cycle during which public water systems must monitor. Each compliance cycle consists of three, three-year compliance periods. [~~The first compliance cycle begins January 1, 1993, and ends December 31, 2001. The second begins January 1, 2002, and ends December 31, 2010. The third begins January 1, 2011, and ends December 31, 2019. The cycle continues thereafter in a similar pattern.~~]

(4) Compliance period--A three-year (calendar year) period within a compliance cycle. Each compliance cycle has three, three-year compliance periods. Within the first compliance cycle, the first compliance period is called the initial compliance period [~~and runs from January 1, 1993, to December 31, 1995. The second period from January 1, 1996, to December 31, 1998. The third period from January 1, 1999, to December 31, 2001. Compliance periods in subsequent compliance cycles follow the same pattern~~].

(5) Comprehensive performance evaluation (CPE)--A thorough review and analysis of a treatment plant's performance-based capabilities and the associated administrative, operation and maintenance practices. It is conducted to identify factors that may be adversely impacting a plant's capability to achieve compliance and to emphasize approaches that can be implemented without significant capital improvements. The comprehensive performance evaluation consists of the following components: assessment of plant performance; evaluation of major unit processes; identification and prioritization of performance limiting factors; assessment of the applicability of comprehensive technical assistance; and preparation of a CPE report.

(6) Consecutive system--A public water system that receives some or all of its raw water or finished water from one or more other public water systems.

(7) Disinfection profile--A summary of daily *Cryptosporidium, Giardia lamblia,* and viral inactivation obtained through disinfection at the treatment plant.

(8) Disinfection by-products (DBP)--Chemical compounds formed by the reaction of a disinfectant with the natural organic matter present in water.

(9) Domestic or other non-distribution system plumbing problem--A coliform contamination problem in a public water system with more than one service connection that is limited to the specific service connection from which the coliform-positive sample was taken.

(10) [~~(9)~~] DPD--Abbreviation for N,N-diethyl-p-phenylenediamine, a reagent used in the determination of several residuals. DPD methods are available for both volumetric (titration) and colorimetric determinations, and are commonly used in the field as part of a colorimetric test kit.

(11) [~~(10)~~] Dual sample set--A set of two samples collected at the same time and same location, with one sample analyzed for total trihalomethanes (TTHM) and the other sample analyzed for haloacetic acids-group of five (HAA5). Dual sample sets are collected for the purposes of conducting an initial distribution system evaluation and determining compliance with the TTHM and HAA5 maximum contaminant levels.

(12) [~~(11)~~] Enhanced coagulation--The removal of disinfection by-product precursors to a specified level by conventional coagulation and sedimentation.

(13) [~~(12)~~] Enhanced softening--The removal of disinfection by-product precursors to a specified level by softening.

(14) [~~(13)~~] Entry point--Any point where a source of treated water first enters the distribution system. Entry points to the distribution system may include points where chlorinated well water, treated surface water, rechlorinated water from storage, or water purchased from another supplier enters the distribution system.

(15) [~~(14)~~] Entry point sampling site--A sampling site representing the quality of the water entering the distribution system at each designated entry point.

(16) [~~(15)~~] Fecal indicators--Microbiological organisms used to indicate the presence of fecal contamination. Examples include; fecal coliform, *Escherichia coli (E. coli)* [~~*E. coli*~~], enterococci, and coliphage.

(17) [~~(16)~~] Filter assessment--An in-depth evaluation of an individual filter, including the analysis of historical filtered water turbidity from the filter, development of a filter profile, evaluation of media condition, identification and prioritization of factors limiting filter performance, appraisal of the applicability of corrections, and preparation of a filter self-assessment report.

(18) [~~(17)~~] Filter profile--A graphical representation of individual filter performance, based on continuous turbidity measurements or total particle counts versus time for an entire filter run. The filter profile must include all the data collected from the time that the filter placed into service until the time that the backwash cycle is complete and the filter is restarted. The filter profile must also include data collected as another filter is being backwashed.

(19) [~~(18)~~] Finished water--Water that is introduced into the distribution system of a public water system and intended for distribution and consumption without further treatment, except as necessary to maintain water quality within the distribution system (e.g., booster disinfection, addition of corrosion control chemicals).

(20) [~~(19)~~] Groundwater corrective action--Action required when a raw groundwater source sample is found to be positive for *Escherichia coli (E. coli)* [~~*E. coli*~~] or other fecal indicators as described under §290.116(b) of this title (relating to Groundwater Corrective Actions and Treatment Techniques).

(21) [~~(20)~~] Groundwater corrective action plan--A plan approved by the executive director documenting the steps to be taken to address fecal contamination of a groundwater source as described under §290.116(b) of this title (relating to Groundwater Corrective Actions and Treatment Techniques). The groundwater corrective action plan must be approved within 30 days of being notified of the fecal contamination.

(22) [~~(21)~~] Groundwater system--For the purposes of compliance with §290.109 of this title (relating to Microbial Contaminants) and with §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques), a public water system that provides, uses, or distributes any groundwater except if the groundwater is combined with surface water (or with groundwater under the direct influence of surface water) prior to treatment.

(23) [~~(22)~~] Haloacetic acids (five) (HAA5)--The sum of the monochloroacetic acid, dichloroacetic acid, trichloroacetic acid, monobromoacetic acid, and dibromoacetic acid concentrations in milligrams per liter, rounded to two significant figures after adding the sum.

(24) [~~(23)~~] Halogen--One of the chemical elements chlorine, bromine, or iodine.

(25) [~~(24)~~] Hydrogeologic sensitivity assessment--A determination of whether groundwater systems obtain water from hydrogeologically sensitive sources.

(26) Level 1 assessment--An evaluation to identify the possible presence of sanitary defects, defects in distribution system coliform monitoring practices, and (when possible) the likely reason that the public water system triggered the assessment. Minimum elements include review and identification of atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including, but not limited to water storage); source and treatment considerations that bear on distributed water quality, where appropriate; existing water quality monitoring data; and inadequacies in sample sites, sampling protocol, and sample processing. The public water system must conduct the assessment consistent with any executive director directives that tailor specific assessment elements with respect to the size and type of the public water system and the size, type, and characteristics of the distribution system.

(27) Level 2 assessment--An evaluation to identify the possible presence of sanitary defects, defects in distribution system coliform monitoring practices, and (when possible) the likely reason that the public water system triggered the assessment. A Level 2 assessment provides a more detailed examination of the public water system (including, but not limited to the public water system's monitoring and operational practices) than does a Level 1 assessment through the use of a more comprehensive investigation and review of available information, additional internal and external resources, and other relevant practices. Minimum elements include review and identification of atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including, but not limited to water storage); source and treatment considerations that bear on distributed water quality, where appropriate; existing water quality monitoring data; and inadequacies in sample sites, sampling protocol, and sample processing. The public water system must conduct the assessment consistent with any executive director directives that tailor specific assessment elements with respect to the size and type of the public water system and the size, type, and characteristics of the distribution system. The public water system must comply with any expedited actions or additional actions

required by the executive director in the case of an *Escherichia coli (E.coli)* maximum contaminant level violation.

(28) [~~(25)~~] Locational running annual average (LRAA)--The average of analytical results for samples taken at a specific monitoring location during the previous four calendar quarters.

(29) [~~(26)~~] Maximum contaminant level (MCL)--The maximum concentration of a regulated contaminant that is allowed in drinking water before the public water system is cited for a violation. MCLs [~~Maximum contaminant levels~~] for regulated contaminants are defined in the applicable sections of this subchapter.

(30) [~~(27)~~] Maximum residual disinfectant level (MRDL)--The disinfectant concentration that may not be exceeded in the distribution system. There is convincing evidence that addition of a disinfectant is necessary for control of waterborne microbial contaminants.

(31) [~~(28)~~] Minimum acceptable disinfectant residual--The lowest disinfectant concentration allowed in the distribution system for microbial control.

(32) [~~(29)~~] Operational evaluation level (OEL)--Calculated level of total trihalomethanes (TTHM) or haloacetic acid group of five (HAA5), an exceedance of which requires a system to perform an evaluation of factors in the distribution system contributing to disinfection by-product formation and submit an operation evaluation report as described in §290.115(e)(2) of this title (relating to Stage 2 Disinfection Byproducts (TTHM and HAA5)). The OEL at any monitoring location is the sum of the two previous quarters' results plus twice the current quarter's result, divided by 4 to determine an average.

(33) [~~(30)~~] Raw water--Water prior to any treatment including disinfection that is intended to be used, after treatment, as drinking water.

(A) Raw groundwater is water from a groundwater source.

(B) Raw surface water is any water from a surface water source or from a groundwater under the direct influence of surface water source.

(34) [~~(31)~~] Raw groundwater source monitoring--Fecal indicator sampling at untreated groundwater sources including triggered source water and assessment source monitoring.

(35) Sanitary defect--A defect that could provide a pathway of entry for microbial contamination into the distribution system or that is indicative of a failure or imminent failure in a barrier that is already in place.

(36) Seasonal public water system--A noncommunity public water system that is not operated as a public water system on a year-round basis and starts up and shuts down at the beginning and end of each operating season.

(37) [~~(32)~~] Significant deficiency--Significant deficiencies cause, or have the potential to cause, the introduction of contamination into water delivered to customers. This could include defects in design, operation, or maintenance of the source, treatment, storage, or distribution systems.

(38) [~~(33)~~] Specific ultraviolet absorption at 254 nanometers (nm) (SUVA)--An indirect indicator of whether the organic carbon in water is humic or non-humic. It is calculated by dividing a sample's ultraviolet absorption at a wavelength of 254 nm (UV254) (in inverse meters) by its concentration of dissolved organic carbon (DOC) (in milligrams per liter).

(39) [~~(34)~~] Total organic carbon (TOC)--The concentration of total organic carbon, in milligrams per liter, measured using heat, oxygen, ultraviolet irradiation, chemical oxidants, or combinations of these oxidants that convert organic carbon to carbon dioxide, rounded to two significant figures. TOC is a surrogate measure for precursors to formation of disinfection by-products.

(40) [~~(35)~~] Total trihalomethanes (TTHM)--The sum of the chloroform, dibromochloromethane, bromodichloromethane, and bromoform concentrations in milligrams per liter, rounded to two significant figures after summing.

(41) [~~(36)~~] Triggered source water monitoring--Raw groundwater source monitoring required for systems not providing at least 4-log treatment of viruses when a routine distribution coliform sample is positive.

(42) [~~(37)~~] Trihalomethane (THM)--One of the family of organic compounds named as derivatives of methane, wherein three of the four hydrogen atoms in methane are each substituted by a halogen atom in the molecular structure.

(43) [~~(38)~~] Wholesale system--A public water system that delivers water to another public water system.

(44) [~~(39)~~] 4-log treatment--At least 99.99% (4-log) treatment of viruses using inactivation, removal, or an [~~a~~] executive director-approved combination of 4-log virus inactivation and removal. The 4-log treatment must be able to be properly validated and achieved before the first connection of the specified water source.

§290.104. Summary of Maximum Contaminant Levels, Maximum Residual Disinfectant Levels, Treatment Techniques, and Action Levels.

(a) Summary table purpose. The maximum contaminant levels (MCLs), maximum residual disinfectant levels (MRDLs), treatment techniques, and action levels are presented in this section as a reference source. Only the regulatory concentrations are shown in these tables. Compliance requirements are given in the specific section for each chemical.

(b) MCLs for inorganic compounds. The MCLs for inorganic contaminants listed in this subsection apply to public water systems as provided in §290.106 of this title (relating to Inorganic Contaminants).
Figure: 30 TAC §290.104(b) (No change.)

(c) MCLs for organic compounds. The following MCLs for synthetic organic contaminants and volatile organic contaminants apply to public water systems as provided in §290.107 of this title (relating to Organic Contaminants).

(1) The following are the MCLs for synthetic organic contaminants.
Figure: 30 TAC §290.104(c)(1) (No change.)

(2) The following are the MCLs for volatile organic contaminants.
Figure: 30 TAC §290.104(c)(2) (No change)

(d) MCLs for radionuclide contaminants. MCLs for radionuclide contaminants apply to public water systems as provided in §290.108 of this title (relating to Radionuclides Other than Radon).

(e) Microbial contaminants. The MCL for microbial or bacteriological contaminants applies to public water systems as provided in §290.109 of this title (relating to Microbial Contaminants). The MCL for microbiological contaminants is based on the presence or absence of *Escherichia coli (E. coli).* [~~The MCL for microbiological contaminants is based on the presence or absence of total coliform bacteria in a sample.~~]

(f) Minimum residual disinfectant concentrations and MRDLs. Minimum residual disinfectant concentrations and MRDLs apply to public water systems as provided in §290.110 of this title (relating to Disinfectant Residuals).

(1) The minimum residual disinfectant concentration in the water entering the distribution system is 0.2 milligrams per liter (mg/L) free chlorine or 0.5 mg/L chloramine.

(2) The minimum residual disinfectant concentration in the water within the distribution system is 0.2 mg/L free chlorine or 0.5 mg/L chloramine.

(3) The MRDL of chlorine dioxide in the water entering the distribution system is 0.8 mg/L.

(4) The MRDL of free chlorine or chloramine in the water within the distribution system is 4.0 mg/L based on a running annual average.

(g) Surface water treatment. Systems treating surface water or groundwater under the direct influence of surface water must meet the turbidity treatment technique requirements as provided in §290.111 of this title (relating to Surface Water Treatment).

(1) The turbidity level of the combined filter effluent must never exceed 1.0 nephelometric turbidity unit (NTU) and the turbidity level of the combined filter effluent must be 0.3 NTU or less in at least 95% of the samples tested each month.

(2) Systems are subject to the raw water monitoring, pathogen removal and inactivation and individual filter turbidity provisions of §290.111 of this title.

(h) Disinfection by-product precursors. The treatment technique requirements for disinfection by-product precursors apply to water systems as provided in §290.112 of this title (relating to Total Organic Carbon (TOC)).

(i) Disinfection by-products (total trihalomethanes (TTHM) and haloacetic acids (HAA5)). The MCLs for TTHM and HAA5 apply to water systems as provided in §290.113 of this title (relating to Stage 1 Disinfection By-products (TTHM and HAA5)) and in §290.115 of this title (relating to Stage 2 Disinfection By-products (TTHM and HAA5)). The MCLs for TTHM and HAA5 are:

(1) 0.080 mg/L for TTHM; and

(2) 0.060 mg/L for HAA5.

(j) Disinfection by-products other than TTHM and HAA5. The MCLs for chlorite and bromate apply to water systems as provided in §290.114 of this title (relating to Other Disinfection By-products (Chlorite and Bromate)). The MCLs for chlorite and bromate are as follows:

(1) 1.0 mg/L for chlorite; and

(2) 0.010 mg/L for bromate.

(k) Lead and copper action levels. The action levels for lead and copper apply to water systems as provided in §290.117 of this title (relating to Regulation of Lead and Copper). Action levels for lead and copper are as follows:

(1) 0.015 mg/L for lead; and

(2) 1.3 mg/L for copper.

(l) Recycle streams. The treatment technique requirements for recycle streams are specified in §290.42(c)(6) and (d)(3) of this title (relating to Water Treatment).

§290.106. Inorganic Contaminants.

(a) Applicability. All public water systems are subject to the requirements of this section.

(1) Community and nontransient, noncommunity systems shall comply with the requirements of this section regarding monitoring, reporting, and maximum contaminant levels (MCLs) for all inorganic contaminants (IOCs) listed in this section.

(2) Transient, noncommunity systems shall comply with the requirements of this section regarding monitoring, reporting, and MCL for nitrate and nitrite.

(3) For purposes of this section, systems using groundwater under the direct influence of surface water shall meet the inorganic sampling requirements given for surface water systems.

(b) MCLs [~~Maximum contaminant levels~~] for IOCs. The MCLs for IOCs listed in the following table apply to community and nontransient, noncommunity water systems. The MCLs for nitrate, nitrite, and total nitrate and nitrite also apply to transient, noncommunity water systems.
Figure: 30 TAC §290.106(b) (No change.)

(c) Monitoring requirements for IOCs. Public water systems shall monitor for IOCs at the locations specified by the executive director. All monitoring conducted under the requirements of this section must be conducted at sites designated in the public water system's monitoring plan. Each public water system shall monitor at the time designated during each compliance period.

(1) Routine monitoring locations for IOCs except asbestos. Antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, nitrate, nitrite, selenium, and thallium shall be monitored at each entry point to the distribution system.

(A) If a system draws water from more than one source and the sources are combined before distribution, the system must sample at an entry point that is representative of all sources and during periods of normal operating conditions.

(B) Systems shall take all subsequent samples at the same entry point to the distribution system unless the executive director determines that conditions make another entry point more representative of the source or treatment plant being monitored.

(C) The executive director may approve the use of composite samples.

(i) Compositing must be done in the laboratory or in the field by persons designated by the executive director.

(ii) Compositing shall be allowed only at groundwater entry points to the distribution system.

(iii) Compositing shall be allowed only within a single system. Samples from different systems shall not be included in a composite sample.

(iv) No more than five individual samples shall be included in a composite sample.

(v) The maximum number of individual samples allowed in a composite sample shall not exceed the number obtained by dividing the MCL for the contaminant by the detection limit of the analytical method and rounding the quotient to the next lowest integer. Detection limits for each analytical method are as listed in 40 Code of Federal Regulations (CFR) §141.23(a)(4)(i).

(vi) If the concentration in the composite sample is greater than or equal to the proportional contribution of the MCL (e.g., 20% of MCL when five points are composited) for any inorganic chem-

ical, then a follow-up sample must be collected from each sampling point included in the composite sample.

(I) Follow-up samples must be collected within 14 days of receipt of the composite sample results.

(II) If duplicates of the original sample taken from each entry point to the distribution system used in the composite are available, the system may use these instead of resampling. The duplicates must be analyzed within 14 days of the composite.

(III) The follow-up or duplicate samples must be analyzed for the contaminant(s) which were excessive in the composite sample.

(D) Initial monitoring for a new water source must be conducted at a site representative of the water quality of the new source of water. For systems with one well and one entry point, initial monitoring may be conducted at the entry point to the distribution system.

(2) Monitoring locations for asbestos. Asbestos shall be monitored at locations where asbestos contamination is most likely to occur.

(A) A system vulnerable to asbestos contamination due solely to source water shall sample at the entry point to the distribution system.

(B) A system vulnerable to asbestos contamination due solely to corrosion of asbestos-cement pipe shall sample at a tap served by asbestos-cement pipe, under conditions where asbestos contamination is most likely to occur.

(C) A system vulnerable to asbestos contamination due both to its source water supply and corrosion of asbestos-cement pipe shall sample at a tap served by asbestos-cement pipe, under conditions where asbestos contamination is most likely to occur.

(D) The executive director may require additional sampling locations based on the size, length, age, and location of asbestos-cement pipe in the distribution system. The system must provide information regarding the size, length, age, and location of asbestos-cement pipe in the distribution system to the executive director upon request.

(3) Initial monitoring frequency for IOCs except asbestos. Prior to using water as a drinking water source, public water systems shall monitor at the frequency determined by the executive director to ensure that the water distributed to customers will comply with the MCLs for antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, nitrate, nitrite [~~nitrate~~], nitrate and nitrite (total), mercury, selenium, and thallium.

(4) Monitoring frequency for IOCs except asbestos, nitrate, and nitrite. Community and nontransient, noncommunity public water systems shall monitor for antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, and thallium at the following frequency.

(A) Routine monitoring frequency. A public water system shall routinely monitor for antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, and thallium.

(i) Each groundwater entry point shall be sampled once every three years.

(ii) Each surface water entry point shall be sampled annually.

(iii) Each of the sampling frequencies listed in this paragraph constitutes one round of sampling for groundwater and surface water entry points, respectively.

(B) Reduced monitoring. The executive director may reduce the monitoring frequency for a system that has completed a minimum of three rounds of sampling by granting a waiver to the routine monitoring frequency for antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, and thallium.

(i) Systems that use a new water source are not eligible for a waiver until three rounds of sampling from the new source have been completed.

(ii) To be considered for a waiver, systems shall demonstrate that all previous analytical results at that sample site were less than the MCL.

(iii) In determining the appropriate reduced monitoring frequency, the executive director shall consider:

(I) the reported contaminant concentrations from all previous samples;

(II) the degree of variation in reported concentrations; and

(III) other factors that may affect contaminant concentrations such as changes in groundwater pumping rates, changes in the system's configuration, changes in the system's operating procedures, or changes in the flow or characteristics of a reservoir or stream used as the water source.

(iv) If the executive director grants a waiver, it shall be made in writing and shall set forth the basis for the determination. The determination may be initiated by the executive director. The executive director shall review and, where appropriate, revise the waiver of monitoring frequency when other data relevant to the system becomes available.

(v) The term during which the waiver is effective shall not exceed one compliance cycle (i.e., nine years).

(vi) A system must take a minimum of one sample during each compliance cycle while the waiver is effective.

(C) Increased monitoring. The executive director may increase the monitoring frequency for antimony, arsenic, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, or thallium.

(i) If the results from a sample site exceed any of the MCLs in subsection (b) of this section, the system shall immediately begin quarterly sampling at that sample site starting in the next quarter after the exceedance occurs.

(ii) After the initiation of quarterly monitoring, the executive director may return a system to the routine monitoring frequency if monitoring shows that the sampling site is reliably and consistently below the MCL.

(I) The executive director shall not decrease the quarterly sampling requirement until a groundwater system has taken a minimum of two quarterly samples.

(II) The executive director shall not decrease the quarterly sampling requirement until a surface water system has taken a minimum of four quarterly samples.

(5) Asbestos monitoring frequency. Community and nontransient, noncommunity water systems shall monitor for asbestos at the following frequency.

(A) A public water system shall routinely monitor for asbestos once during the first three years of each compliance cycle.

(B) The executive director may waive the routine monitoring frequency requirements for asbestos.

(i) When determining if a waiver should be granted, the executive director shall consider:

(I) the potential for asbestos contamination of the water source;

(II) the use of asbestos-cement pipe for finished water distribution; and

(III) the corrosivity of the water.

(ii) If the executive director grants a waiver, it shall be made in writing and shall set forth the basis for the determination. The determination may be initiated by the executive director. The executive director shall review and, where appropriate, revise the waiver of monitoring frequency when other data relevant to the system becomes available.

(iii) The term during which the waiver is effective shall not exceed one compliance cycle (i.e., nine years).

(C) The executive director may increase the monitoring frequency for asbestos.

(i) A system that exceeds the MCL for asbestos shall sample quarterly beginning in the next quarter after the violation occurs.

(ii) After the initiation of quarterly sampling, the executive director may return a system to the routine monitoring frequency if monitoring shows that the system is reliably and consistently below the MCL.

(I) The executive director shall not decrease the quarterly sampling requirement until a groundwater system has taken a minimum of two quarterly samples.

(II) The executive director shall not decrease the quarterly sampling requirement until a surface (or combined surface water and groundwater) water system has taken a minimum of four quarterly samples.

(6) Nitrate monitoring frequency. All public water systems shall monitor for nitrate at the following frequency.

(A) Routine nitrate monitoring frequency. All public water systems shall routinely monitor for nitrate.

(i) All public water systems shall annually sample at each groundwater entry point to the distribution system.

(ii) A community or nontransient, noncommunity water system shall sample quarterly at each surface water entry point to the distribution system.

(iii) A transient, noncommunity water system shall sample annually at each surface water entry point to the distribution system.

(B) Reduced nitrate monitoring frequency. The executive director may reduce the monitoring frequency for community or nontransient, noncommunity water systems using surface water sources by granting a waiver to the routine monitoring frequency.

(i) To be considered for a waiver, a system shall demonstrate that the nitrate concentration in each sample collected during the previous four consecutive quarters was less than 50% of the nitrate MCL.

(ii) If the executive director grants a waiver, it shall be made in writing and shall set forth the basis for the determination. The determination may be initiated by the executive director. The executive director shall review and, where appropriate, revise the waiver of monitoring frequency when other data relevant to the system becomes available.

(iii) A system that receives a waiver to the routine nitrate monitoring frequency must sample annually for nitrate. The annual sample must be collected in the quarter that previously resulted in the highest nitrate concentration.

(C) Increased nitrate monitoring frequency. The executive director may increase the nitrate monitoring frequency for community or nontransient, noncommunity water systems using groundwater sources.

(i) A system that is sampling annually shall begin quarterly nitrate sampling if the nitrate concentration in any sample is equal to or greater than 50% of the nitrate MCL. Quarterly sampling must begin the first quarter after the elevated nitrate level was detected.

(ii) After the initiation of quarterly sampling, the executive director may return a system to the routine annual nitrate monitoring frequency if quarterly sampling shows that the system is reliably and consistently below the nitrate MCL for a minimum of four consecutive quarters.

(7) Nitrite monitoring frequency. All public water systems shall monitor for nitrite at the following frequency.

(A) All public water systems shall routinely take one nitrite sample during [~~the first three years of~~] each nine-year compliance cycle. All public water systems shall monitor at the time designated by the executive director during each compliance period during each nine-year compliance cycle. New entry points will be scheduled for nitrite sample collection during the first year of operation, and then every nine years thereafter unless increased nitrite monitoring is required in accordance with this paragraph.

(B) The executive director may reduce the monitoring frequency for nitrite by granting a waiver to the routine monitoring frequency.

(i) To be considered for a waiver, a system shall demonstrate that the nitrite concentration in the initial sample was less than 50% of the nitrite MCL.

(ii) If the executive director grants a waiver, it shall be made in writing and shall set forth the basis for the determination. The determination may be initiated by the executive director. The executive director shall review and, where appropriate, revise the waiver of monitoring frequency when other data relevant to the system becomes available.

(iii) A system that receives a waiver to the routine nitrite monitoring frequency must sample at a frequency specified by the executive director.

(C) The executive director may increase the monitoring frequency for nitrite.

(i) A system shall sample quarterly for at least one year following any sample in which the nitrite concentration is greater than or equal to 50% of the MCL.

(ii) The executive director may allow a system to return to the routine monitoring frequency after determining the system is reliably and consistently less than the MCL.

(8) Confirmation sampling for all IOCs. The executive director may require a public water system to confirm the results of any individual sample.

(A) If a sample result exceeds the MCL, a public water system may be required to collect one additional sample to confirm the results of the initial test. If an additional sample is required:

(i) Confirmation samples must be collected at the same entry point to the distribution system as the sample that exceeded the MCL;

(ii) Confirmation samples for IOCs except nitrate and nitrite shall be collected as soon as possible after the system receives the analytical results of the first sample; and

(iii) Confirmation samples for nitrate and nitrite shall be collected within 24 hours of the system's receipt of notification of the analytical results of the first sample. Systems unable to comply with the 24-hour sampling requirement must immediately notify the consumers served by the public water system in accordance with subsection (f) of this section. Systems exercising this option must take and analyze a confirmation sample within two weeks of notification of the analytical results of the first sample.

(B) The executive director may require a confirmation sample for any sample with questionable results.

(9) More frequent monitoring. The executive director may require more frequent monitoring than specified in paragraphs (4) - (7) of this subsection.

(d) Analytical requirements for IOCs. Analytical procedures shall be performed in accordance with §290.119 of this title (relating to Analytical Procedures). Testing for inorganic contaminants shall be performed at a laboratory certified by the executive director.

(e) Reporting requirements for IOCs. The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~ten days of the request or within ten days of their receipt by the public water system, whichever is later~~]. The copies must be mailed to the Texas Commission on Environmental Quality, Water Supply Division, MC 155, P.O. Box 13087, Austin, Texas 78711-3087.

(f) Compliance determination for IOCs. Compliance with this section shall be determined using the following criteria.

(1) Compliance with the MCL for each IOC shall be based on the analytical results obtained at each individual sampling point.

(2) A public water system that exceeds the levels for nitrate, nitrite, or the sum of nitrate and nitrite specified in subsection (b) of this section commits an acute MCL violation. Compliance shall be based on the results of the single sample. If a confirmation sample is collected, compliance shall be based on the average result of the original and confirmation samples.

(3) A public water system that exceeds the levels of antimony, arsenic, asbestos, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, or thallium (i.e., any IOC except nitrate and nitrite) specified in subsection (b) of this section at any sampling point commits an MCL violation.

(A) For systems that are sampling annually or less frequently, compliance may be based on the results of a single sample, if a confirmation sample is not collected.

(B) For systems that are sampling annually or less frequently, if a confirmation sample is collected, compliance will be based on the average result of the original and confirmation samples.

(C) For systems that are sampling more frequently than annually, compliance is based on the running annual average for each sampling point.

(D) If a single quarterly sample would cause the running annual average to be exceeded, then the system is immediately out of compliance.

(4) Any result below the method detection limits of 40 CFR §141.23(a)(4)(i) shall be considered to be zero for the purpose of calculating compliance.

(5) The executive director may exclude the results of obvious sampling errors from the compliance calculations.

(6) Compliance with the IOC MCLs must be based on the results of all samples required by the executive director, regardless of whether that number is greater or less than the minimum required number.

(7) For purposes of determining compliance, arsenic results must be reported to the nearest 0.001 milligram per liter [~~mg/L~~].

(8) A public water system that fails to do a required public notice or certify that the public notice has been performed commits a public notice violation.

(g) Public notice for IOCs. A public water system that violates the requirements of this section must notify the executive director and the system's customers.

(1) A public water system that violates the MCL for nitrate, nitrite, or the sum of nitrate and nitrite shall notify the executive director within 24 hours and the water system customers of this acute violation in accordance with the requirements of §290.122(a) of this title (relating to Public Notification).

(2) A public water system that violates the MCL for nitrate, nitrite, or the sum of nitrate and nitrite that is unable to comply with the 24-hour confirmation sampling requirement must immediately notify the consumers served by the public water system in accordance with §290.122(a) of this title.

(3) A public water system that fails to meet the MCL for any of the regulated IOCs except nitrate and nitrite (i.e., antimony, arsenic, asbestos, barium, beryllium, cadmium, chromium, cyanide, fluoride, mercury, selenium, and thallium) shall notify the executive director by the end of the next business day and the water system customers in accordance with the requirements of §290.122(b) of this title.

(4) A public water system that fails to conduct the monitoring required by this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(5) If a public water system has a distribution system separable from other parts of the distribution system with no interconnections, the executive director may allow the system to give public notice to only the area served by that portion of the system that is out of compliance.

(h) Best available technology (BAT) for IOCs. BAT for treatment of violations of MCLs in subsection (b) of this section are listed in 40 CFR §141.62.

(i) Small system compliance technologies (SSCTs) for arsenic. SSCTs for arsenic are listed in 40 CFR §141.62(d) and may be utilized with commission approval. When point-of-use or point-of-entry devices are used for compliance, the water system must develop a pro-

gram for the long-term operation, maintenance, and monitoring of the devices to ensure adequate performance.

(j) Bottled water. In accordance with 40 CFR §141.101, bottled water may be used on a temporary basis only and with approval by the commission in order to avoid unreasonable risk to health.

§290.107. Organic Contaminants.

(a) Applicability. All community and nontransient, noncommunity water systems shall comply with the requirements of this section regarding organic contaminants. For purposes of this section, systems using groundwater under the direct influence of surface water shall meet the organic sampling requirements given for surface water systems.

(b) Maximum contaminant levels (MCLs) for organic contaminants. The concentration of synthetic and volatile organic chemicals shall not exceed the MCLs specified in this section.

(1) The following are MCLs for synthetic organic chemical (SOC) contaminants.
Figure: 30 TAC §290.107(b)(1) (No change.)

(2) The following are MCLs for volatile organic chemical (VOC) contaminants.
Figure: 30 TAC §290.107(b)(2) (No change.)

(3) Each public water system must certify annually to the executive director (using third-party or manufacturer's certification) that when acrylamide or epichlorohydrin are used in drinking water systems, the combination (or product) of dose and monomer level does not exceed 0.05% dosed at 1.0 milligrams per liter (mg/L) (or equivalent) for acrylamide and 0.01% dosed at 20 mg/L (or equivalent) for epichlorohydrin.

(c) Monitoring requirements for organic contaminants. Public water systems shall monitor for organic contaminants at the locations and frequency in paragraphs (1) and (2) of this subsection. All monitoring conducted under the requirements of this section must be conducted at sites designated in the public water system's monitoring plan. All samples must be taken during periods of normal operation.

(1) SOC monitoring requirements. Monitoring of the SOC contaminants shall be conducted at the frequency and locations given in this paragraph.

(A) SOC monitoring locations. Monitoring of the SOC contaminants shall be conducted at the following locations.

(i) Systems shall routinely sample at sample sites representative of each entry point to the distribution system.

(ii) Subsequent samples must be taken at the same sample site unless the executive director determines that a change in conditions makes a different sample site more representative of the water available to customers.

(iii) The executive director must approve any change in sampling location.

(B) Initial SOC monitoring frequency. Prior to using a new source of water as drinking water, public water systems shall monitor at the frequency established by the executive director to ensure that the water distributed to customers will comply with the MCLs for SOCs.

(C) Routine SOC monitoring frequency. Monitoring of the SOC contaminants shall be conducted at the following frequency.

(i) Community and nontransient, noncommunity water systems shall take four consecutive quarterly samples for each SOC contaminant listed in subsection (b)(1) of this section during each compliance period beginning with the initial compliance period.

(ii) Community and nontransient, noncommunity water systems serving more than 3,300 persons that do not detect a contaminant in the initial compliance period may reduce the sampling frequency at that sample site to a minimum of two consecutive quarterly samples in one year during each repeat compliance period.

(iii) Community and nontransient, noncommunity water systems serving 3,300 persons or fewer that do not detect a contaminant in the initial compliance period may reduce the sampling frequency at that sample site to a minimum of one sample during each repeat compliance period.

(iv) Each public water system shall monitor at the time designated by the executive director within each compliance period.

(D) Increased SOC monitoring. The executive director may change the monitoring frequency for SOCs.

(i) Entry points that exceed the SOC MCLs of subsection (b)(1) of this section as determined by subsection (f) of this section must be monitored quarterly. After a minimum of four quarterly samples shows the system is in compliance and the executive director determines the system is reliably and consistently below the MCL, as determined by the methods specified in subsection (f) of this section, the executive director may allow the system to monitor annually. Systems that monitor annually must monitor during the quarter that previously yielded the highest analytical result.

(ii) The executive director may change the monitoring frequency if an organic SOC contaminant is detected in any sample.

(I) If an organic SOC contaminant is detected in any sample, the system must monitor quarterly at each entry point to the distribution system at which a detection occurs.

(II) After a system collects a minimum of two consecutive quarterly samples at a groundwater sample site, the executive director may decrease the quarterly monitoring requirement specified in subclause (I) of this clause, if the sample site is reliably and consistently below the MCL.

(III) After a system collects a minimum of four consecutive quarterly samples at a surface water sample site or a groundwater under the direct influence of surface water sample site, the executive director may decrease the quarterly monitoring requirement specified in subclause (I) of this clause, if the sample site is reliably and consistently below the MCL.

(IV) After the executive director determines that a sample site is reliably and consistently below the MCL, the executive director may allow the sample site to be monitored annually. Systems that monitor annually must monitor during the quarter that previously yielded the highest analytical result.

(V) Sample sites that have three consecutive annual samples with no detection of a contaminant may be granted a waiver at the discretion of the executive director. The executive director will consider the waiver for each compliance period.

(VI) If monitoring results in detection of one or more of certain related contaminants (i.e., heptachlor and heptachlor epoxide), then subsequent monitoring shall analyze for all related contaminants.

(iii) The executive director may increase the required SOC monitoring frequency, where necessary, to detect

variations within the system (e.g., fluctuations in concentration due to seasonal use, changes in water source, etc.).

(iv) The executive director may require a confirmation sample for positive or negative results. If a confirmation sample is required by the executive director, the result must be averaged with the first sampling result and the average used for the compliance determination as specified in subsection (f) of this section. The executive director has discretion to delete results of obvious sampling errors from this calculation.

(E) Waivers for SOC monitoring. The executive director may grant a waiver to reduce the SOC monitoring frequency from the monitoring frequency requirements of subparagraphs (B) and (C) of this paragraph, based on previous use of the contaminant within the watershed or zone of influence of the water source. Examples of use of a contaminant include transport, storage, or disposal. If a determination by the executive director reveals no previous use of the contaminant within the watershed or zone of influence, a waiver may be granted. If the executive director cannot determine whether the contaminant has been used in the watershed or if the contaminant has been used previously, then the following factors shall be used to determine whether a waiver is granted:

(i) previous analytical results;

(ii) the proximity of the system to a potential point or non-point source of contamination. Point sources include spills and leaks of chemicals at or near a water treatment facility or at drinking water sources, manufacturing, distribution, or storage facilities, or from hazardous and municipal waste landfills and other waste handling or treatment facilities. Non-point sources include the use of pesticides to control insects, weeds, or pests on agricultural areas, forest lands, home and garden property, or other land application uses;

(iii) the environmental persistence and transport of the pesticide herbicide or contaminant;

(iv) how well the water source is protected against contamination due to such factors as depth of the well, type of soil, and the integrity of well construction. Surface water systems must consider watershed vulnerability and protection;

(v) elevated nitrate levels at the water supply source; and

(vi) use of polychlorinated byphenyls (PCBs) in equipment used in the production, storage, or distribution of water (i.e., PCBs used in pumps, transformers, etc.).

(F) Compositing for SOC monitoring. The executive director may reduce the total number of samples required from a system for analysis by allowing the use of compositing. Composite samples from a maximum of five entry points to the distribution system are allowed. Compositing of samples must be done in the laboratory and analyzed within 14 days of sample collection.

(i) If any of the SOC contaminants listed in subsection (b)(1) of this section are detected in a composite sample, then a follow-up sample must be taken from each entry point to the distribution system included in the composite and analyzed within 14 days of collection.

(ii) If duplicates of the original SOC sample taken from each entry point to the distribution system used in the composite are available, the executive director may use these duplicates instead of resampling. The duplicate must be analyzed within 14 days of collection and the results reported to the executive director.

(iii) Compositing may only be permitted at entry points to the distribution system within a single system.

(2) VOC monitoring requirements. Monitoring of the VOC contaminants shall be conducted at the frequency and locations given in this paragraph.

(A) VOC monitoring locations. Monitoring of the VOC contaminants shall be conducted at the following locations.

(i) Systems shall routinely sample at sample sites representative of each entry point to the distribution system.

(ii) Subsequent samples must be taken at the same sample site unless the executive director determines that a change in conditions makes a different sample site more representative of the water available to customers.

(iii) The executive director must approve any change in sampling location.

(B) Initial VOC monitoring frequency. Prior to using water as a drinking water source, public water systems shall monitor at the frequency established by the executive director to ensure that the water distributed to customers will comply with the MCLs for VOCs.

(C) Routine VOC monitoring frequency. Monitoring of the VOC contaminants shall be conducted at the following frequency.

(i) Community and nontransient, noncommunity water systems shall take four consecutive quarterly samples for each VOC contaminant listed in subsection (b)(2) of this section during each compliance period, beginning with the initial compliance period.

(ii) If the initial monitoring for VOC contaminants has been completed, and the system did not detect any VOC contaminant listed in subsection (b)(2) of this section, the system shall take one sample annually beginning with the initial compliance period.

(iii) After a minimum of three years of annual sampling, the executive director may allow groundwater systems with no previous detection of any VOC contaminant listed in subsection (b)(2) of this section to take one sample during each compliance period.

(iv) Each community and nontransient, noncommunity groundwater system that does not detect a VOC contaminant listed in subsection (b)(2) of this section may be granted a waiver from the annual or triennial requirements of subsection (c)(2)(C)(ii) and (iii) of this section after completing the initial monitoring. For the purposes of this section, detection is defined as an analytical result of 0.0005 mg/L or greater. A waiver shall be effective for no more than six years (two compliance periods).

(v) Each public water system shall monitor at the time designated by the executive director within each compliance period.

(D) Increased VOC monitoring. The executive director may change the monitoring frequency for VOCs.

(i) Sample sites that exceed the VOC MCLs of subsection (b)(2) of this section, as determined by subsection (f) of this section, must be monitored quarterly. After a minimum of four consecutive quarterly samples that show the system is in compliance as specified in subsection (f) of this section and after the executive director determines that the system is reliably and consistently below the MCL, the executive director may allow the system to monitor annually during the quarter that previously yielded the highest analytical result.

(ii) The executive director may require a confirmation sample for positive or negative results. If a confirmation sample is required by the executive director, the result must be averaged with the

first sampling result and the average is used for the compliance determination as specified by subsection (f) of this section. The executive director has discretion to delete results of obvious sampling errors from this calculation.

(iii) If a VOC contaminant listed in subsection (b)(2) of this section is detected at a level exceeding 0.0005 mg/L in any sample, then:

(I) the system must monitor quarterly at each entry point to the distribution system that resulted in a detection;

(II) the executive director may decrease the quarterly monitoring requirement specified in subsection (c)(2)(D)(iii)(I) of this section provided that the executive director has determined that the system is reliably and consistently below the MCL. In no case shall the executive director make this determination unless a groundwater system takes a minimum of two quarterly samples and a surface water system takes a minimum of four quarterly samples;

(III) if the executive director determines that the system is reliably and consistently below the MCL, the executive director may allow the system to monitor annually. Systems that monitor annually must monitor during the quarter that previously yielded the highest analytical result;

(IV) systems which have three consecutive annual samples with no detection of a contaminant may be granted a waiver as specified in subparagraph (E) of this paragraph; and

(V) groundwater systems that have detected one or more of the following two-carbon organic compounds: trichloroethylene, tetrachloroethylene, 1,2-dichloroethane, 1,1,1-trichloroethane, cis-1,2-dichloroethylene, trans-1,2-dichloroethylene, or 1,1-dichloroethylene shall monitor quarterly for vinyl chloride. A vinyl chloride sample shall be taken at each entry point to the distribution system at which one or more of the two-carbon organic compounds was detected. If the result of the first analysis does not detect vinyl chloride, the executive director may reduce the quarterly monitoring frequency for vinyl chloride to one sample during each compliance period. Surface water systems are required to monitor for vinyl chloride as specified by the executive director.

(iv) The executive director may increase the required VOC monitoring frequency, where necessary, to detect variations within the system (e.g., fluctuations in concentration due to seasonal use, changes in water source, etc.).

(E) Waivers for VOC monitoring. The executive director may grant a waiver after evaluating the previous use (including transport, storage, or disposal) of the contaminant within the watershed or zone of influence of the water sources. If a determination by the executive director reveals no previous use of the contaminant within the watershed or zone of influence, a waiver may be granted. If previous use of the contaminant is unknown or it has been used previously, then the following factors shall be used to determine whether a waiver is granted:

(i) previous analytical results;

(ii) the proximity of the system to a potential point or non-point source of contamination. Point sources include spills and leaks of chemicals at or near a water treatment facility or at drinking water sources manufacturing, distribution, or storage facilities, or from hazardous and municipal waste landfills and other waste handling or treatment facilities;

(iii) the environmental persistence and transport of the contaminants;

(iv) the number of persons served by the public water system and the proximity of a smaller system to a larger system;

(v) how well the water source is protected against contamination (e.g., is it a surface or groundwater system). Groundwater systems must consider factors such as depth of the well, the type of soil, and well construction. Surface water systems must consider watershed protection;

(vi) as a condition of the waiver, a groundwater system must take one sample at each entry point to the distribution system during the time the waiver is effective (i.e., one sample during two compliance periods or six years) and update its vulnerability assessment considering the factors listed in this paragraph. Based on this updated vulnerability assessment, the executive director must reconfirm that the system is not vulnerable. If the executive director does not make this reconfirmation within three years of the initial determination, then the waiver is invalid and the system is required to sample annually; and

(vii) community and nontransient surface water systems that do not detect a VOC contaminant listed in subsection (b)(2) of this section may be considered by the executive director for a waiver from the annual sampling requirements of subparagraph (C)(ii) of this paragraph after completing the initial monitoring. Systems meeting this criteria must be determined by the executive director to be non-vulnerable based on a vulnerability assessment during each compliance period. Each system receiving a waiver shall sample at the frequency specified by the executive director (if any).

(F) Compositing for VOC monitoring. The executive director may reduce the total number of samples a system must analyze by allowing the use of compositing. Composite samples from a maximum of entry points to the distribution system are allowed. Compositing of samples must be done in the laboratory and analyzed within 14 days of sample collection.

(i) If the VOC concentration in the composite sample is 0.0005 mg/L or greater for any contaminant listed in subsection (b)(2) of this section, then a follow-up sample must be taken and analyzed within 14 days from each entry point to the distribution system included in the composite.

(ii) If duplicates of the original sample taken from each entry point to the distribution system used in the composite are available, the system may use these instead of resampling. The duplicate must be analyzed within 14 days of collection.

(iii) Compositing may only be permitted by the executive director at entry points to the distribution system within a single system.

(iv) Procedures for compositing VOC samples are as stated in 40 Code of Federal Regulations (CFR) §141.24(f)(14)(iv).

(d) Analytical requirements for organic contaminants. Analytical procedures shall be performed in accordance with §290.119 of this title (relating to Analytical Procedures). Testing for organic contaminants shall be performed at a laboratory certified by the executive director.

(e) Reporting requirements for organic contaminants. The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~of the request or within ten days of their receipt by the public~~

~~water system, whichever is later~~]. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(f) Compliance determination for organic contaminants. Compliance with the MCLs of subsection (b)(1) and (2) of this section shall be determined based on the analytical results obtained at each entry point to the distribution system.

(1) If one sampling point is in violation of any MCL in subsection (b) of this section, then the system is in violation of the MCL for that contaminant.

(A) For systems monitoring more than once per year, compliance with the MCL is determined by a running annual average at each sampling point.

(B) Systems monitoring annually or less frequently whose sample result exceeds the MCL must begin quarterly sampling; systems will not be considered in violation of the MCL until they have completed one year of quarterly sampling

(C) If any sample result will cause the running annual average to exceed the MCL at any sampling point, the system is out of compliance with the MCL immediately.

(D) If a system fails to collect the required number of samples,
compliance will be based on the total number of samples collected.

(E) If a sample result is less than the detection limit, zero will be used to calculate the annual average.

(2) The executive director has the authority to determine compliance or
initiate enforcement action based upon analytical results and other information compiled by sanctioned representatives and agencies.

(3) A public water system that fails to do a required public notice or certify
that the public notice has been performed commits a public notice violation.

(g) Public notification requirements for organic contaminants. A public water system that violates the requirements of this section must notify the executive director and the system's customers. If a public water system has a distribution system separate from other parts of the distribution system with no interconnections, the executive director may allow the system to give public notice to only that portion of the system that is out of compliance.

(1) A system that violates an MCL given in subsection (b) of this section, shall report to the executive director and notify the public as provided under §290.122(b) of this title (relating to Public Notification).

(2) A public water system that fails to conduct the monitoring required by this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(h) Best available technology for organic contaminants. Best available technology for treatment of violations of MCLs in subsection (b) of this section are listed in 40 CFR §141.61. Copies are available for review in the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

§290.108. Radionuclides Other than Radon.

(a) Applicability. All community water systems shall comply with the requirements of this section regarding radionuclide contaminants. Public water systems treating groundwater under the direct influence of surface water must comply with the radionuclide requirements for surface water systems. Public water systems shall comply with the initial monitoring requirements.

(b) Maximum contaminant levels (MCL). The concentration of radionuclide contaminants in the water entering the distribution system shall not exceed the following MCLs.

(1) MCLs for naturally occurring radionuclides are as follows:

(A) 5 picoCuries per liter (pCi/L) for combined radium-226 and radium-228, as calculated by the summation of the results for radium-226 and radium-228;

(B) 15 pCi/L for gross alpha particle activity (including radium-226 but excluding radon and uranium); and

(C) 30 micrograms per liter [~~(µg/L)~~] for uranium.

(2) MCLs for beta particle and photon radioactivity from man-made radionuclides in drinking water in community water systems are equivalent to the MCLs under 40 Code of Federal Regulations (CFR) §141.66(d), as amended and adopted in the CFR through December 7, 2000 (65 FR 76708), which is adopted by reference.

(c) Monitoring requirements. Public water systems shall measure the concentration of radionuclides at locations and frequencies specified in the system's monitoring plan. All samples must be collected during normal operating conditions.

(1) Monitoring frequency for naturally occurring radionuclides. The monitoring frequency requirements for gross alpha particle activity, combined radium-226 and radium-228, and uranium are as follows.

(A) Initial monitoring frequency. All systems that use a new source of water must begin to conduct initial monitoring of the new source within 90 days after initiating use of the source.

(i) If the initial monitoring results are at or above an MCL, the system must perform quarterly monitoring as described in subparagraph (C) of this paragraph.

(ii) If the initial monitoring results are below all of MCLs given in subsection (b)(1) of this section, the system shall perform routine monitoring as described in subparagraph (B) of this paragraph.

(B) Routine monitoring. The results of samples collected during initial and routine monitoring periods will be used to determine the monitoring frequency for subsequent monitoring periods.

(i) If the results for all contaminants (gross alpha particle activity, combined radium-226 and radium-228, and uranium) are below the detection limits specified in Table A of this clause, the system must collect and analyze at least one sample at that sampling point once every nine years.
Figure: 30 TAC §290.108(c)(1)(B)(i) (No change.)

(ii) If the result for any contaminant is at or above the detection limit but at or below one-half the MCLs given in subsection (b) of this section, the system must collect and analyze at least one sample at that sampling point every six years.

(iii) If the result for any contaminant is above one-half the MCLs given in subsection (b) of this section but below the MCL, the system must collect and analyze at least one sample at that sampling point every three years.

(iv) If the result for any contaminant is at or above any of the MCLs given in subsection (b) of this section, monitoring

must be performed at the frequency given in subparagraph (C) of this paragraph.

(C) Increased monitoring. A system must perform increased monitoring if any results at a sampling point are at or above the MCLs, or at the direction of the executive director.

(i) If the results for any contaminant are at or above any of the MCLs given in subsection (b) of this section, consecutive quarterly monitoring must be performed at that sample point.

(ii) If the average of quarterly monitoring results is less than the MCLs in subsection (b) of this section, the sample point may be returned to the routine sampling frequency given in subparagraph (B) of this paragraph.

(iii) To fulfill quarterly monitoring requirements a system may composite up to four consecutive quarterly samples from a single entry point if analysis is done within a year of the first sample.

(iv) The analytical results from a composite sample will be treated as the annual average to determine compliance with the MCLs and future monitoring frequency requirements.

(v) When required by the executive director, more frequent monitoring must be conducted in the vicinity of mining or other operations that may contribute alpha particle radioactivity to either surface or groundwater sources of drinking water, or when changes in the distribution system or treatment processing occur that may increase the concentration of radionuclide in the finished water.

(vi) Community public water systems shall conduct monitoring when required by the executive director.

(D) Historical data. A system may use historical data to comply with the initial monitoring requirement, if approved by the executive director.

(i) A system having only one entry point to the distribution system may use the monitoring data from the previous entry point or distribution system compliance monitoring to satisfy initial monitoring requirements.

(ii) A system with multiple entry points that has appropriate historical monitoring data for each entry point to the distribution system may use previous compliance monitoring data to satisfy initial monitoring requirements.

(iii) To satisfy initial monitoring requirements, a community water system with appropriate historical data for a representative point in the distribution system may use the monitoring data from the distribution system, provided that the executive director finds that the historical data satisfactorily demonstrates that each entry point to the distribution system is expected to be in compliance based upon the historical data and reasonable assumptions about the variability of contaminant levels between entry points.

(E) Sample invalidation. The executive director may invalidate the results of obvious sampling or analytic errors.

(F) Confirmation samples. The executive director may require more frequent monitoring or may require confirmation samples at the executive director's discretion.

(G) Sampling scheduling. Systems shall monitor at the time designated by the executive director.

(2) Monitoring and compliance for man-made radionuclides. The monitoring and compliance requirements for man-made radionuclide under 40 CFR §141.26(b), as amended and adopted in the CFR through December 7, 2000 (65 FR 76708), are adopted by reference.

(3) Monitoring locations for radionuclide contaminants. Systems must monitor at sample sites described in the system's monitoring plan.

(A) Initial monitoring for a new water source must be conducted at a site representative of the water quality of the new source of water.

(B) Routine compliance monitoring for the radionuclide covered by this section must be performed at sampling points representing each entry point to the distribution system. If results from an entry point exceed one-half the MCL, the executive director may require the system to sample all water sources providing water to that entry point.

(d) Analytical requirements for radionuclide contaminants. Analytical procedures shall be performed in accordance with §290.119 of this title (relating to Analytical Procedures). Testing for radionuclide contaminants shall be performed at a laboratory certified by the executive director.

(e) Reporting requirements. The [~~Upon the request of the executive director the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this section. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~of the request or within ten days of their receipt by the public water system, whichever is later~~]. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(f) Compliance determination. Compliance with the requirements of this section shall be determined as follows.

(1) If the running average annual MCL for gross alpha particle activity, combined radium-226 and radium-228, or uranium as set forth in subsection (b) of this section is exceeded, based on quarterly monitoring results, the system has committed an MCL violation.

(A) A gross alpha particle activity measurement may be substituted for the required radium-226 and radium-228 analysis provided that the measured gross alpha particle activity does not exceed 5 pCi/L at a confidence level of 95% (1.65 theta where theta is the standard deviation of the net counting rate of the sample).

(B) When the gross alpha particle activity exceeds 5 pCi/L, the same or an equivalent sample shall be analyzed for radium-226 and radium-228.

(C) If a sample result is less than the detection limit, zero will be used to calculate the annual average, unless a gross alpha particle activity is being used in lieu of radium-226 and/or uranium. If the gross alpha particle activity result is less than detection, one-half the detection limit will be used to calculate the annual average.

(D) The results of all samples taken and analyzed under the provisions of this section will be used in determining compliance, even if that number is greater or less than the minimum required.

(E) If a system fails to complete required increased monitoring, the executive director may base compliance on all available sample results.

(F) If the results at one sample site are in violation, the public water system is in violation.

(G) When confirmation samples are collected, the average of an initial sample and its confirmation sample must be averaged for the purposes of determining compliance.

(H) To judge compliance with the MCLs, sample results must be rounded to the same number of significant figures as the MCL for the substance in question.

(2) If the average annual MCL [~~maximum contaminant level~~] for man-made radionuclide set forth in subsection (b) of this section is exceeded, the system has committed an MCL violation.

(3) A public water system that fails to conduct the monitoring tests required by this subsection commits a monitoring violation.

(4) A public water system that fails to report the results of the monitoring tests required by this subsection commits a reporting violation.

(5) A public water system that fails to do a required public notice or certify that the public notice has been performed commits a public notice violation.

(g) Public notification. A public water system that violates the requirements of this section must notify the executive director and the system's customers, as follows.

(1) A public water system that violates the MCL for gross alpha particle activity, combined radium-226 and radium-228, or uranium shall give notice to the executive director and notify the public as required by §290.122(b) of this title (relating to Public Notification).

(2) The operator of a community water system that violates the MCL for man-made radionuclide shall give notice to the executive director and to the public as required by §290.122(b) of this title.

(3) A public water system that fails to conduct the monitoring required by this subsection must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(h) Best available technology for radionuclides other than radon. Best available technology for treatment of violations of MCLs in subsection (b) of this section are listed in 40 CFR §141.66(g).

(i) Small system compliance technologies (SSCTs) for radionuclides. SSCTs for radionuclides are listed in 40 CFR §141.66(h) and may be utilized with commission approval. When point-of-use or point-of-entry devices are used for compliance, the water system must develop a program for the long-term operation, maintenance, and monitoring of the devices to ensure adequate performance.

(j) Bottled water. In accordance with 40 CFR §141.101, bottled water may be used on a temporary basis only and with approval by the commission in order to avoid unreasonable risk to health.

§290.109. Microbial Contaminants.

(a) Applicability. All public water systems must produce and distribute water that meets the provisions of this section regarding microbial contaminants.

(b) Maximum contaminant levels (MCL) for microbial contaminants. Treatment techniques and MCL requirements for microbial contaminants are based on detection of those contaminants or fecal indicator organisms.

(1) A public water system is in compliance with the MCL for *Escherichia coli (E. coli)* unless any of the following conditions occur: [~~The MCL for microbial contaminants in the distribution system is based on the presence of total or fecal coliform bacteria in routine, repeat, and increased monitoring distribution samples.~~]

(A) The public water system has an *E. coli*-positive repeat sample following a total-coliform-positive routine sample; [~~For a system which collects at least 40 routine distribution samples per month, the MCL is defined as when more than 5.0% of samples collected in a month are coliform positive.~~]

(B) The public water system has a total coliform-positive repeat sample following an *E. coli*-positive routine sample; [~~For a system which collects fewer than 40 routine distribution samples per month, the MCL is defined as when more than one sample is coliform positive.~~]

(C) The public water system fails to take all required repeat samples following an *E. coli*-positive routine sample; or [~~The acute MCL is defined as when a repeat sample is fecal coliform or *Escherichia coli (E. coli)* positive; or a total coliform positive repeat sample follows a fecal coliform or *E. coli* positive routine sample.~~]

(D) The public water system fails to test for *E. coli* when any repeat sample tests positive for total coliform.

(E) The *E. coli* MCL is defined as when a condition described in subparagraphs (A) - (D) of this paragraph occurs.

(2) For public water systems required to collect raw groundwater samples, the standard is no detection of fecal indicators in a raw groundwater sample [~~samples~~].

(c) Treatment technique triggers and assessment requirements for microbial contaminants. All public water systems shall comply with the requirements as described in this subsection. Public water systems shall conduct assessments after exceeding any of the treatment technique triggers as described in paragraphs (1) and (2) of this subsection.

(1) Level 1 treatment technique triggers are:

(A) For a public water system which collects 40 or more distribution samples per month, the treatment technique trigger is defined as when more than 5.0% of samples collected in a month are total coliform-positive.

(B) For a public water system which collects fewer than 40 distribution samples per month, the treatment technique trigger is defined as when two or more samples collected in a month are total coliform-positive.

(C) When a public water system fails to collect all required repeat samples after a total coliform-positive result.

(2) Level 2 treatment technique triggers are:

(A) An *E. coli* MCL violation as specified in subsection (b)(1)(A) - (D) of this section occurs.

(B) A second Level 1 treatment technique trigger occurs as defined in paragraph (c)(1) of this section, within a rolling 12-month period. If the executive director has determined the reason that the samples that caused the first Level 1 treatment technique trigger were total coliform-positive and has established that the public water system has corrected the problem, a public water system will not be required to conduct and complete a Level 2 assessment. The public water system shall have identified any sanitary defect and provided adequate documentation to the executive director in the initial Level 1 assessment which established the reason that caused the first Level 1 treatment technique trigger and that the public water system corrected the problem. If the executive director has determined that a public water system is not required to conduct a Level 2 assessment based on the occurrence of a second Level 1 treatment technique trigger within a rolling 12-month period, the public water system shall still conduct the required Level 1 assessment.

(3) Treatment technique assessment requirements are:

(A) Level 1 and Level 2 assessments are conducted in order to identify the possible presence of sanitary defects and defects in distribution system coliform monitoring practices. The assessments may also indicate that no sanitary defects were identified. When conducting assessments, systems shall ensure that the assessor evaluates minimum elements that include review and identification of inadequacies in sample sites; sampling protocol; sample processing; atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including, but not limited to water storage); source and treatment considerations that bear on distributed water quality; and existing water quality monitoring data. The system shall conduct and complete the assessment in the format as prescribed by the executive director that tailors specific assessment elements with respect to the size and type of the system and the size, type, and characteristics of the distribution system.

(i) Level 1 and Level 2 assessments shall be conducted and completed by the public water system, licensed operators as required under §290.46(e) of this title (relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems), or other parties approved by the executive director. The public water system, licensed operators, as required under §290.46(e) of this title, and other parties approved by the executive director shall have also completed any training required by the executive director in writing, upon notice to the public water system, licensed operators, and other parties approved by the executive director.

(ii) Other parties approved by the executive director include, but are not limited to:

(I) backflow prevention assembly testers and customer service inspectors licensed under Chapter 30 of this title (relating to Occupational Licenses and Registrations);

(II) plumbing inspectors and water supply protection specialists licensed by the Texas State Board of Plumbing Examiners;

(III) licensed professional engineers licensed by the Texas Board of Professional Engineers;

(IV) circuit riders or technical assistance providers under contract with the executive director or other government agency as approved by the executive director; or

(V) utility supervisor or manager supported by various utility staff or other individuals that meet the assessment requirements as described in this paragraph.

(B) The Level 1 and Level 2 assessments shall be conducted and completed consistent with all directives set forth by the executive director and with respect to the size, type, and characteristics of the public water system. When conducting assessments, at a minimum, public water systems shall ensure that the following items are evaluated:

(i) review and identification of inadequacies in sample sites;

(ii) sampling protocol;

(iii) sample processing;

(iv) atypical events that could affect distributed water quality or indicate that distributed water quality was impaired;

(v) changes in distribution system maintenance and operation that could affect distributed water quality (including, but not limited to water storage);

(vi) source and treatment considerations that bear on distributed water quality, where appropriate; and

(vii) existing water quality monitoring data.

(C) A public water system shall conduct a Level 1 assessment when the public water system exceeds one of the treatment technique triggers in paragraph (1) of this subsection.

(i) A Level 1 assessment shall be completed and submitted to the executive director as soon as practical, but in no case later than 30 days after the public water system learns that it has exceeded a trigger.

(ii) If the executive director determines that the Level 1 assessment is not sufficient, the public water system shall consult with the executive director and submit a revised assessment form to the executive director within 30 days from the date of consultation.

(iii) The executive director will determine if the public water system has identified a cause of the trigger and, if so, was the cause corrected, or has an acceptable schedule to correct the problem been included.

(D) A public water system shall ensure that a Level 2 assessment is conducted consistently with all directives set forth by the executive director if the public water system exceeds one of the treatment technique triggers in paragraph (2) of this subsection. The public water system shall comply with any expedited actions or additional actions required by the executive director in the case of an *E. coli* MCL violation.

(i) The public water system shall ensure that a Level 2 assessment is completed by the public water system, licensed operators as required under §290.46(e) of this title, or by parties approved by the executive director as soon as practical after any trigger in paragraph (2) of this subsection. The public water system shall submit a completed executive director-approved Level 2 assessment form to the executive director within 30 days after the public water system learns that it has exceeded a trigger.

(ii) If the executive director determines that the completed Level 2 assessment is not sufficient or the proposed timetable for any corrective actions not completed is not sufficient, the public water system shall consult with the executive director. If any revisions are required after consultation, the public water system shall submit a revised assessment form to the executive director within 30 days.

(iii) After the Level 2 assessment is submitted, the executive director will determine if the public water system has identified the cause of the trigger and corrected the cause, or has included an acceptable timetable for correcting the cause.

(E) Public water systems must correct sanitary defects found through either Level 1 or Level 2 assessments described in this subsection. For corrective actions not completed by the time of submission of the assessment form, the public water system must complete the corrective actions in compliance with a timetable approved by the executive director in consultation with the public water system. The public water system must notify the executive director when scheduled corrective actions have been completed.

(F) At any time during the assessment or corrective action phase, either the public water system or the executive director may request a consultation with the other party to determine the appropriate

actions. The public water system shall consult with the executive director on all relevant information that may impact its ability to comply with a requirement of this subsection.

(d) [~~(c)~~] Monitoring requirements for microbial contaminants. Public water systems shall collect samples for total coliform, fecal coliform, *E. coli* (or other approved fecal indicator) [~~*E. coli,* or other fecal indicator organisms~~] at sampling sites and a sample collection schedule, as designated by the public water system, which are subject to review and revision [~~locations and frequency~~] as directed by the executive director. All compliance samples must be collected at sampling sites and a sample collection schedule that are representative of water throughout the distribution system and shall be reflected in the public water system's Sample Siting Plan and included with the public water system's monitoring plan in accordance with §290.121 of this title (relating to Monitoring Plans). All public water systems shall develop a written Sample Siting Plan as described in paragraph (6) of this subsection [~~during normal operating conditions~~].

(1) Routine microbial sampling locations. Public water systems shall routinely monitor for microbial contaminants at the following locations.

(A) Public water systems must collect routine distribution coliform samples at a customer's premise, dedicated sampling station, or other designated compliance sampling location at active service connections which are representative of water quality throughout the distribution system. Other sampling sites may be used if located adjacent to active service connections.

(B) Public water systems shall collect distribution coliform samples at locations specified in the public water system's Sample Siting Plan which shall be included in the public water system's monitoring plan.

(2) Routine distribution coliform sampling frequency. All public [~~Public~~] water systems must sample for distribution coliform at the following frequency. [~~:~~]

(A) Community and noncommunity public water systems must collect routine distribution coliform samples at a frequency based on the population served by the system.

(i) The [~~the~~] population for noncommunity systems will be based on the maximum number of persons served on any given day during the month based on the data reported by the public water system to the executive director during the most recent sanitary survey of the public water system or any other data as required by the executive director. [~~;~~]

(ii) The [~~the~~] population of community systems will be based on the data reported by the public water system to the executive director during the most recent sanitary survey of the public water system or any other data as required by the executive director. [~~; and~~]

(iii) The [~~the~~] minimum sampling frequency for public water systems is shown in the following table.
Figure: 30 TAC §290.109(d)(2)(A)(iii)
[~~Figure: 30 TAC §290.109(c)(2)(A)(iii)~~]

(B) A public water system which uses surface water or groundwater under the direct influence of surface water must collect routine distribution coliform samples at regular time intervals throughout the month.

(C) A public water system which uses only [~~uses only~~] purchased water or groundwater not under the direct influence of surface water and serves more than 4,900 persons must collect routine distribution coliform samples at regular time intervals throughout the month.

(D) A public water system which uses only purchased water or groundwater not under the direct influence of surface water and serves 4,900 persons or fewer may collect all required routine distribution coliform samples on a single day if they are taken from different sites.

(E) A total coliform-positive sample invalidated under this subsection does not count towards meeting the minimum routine monitoring requirements of this subsection.

(F) All public water system shall collect at least the minimum number of required routine microbial samples even if the public water system has had an *E. coli* MCL violation under any of the conditions as described in subsection (b)(1)(A) - (D) of this section or has exceeded the coliform treatment technique triggers as described in subsection (c)(1) and (2) of this section. [~~If a system collecting fewer than five routine distribution coliform samples per month has one or more total coliform-positive samples and the executive director does not invalidate the sample(s) in accordance with subsection (d)(1) of this section, it must collect at least five routine distribution coliform samples during the next month the system provides water to the public.~~]

(G) A public water system may conduct more microbial compliance monitoring than is required by this subsection to investigate potential problems in the public water system treatment facilities and distribution system and use monitoring to assist in identifying problems. A public water system may collect more than the minimum number of required routine samples required by this subsection. A public water system that collects more than the minimum number of required routine samples required by this subsection shall include the results of these samples in calculating whether the coliform treatment technique triggers as described in subsection (c)(1) and (2) of this section have been exceeded. The additional routine sample sites shall be included in the public water system's Sample Siting Plan and collected in accordance with the Sample Siting Plan and shall be representative of water throughout the distribution system.

(3) Repeat distribution coliform sampling requirements. Public water systems [~~Systems~~] shall conduct repeat monitoring if one or more of the routine samples is found to contain coliform organisms.

(A) If a routine distribution coliform sample is coliform-positive, the public water system must collect a set of repeat distribution coliform samples within 24 hours of being notified of the positive result, or as soon as possible if the local laboratory is closed. The executive director may extend the 24-hour limit on a case-by-case basis if the public water system has a logistical problem in collecting the repeat samples within 24 hours that is beyond the public water system's control. All public water systems shall collect no fewer than three repeat samples for each total coliform-positive sample found.

~~*f(i)* A system which collects more than one routine distribution coliform sample per month must collect no fewer than three repeat samples for each coliform-positive sample found.]~~

~~*f(ii)* A system which collects one routine distribution coliform sample per month must collect no fewer than four repeat samples for each coliform-positive sample found.]~~

(B) The public water system must collect all repeat samples on the same day, except a public water system with a single service connection may collect daily repeat samples over a three-day period until the required number of repeat samples has been collected.

(C) Unless the public water system meets the provisions of clause (i) or (ii) of this subparagraph, the public water [~~The~~] system must collect at least one repeat sample from the sampling tap where the original coliform-positive sample was taken, and at least one repeat

sample at a tap within five service connections upstream and at least one repeat sample at a tap within five service connections downstream of the original sampling site. [~~If a fourth repeat sample is required, it must be collected within five service connections upstream or downstream.~~] If the positive routine sample was collected at the end of the distribution system, or one service connection away from the end of the distribution system, [~~line~~] one repeat sample must be collected at that point and all other samples must be collected within five connections upstream of that point.

(i) As approved by the executive director, public water systems may propose repeat monitoring locations to the executive director that the public water system considers to be representative of a pathway for contamination of the distribution system. A public water system may elect to specify either alternative fixed locations or criteria for selecting repeat sampling sites on a situational basis in a written standard operating procedure (SOP) in its Sample Siting Plan. The public water system shall design its SOP to focus the repeat samples at locations that best verify and determine the extent of potential contamination of the distribution system area based on specific situations. The executive director may modify the SOP or require alternative monitoring locations as needed.

(ii) As approved by the executive director, groundwater public water systems serving 1,000 or fewer people may propose repeat sampling locations to the executive director, in a written SOP in its Sample Siting Plan, that differentiate potential source water and distribution system contamination (e.g., by sampling at entry points to the distribution system). A groundwater public water system with a single well required to conduct triggered source water monitoring may, with written executive director approval, take one of its repeat samples at the monitoring location required for triggered source water monitoring under paragraph (4) and (4)(A) of this subsection if the public water system demonstrates to the executive director that the Sample Siting Plan remains representative of water quality in the distribution system. If approved by the executive director, the public water system may use that sample result to meet the monitoring requirements for both repeat monitoring under this paragraph and triggered source monitoring under paragraph (4) and (4)(A) of this subsection.

(iii) All public water systems shall include all sample sites as required by this subparagraph and any required SOPs for any proposed sampling sites as described in clauses (i) and (ii) of this subparagraph in the public water system's Sample Siting Plan in accordance with paragraph (6) of this subsection.

(D) If one or more repeat samples in the set is total coliform-positive, the public water system must collect an additional set of repeat samples in the manner specified in subparagraphs (A) - (C) of this paragraph. The additional samples must be collected within 24 hours of the public water system being notified of the positive result or as soon as possible if the local laboratory is closed. The executive director may extend the 24-hour limit on a case-by-case basis if the public water system has a logistical problem in collecting the repeat samples within 24 hours that is beyond the public water system's control. The public water system must repeat this process until either one of the following occurs:

(i) total coliforms are not detected in one complete set of repeat samples:

(ii) a coliform treatment technique trigger as described in subsection (c)(1) and (2) of this section has been exceeded; or

(iii) If a treatment technique trigger as described in subsection (c)(1) and (2) of this section is exceeded as a result of a routine sample being total coliform-positive, public water systems are required to conduct only one round of repeat monitoring for each total coliform-positive routine sample. [~~or the system determines that the MCL for total coliforms has been exceeded.~~]

(E) After a public water system collects a routine sample and before it learns the results of the analysis of that sample, if it collects another routine sample(s) from within five adjacent service connections of the initial sample, and the initial sample is found to contain total coliform bacteria, then the public water system may count the subsequent sample(s) as a repeat sample instead of as a routine sample.

(4) General requirements for raw [~~Raw~~] groundwater source monitoring. Groundwater systems must comply, unless otherwise noted, with the requirements of this section. Any raw groundwater source sample required under this paragraph must be collected at a location prior to any treatment of the groundwater source and use analytical procedures and methods described in §290.119(b)(10) of this title (relating to Analytical Procedures). The public water system may collect a sample at an executive director-approved location prior to any treatment to meet the requirements of this paragraph and subparagraph (A) of this paragraph if the sample is representative of the water quality of that well.

(A) Triggered source monitoring general [~~General~~] requirements. A groundwater system must conduct triggered source water monitoring for *E. coli* (or other approved fecal indicator) [~~indicators~~], if both of the following conditions exist.

(i) The system does not provide at least 4-log treatment of viruses (as defined in §290.103(44) [~~§290.103(39)~~] of this title (relating to Definitions)) before the first customer for each groundwater source; and

(ii) The system is notified that a routine distribution coliform sample is positive and the sample is not invalidated under subsection (e)(1) [~~(d)(1)~~] of this section.

(B) Triggered source monitoring sampling [~~Sampling~~] requirements. A groundwater system must collect, within 24 hours of notification of the routine distribution total coliform-positive sample, at least one raw groundwater source *E. coli* (or other approved fecal indicator) sample from each groundwater source in use at the time the distribution coliform-positive sample was collected.

(i) The executive director may extend the 24-hour time limit on a case-by case basis if the system cannot collect the raw groundwater source sample within 24 hours due to circumstances beyond its control.

(ii) If approved by the executive director and documented in the public water system's monitoring plan, public water systems with more than one groundwater source may be allowed to sample a representative groundwater source or sources. Public water systems shall [~~Systems must~~] modify their current monitoring plan to identify one or more groundwater sources that are representative of each distribution coliform sampling site and is intended to be used for representative source sampling.

(iii) A groundwater system with a single well serving 1,000 people or fewer may use one of the three required repeat samples collected from a raw groundwater source to meet both the repeat requirements of paragraph (3) of this subsection and the triggered raw source monitoring requirements in this paragraph. If a required repeat sample is used to meet both requirements and found to be *E. coli*-positive, the public water system will have achieved an *E. coli* MCL as defined in subsection (b)(1)(A) - (D) of this section and corrective action will be required for the groundwater source where the sample was found to be *E. coli*-positive. [~~A groundwater system serving 1,000 people or fewer may use one of the four required repeat samples collected~~

~~from a raw groundwater source to meet both the repeat requirements of subparagraph (A)(ii) of this paragraph and the triggered raw source monitoring requirements in this paragraph. If a required repeat sample is used to meet both requirements and found to be *E. coli* positive, the system will have achieved an acute MCL as defined in subsection (b)(1)(C) of this section and corrective action will be required for the groundwater source were the sample was found to be *E. coli* positive.~~]

(iv) If the executive director does not require corrective action under §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques) for a fecal indicator positive source water sample collected under subparagraph (B) of this paragraph that is not invalidated under subsection (e) of this section, the public water system shall collect five additional source water samples from the same source within 24 hours of being notified of the fecal indicator positive sample.

(v) If a public water system takes more than one repeat sample at the monitoring location required for triggered source water monitoring, the public water system may reduce the number of additional source water samples required under subsection (d)(4)(B)(iv) of this section by the number of repeat samples taken at that location that were not *E. coli*-positive.

(C) Consecutive and wholesale systems. Consecutive groundwater systems receiving drinking water from a wholesaler must notify the wholesale system(s) within 24 hours of being notified of the positive coliform distribution sample. The wholesale groundwater system(s) must comply with the following:

(i) A wholesale groundwater system that receives notice of a distribution coliform sample positive from a consecutive system it serves must collect a sample from each of its groundwater sources within 24 hours of the notification and analyze each sample for the presence of *E. coli* (or other approved fecal indicator).

(ii) If any raw source sample is *E. coli*- (or other approved fecal indicator) positive, the wholesale groundwater system must notify all consecutive systems served by that groundwater source of the fecal indicator positive within 24 hours of being notified. The wholesale system and all consecutive systems served by that groundwater source must notify their water system customers in accordance with subsection (h)(2) [~~(g)(2)~~] of this section and shall meet the requirements of subsection (d)(4)(B)(iv) of this section.

(iii) If any raw source sample is *E. coli*- positive, the wholesale groundwater system shall notify all consecutive systems served by that groundwater source of the fecal indicator source water positive within 24 hours of being notified and shall meet the requirements of subsection (d)(4)(B)(iv) of this section.

(D) Exceptions to the triggered source monitoring requirements. A groundwater system is not required to comply with the triggered source monitoring requirements if any of the following conditions exist.

(i) The executive director determines and documents in writing, that the distribution coliform-positive [~~coliform positive~~] sample is caused by a distribution system deficiency; or

(ii) The distribution coliform-positive [~~coliform positive~~] sample is collected at a location that meets the distribution coliform sample invalidation criteria as specified in subsection (e)(1) [~~(d)(1)~~] of this section and the replacement sample is negative for coliforms.

(E) Assessment source monitoring. The executive director may require monthly source assessment raw monitoring without the presence of a positive total coliform distribution sample if well conditions exist that indicate the groundwater may be susceptible to fecal contamination. The executive director may conduct a hydrogeological sensitivity assessment to determine if the source is susceptible to fecal contamination. If requested by the executive director, groundwater systems must provide the executive director with any existing information that will enable the executive director to perform a hydrogeological sensitivity assessment. A groundwater system conducting assessment source monitoring may use a triggered source sample collected under paragraph (4)(A) of this subsection [~~subparagraph (B) of this paragraph~~] to meet the assessment source monitoring requirement. A groundwater system with a groundwater source sample collected under this subparagraph or under paragraph (4)(A) of this subsection that is fecal indicator positive and that is not invalidated under subsection (e)(2) of this section, including consecutive systems served by the groundwater source, shall conduct public notification under §290.122(a) of this title (relating to Public Notification). Additionally, an assessment source monitoring sample may be used as a triggered source monitoring sample if collected within 24 hours of notification of the coliform-positive distribution sample. Assessment source monitoring requirements may include:

(i) Source monitoring, collected in a manner described in §290.119(b)(10) of this title, for a period of 12 months that represents each month that the system provides groundwater to the public from the raw groundwater source or such time period as specified by the executive director.

(ii) Collection of samples from each well unless the system has an approved triggered source monitoring plan under subparagraph (B)(ii) of this paragraph.

(5) Culture analysis. If any routine or repeat sample is total coliform-positive, that total coliform-positive medium will be analyzed to determine if *E. coli* are present. If *E. coli* are present, the public water system shall notify the executive director by the end of the day in accordance with subsection (h) of this section. [~~If any routine or repeat sample is total coliform-positive, that total coliform-positive culture medium will be analyzed to determine if fecal coliforms or bacteria are present. If fecal coliforms or *E. coli* are present, the system must notify the executive director by the end of the day in accordance with subsection (g) of this section.~~]

(6) Sample Siting Plan requirements. All public water systems shall develop and complete a written Sample Siting Plan as described in this paragraph that identifies routine and repeat microbial sampling sites and a sample collection schedule as required by this subsection that are representative of water throughout the distribution system. The Sample Siting Plan shall include all groundwater sources and any associated sampling points necessary to meet the requirements of this subsection. The Sample Siting Plan shall be included as a part of the public water system's monitoring plan as described in §290.121 of this title. Sample Siting Plans shall be completed in a format specified by the executive director and are subject to review and revision by the executive director.

(A) All public water systems shall collect routine and repeat samples according to a written Sample Siting Plan. All routine and repeat sample site locations and any sampling point locations necessary to meet the requirements of this subsection shall be reflected in the written Sample Siting Plan.

(B) All public water systems shall include any required SOP for any proposed repeat sampling sites as described in paragraph (3)(C) of this subsection in the Sample Siting Plan. As required by the executive director, the executive director may review, revise, and approve any repeat sampling proposed by public water systems under paragraph (3)(C) of this subsection.

(C) The Sample Siting Plan shall include a distribution system map which identifies distribution system valves and mains as described in §290.46(n)(2) of this title. The distribution system map shall also include the location of all routine microbial sample sites, water main sizes, entry point source locations, water storage facilities, and any pressure plane boundaries.

(D) All public water systems shall update their written Sample Siting Plan and map as necessary, or as requested by the executive director, to identify the most current microbial routine and repeat sampling sites and a sample collection schedule that are representative of water throughout the public water system's distribution system.

(E) All public water systems shall maintain a copy of their updated Sample Siting Plan and map on-site at the public water system for inspection purposes and at the request of the executive director, provide a copy of their Sample Siting Plan and/or map to the executive director for review and/or revision purposes.

(e) [~~(d)~~] Analytical and invalidation requirements for microbial contaminants. Analytical procedures shall be performed in accordance with §290.119 of this title. Testing for microbial contaminants shall be performed at a laboratory certified by the executive director.

(1) Distribution coliform sample invalidation. The executive director may invalidate a distribution total coliform-positive sample if one of the following conditions is met.

(A) The executive director may invalidate a sample if the laboratory provides written notice that improper sample analysis caused the total coliform-positive result.

(B) The executive director may invalidate a sample if the results of repeat samples collected, as required by this section, determine that the total coliform-positive sample resulted from a domestic or other non-distribution system plumbing problem. The executive director cannot invalidate a sample on the basis of repeat sample results unless all repeat sample(s) collected at the same tap as the original total coliform-positive sample are also total coliform-positive, and all repeat samples collected within five service connections of the original tap are total coliform-negative. Under those circumstances, the system may [~~cease resampling and~~] request that the executive director invalidate the sample. The system must provide copies of the routine positive and all repeat samples.

(C) The executive director may invalidate a sample if there are substantial grounds to believe that the total coliform-positive result is due to a circumstance or condition which does not reflect water quality in the distribution system. In this case, the system must still collect all repeat samples required by this section, and use them to determine compliance with the *E. coli* MCL as described [~~for total coliforms~~] in subsection (g) of this section and whether a coliform treatment technique trigger has been exceeded as described in subsection (c) [~~(f)~~] of this section. The system must provide written documentation which must state the specific cause of the total coliform-positive sample, and the action the system has taken, or will take, to correct this problem. The executive director may not invalidate a total coliform-positive sample solely on the grounds that all repeat samples are total coliform-negative.

(D) The executive director may invalidate a sample if the laboratory provides written notice that the sample was unsuitable for analysis.

(E) If a sample is invalidated by the laboratory, the public water system must collect another sample from the same location as the original sample within 24 hours of being notified, or as soon as possible if the laboratory is closed, and have it analyzed for the presence of total coliform. The system must continue to resample within 24 hours and have the samples analyzed until it obtains a valid result.

(2) A groundwater system may obtain invalidation of a fecal indicator positive groundwater source sample if the conditions of subparagraphs (A) and (B) of this paragraph apply. If the executive director invalidates a fecal indicator positive groundwater source sample, the system must collect another source sample as specified in subsection (d)(4) [~~(c)(4)~~] of this section within 24 hours of being notified of the invalidation.

(A) Notice from the laboratory must document that improper sample analysis occurred. If a laboratory invalidates a sample, the system must collect another sample from the same location as the original sample within 24 hours of being notified of the invalidated sample, and have it analyzed for the presence of *E. coli* (or other approved fecal indicator). The public water system must continue to re-sample within 24 hours and have the samples analyzed until it obtains a valid result. If approved by the executive director, the 24-hour time limit may be extended.

(B) The executive director may invalidate the sample if the public water system provides written documentation that there is substantial evidence that a fecal indicator positive groundwater source sample is not related to source water quality. If the executive director invalidates a sample, the public water system must collect another sample from the same location as the original sample within 24 hours of being notified of the invalidated sample, and have it analyzed for the presence of *E. coli* (or other approved fecal indicator).

(f) [~~(e)~~] Reporting requirements for microbial contaminants. The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~of the request or within ten days of their receipt by the public water system, whichever is later~~]. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(g) [~~(f)~~] Compliance determination for microbial contaminants. Compliance with the requirements of this section shall be determined using the following criteria each month that the system is in operation.

(1) A public water system commits an *E. coli* MCL violation if any of the following conditions occur: [~~A system commits an acute MCL violation if:~~]

(A) The public water system has an *E. coli*-positive repeat samples following a total coliform-positive routine sample; [~~A repeat distribution system sample is fecal coliform-positive or *E.coli*-positive; or~~]

(B) The public water system has a total coliform-positive repeat sample following an *E. coli*-positive routine sample; [~~A total coliform-positive repeat distribution system sample follows a fecal coliform-postive or *E. coli*-positive routine distribution system sample.~~]

(C) The public water system fails to take all required repeat samples following an *E. coli*-positive routine sample; or

(D) The public water system fails to test for *E. coli* when any repeat sample tests positive for total coliform.

(E) The executive director, pursuant to 40 Code of Federal Regulations §141.63(e), recognizes the following as the best tech-

nology, treatment techniques, or other means available for achieving compliance with the MCL for *E. coli* as described in subparagraphs (A) - (D) of this paragraph:

(i) protection of wells from fecal contamination by appropriate placement and construction;

(ii) maintenance of a disinfectant residual throughout the distribution system;

(iii) proper maintenance of the distribution system including appropriate pipe replacement and repair procedures, main flushing programs, proper operation and maintenance of storage tanks and reservoirs, cross-connection control, and continual maintenance of positive water pressure in all parts of the distribution system;

(iv) filtration and disinfection of surface water, as described in this chapter, or disinfection of groundwater, as described in chapter, using strong oxidants such as chlorine, chlorine dioxide, or ozone;

(v) for systems using groundwater, development and implementation of a Wellhead Protection Program, as directed by the executive director, and in accordance with the federal Safe Drinking Water Act, United States Code, §1428; and

(vi) the executive director may require additional best technology, treatment techniques, or other means available for achieving compliance with the MCL for *E. coli* as described in subparagraphs (A) - (D) of this paragraph.

(2) If all repeat samples taken for triggered source water monitoring are *E. coli*-negative and a repeat sample taken at a monitoring location other than the one required for triggered source water monitoring is *E. coli*-positive, the public water system has violated the *E. coli* MCL, but is not required to comply with subsection (d)(4)(B)(v) of this section. If a public water system takes more than one repeat sample at the monitoring location required for triggered source water monitoring under subsection (d)(4) of this section, and more than one repeat sample is *E. coli*-positive, the public water system has violated the E. coli MCL and shall also comply with the treatment technique and corrective action requirements as described in §290.116 of this title. [~~A system that collects at least 40 routine distribution coliform samples per month commits a nonacute MCL violation if more than 5.0% of the samples collected during a month are total coliform-positive, but none of the initial or repeat samples are fecal coliform-positive or *E. coli*-positive.~~]

[~~(3) A system that collects fewer than 40 routine distribution coliform samples per month commits a nonacute MCL violation if more than one sample collected during a month is total coliform-positive, but none of the initial or repeat samples are fecal coliform-positive or *E. coli*-positive.~~]

(3) [~~(4)~~] A public groundwater system that is required to collect raw source samples is required to conduct corrective action as described in §290.116 of this title [~~(relating to Groundwater Corrective Actions and Treatment Techniques)~~] and is required to provide public notification in accordance with §290.122(a) of this title [~~(relating to Public Notification)~~] if a source sample is confirmed positive for *E. coli* or other approved fecal indicators.

(4) [~~(5)~~] A public water system that fails to collect every required routine or additional routine sample in a compliance period and/or to submit the analytical results to the executive director commits a monitoring violation [~~to provide the required number of suitable distribution coliform samples commits a monitoring violation~~].

(5) A public water system that fails to analyze for *E. coli* following a total coliform-positive routine sample commits a monitoring violation.

(6) A public water system that fails to monitor in accordance with the requirements of subsection (d)(4) [~~(e)(4)~~] of this section commits a monitoring violation and must provide public notification in accordance to §290.122 of this title.

(7) A public water system that fails to report the results of the monitoring tests required by this section commits a reporting violation.

(8) A public water system that fails to do a required public notice or certify that notification has been performed commits a public notice reporting violation.

(9) The results of all routine and repeat distribution coliform samples not invalidated by the executive director shall be included in determining compliance with the *E. coli* MCL as described in paragraph (1)(A) - (D) of this subsection and whether a coliform treatment technique trigger has been exceeded as described in subsection (c) of this section. [~~Results of all routine and repeat distribution coliform samples not invalidated by the executive director must be included in determining compliance with the MCL for total coliforms.~~]

(10) The results of all routine and repeat distribution [~~Distribution~~] coliform samples invalidated by the executive director shall not be included in determining compliance with the *E. coli* MCL as described in paragraph (1)(A) - (D) of this subsection and whether a coliform treatment technique trigger has been exceeded as described in subsection (c) of this section [~~MCL for total coliforms~~].

(11) Special purpose samples, such as those taken to determine whether disinfection practices are sufficient following pipe placement, replacement, or repair, shall not be used to determine compliance with the MCL for microbiological contaminants.

(12) All seasonal public water systems shall complete executive director-approved start-up procedures and certification and maintain a copy of the start-up procedures and certification on-site at the public water system for inspection purposes. At the executive director's request, seasonal public water systems shall submit a copy of the start-up procedures and certification to the executive director for review purposes. Failure by a seasonal public water system to complete executive director-approved start-up procedures prior to serving water to the public is a treatment technique violation. Failure by a seasonal public water system to maintain or submit certification of completion of executive director-approved start-up procedures is a reporting violation.

(13) A public water system commits a treatment technique violation when a seasonal public water system fails to complete an executive director-approved start-up procedure prior to serving water to the public.

(14) A public water system commits a treatment technique violation when a public water system exceeds a treatment technique trigger specified in subsection (c) of this section and then fails to conduct the required assessment or corrective actions within the timeframe specified in subsection (c) of this section.

(15) A public water system required to conduct an assessment under the provisions of subsection (c) of this section shall submit the assessment report to the executive director within 30 days. The public water system shall notify the executive director in accordance with subsection (c) of this section when scheduled corrective actions are complete and for corrective actions not completed by the time of submission of the assessment form. For corrective actions not com-

pleted by the time of submission of the assessment form to the executive director, the public water system shall complete corrective actions in compliance with a timetable approved by the executive director in consultation with the public water system. The assessment may also indicate that no sanitary defects were identified.

(h) [~~(g)~~] Public notification for microbial contaminants. A public water system that is out of compliance with the requirements described in this section must notify the public using the procedures described in §290.122 of this title for microbial contamination.

(1) A public water system that commits an acute MCL violation for microbial contaminants must notify the public water system customers in accordance with the boil water notice requirements of §290.46(q) of this title [~~(relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems)~~] and the public notice requirements of §290.122(a) of this title.

(2) A public groundwater system that receives an *E. coli* (or other approved fecal indicator) positive source sample that has not been invalidated by the executive director, or a notice of an *E. coli* (or other approved fecal indicator) positive source sample from a wholesale system, including consecutive systems, must notify the public water system customers within 24-hours in accordance with the requirements of §290.122(a) of this title and include notice in the next Consumer Confidence Report for community public water systems or provide as a special notice for noncommunity systems in accordance with §290.272(g)(7) of this title (relating to Content of the Report) for community public water systems and §290.116(f)(2) of this title for noncommunity public water systems. Consecutive systems must issue public notice in accordance with §290.122(g) of this title. The public water system must continue to notify the public annually until the fecal contamination in the source water is determined by the executive director to be corrected as specified under §290.116 of this title.

(3) A public water system that has [~~fecal coliforms or~~] *E. coli* (or other approved fecal indicator) present must notify the executive director by the end of the day when the public water system is notified of the test result, unless the public water system is notified of the result after the commission's office is closed, in which case the public water system must notify the executive director before the end of the next business day.

(4) A public water system which commits an MCL violation must report the violation to the executive director immediately after it learns of the violation, but no later than the end of the next business day, and notify the public in accordance with §290.122(b) of this title.

(5) A public water system which commits an *E. coli* MCL violation shall report the violation to the executive director immediately after it learns of the violation, but no later than the end of the next business day, and notify the public in accordance with §290.122(a) of this title.

(6) [~~(5)~~] A public water system which has failed to comply with a coliform monitoring requirement must report the monitoring violation to the executive director within ten days after the system discovers the violation and notify the public in accordance with §290.122(c) of this title.

(7) A public water system that has violated the treatment technique for coliforms in subsection (c)(1) and (2) of this section commits a treatment technique violation as described in subsection (g)(15) of this section and shall report the violation to the executive director no later than the end of the next business day after it learns of the violation, and notify the public in accordance with §290.122(b) of this title.

§290.110. Disinfectant Residuals.

(a) Applicability. All public water systems shall properly disinfect water before it is distributed to any customer and shall maintain acceptable disinfectant residuals within the distribution system.

(b) Minimum and maximum acceptable disinfectant concentrations. All public [~~Public~~] water systems shall provide the minimum levels of disinfectants in accordance with the provisions of this section. Public water systems shall not exceed the maximum residual disinfectant levels (MRDLs) provided in this section.

(1) The disinfection process used by public water systems must ensure that water has been adequately disinfected before it enters the distribution system.

(A) The disinfection process used by public water systems treating surface water sources or groundwater sources that are under the direct influence of surface water must meet the requirements of §290.111(d) of this title (relating to Surface Water Treatment).

(B) The executive director may require the disinfection process used by public water systems treating groundwater sources that are not under the direct influence of surface water to meet the requirements of §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques).

(C) The disinfection process at other types of treatment plants shall provide the level of disinfection required by the executive director.

(2) The residual disinfectant concentration in the water entering the distribution system shall be at least 0.2 milligram per liter (mg/L) free chlorine or 0.5 mg/L chloramine (measured as total chlorine).

(3) The chlorine dioxide residual of the water entering the distribution system shall not exceed an MRDL of 0.8 mg/L.

(4) The residual disinfectant concentration in the water within the distribution system shall be at least 0.2 mg/L free chlorine or 0.5 mg/L chloramine (measured as total chlorine).

(5) The running annual average of the free chlorine or chloramine residual (measured as total chlorine) of the water within the distribution system shall not exceed an MRDL of 4.0 mg/L.

(c) Monitoring requirements. All public [~~Public~~] water systems shall monitor the performance of the disinfection facilities to ensure that appropriate disinfectant levels are maintained. All monitoring conducted pursuant to the requirements of this section must be conducted at sites designated in the public water system's monitoring plan.

(1) Entry point compliance monitoring for surface water and groundwater under the direct influence of surface water. Public water systems that treat surface water or groundwater under the direct influence of surface water must verify that they meet the disinfection requirements of subsection (b)(2) of this section.

(A) Public water systems that treat surface water or groundwater under the direct influence of surface water and sell treated water on a wholesale basis or serve more than 3,300 people must continuously monitor and record the disinfectant residual of the water at each entry point. If there is a failure in the continuous monitoring equipment, grab sampling every four hours may be conducted in lieu of continuous monitoring, but for no more than five working days following the failure of the equipment.

(B) Public water systems that treat surface water or groundwater under the direct influence of surface water, serve 3,300 or fewer people and do not sell treated water on a wholesale basis must monitor and record the disinfectant residual of the water at each entry point with either continuous monitors or grab samples.

(i) If a system uses grab samples, the samples must be collected on an ongoing basis at the frequency prescribed in the following table.
Figure: 30 TAC §290.110(c)(1)(B)(i) (No change.)

(ii) The grab samples cannot be taken at the same time and the sampling interval is subject to the executive director's review and approval.

(iii) Treatment plants that use grab samples and fail to detect an appropriate disinfectant residual must repeat the test at four-hour or shorter intervals until compliance has been reestablished.

(C) Continuous monitors must record the disinfectant residual of the water every 30 minutes.

(2) Entry point compliance monitoring for groundwater and purchased water. Public water systems that treat groundwater or that purchase and resell treated water must, upon the request of the executive director, verify that they meet the disinfection requirements of subsection (b)(2) of this section.

(A) A public water system that uses free chlorine must measure free chlorine.

(B) A public water system that has a chloramine residual must measure total chlorine.

(3) Chlorine dioxide compliance monitoring. Each treatment plant using chlorine dioxide must monitor and record the chlorine dioxide residual of the water entering the distribution system at least once each day. If the chlorine dioxide residual in the water entering the distribution system exceeds the MRDL contained in subsection (b)(3) of this section, the treatment plant must conduct additional tests.

(A) If the public water system does not have additional chlorination facilities in the distribution system, it must conduct three additional tests at the service connection nearest the treatment plant where an elevated chlorine dioxide residual was detected. The first additional test must be conducted within two hours after detecting an elevated chlorine dioxide residual at the entry point to the distribution system. The two subsequent tests must be conducted at six-hour to eight-hour intervals thereafter.

(B) If the public water system has additional chlorination facilities in the distribution system, it must conduct an additional test at the service connection nearest the treatment plant where an elevated chlorine dioxide residual was detected, an additional test at the first service connection after the point where the water is rechlorinated, and an additional test at a location in the far reaches of the distribution system. The additional test at the location nearest the treatment plant must be conducted within two hours after detecting an elevated chlorine dioxide residual at the entry point to the distribution system. The two other tests must be conducted at six-hour to eight-hour intervals thereafter.

(4) Distribution system compliance monitoring. All public [~~Public~~] water systems shall monitor the disinfectant residual at various locations throughout the distribution system.

(A) Public water systems that use groundwater or purchased water sources only and serve fewer than 250 connections and fewer than 750 people daily, must monitor the disinfectant residual at representative locations in the distribution system at least once every seven days.

(B) Public water systems that serve at least 250 connections or at least 750 people daily, and use only groundwater or purchased water sources must monitor the disinfectant residual at representative locations in the distribution system at least once per day.

(C) Public water systems using surface water sources or groundwater under the direct influence of surface water must monitor the disinfectant residual tests at least once per day at representative locations in the distribution system.

(D) All public water systems must monitor the residual disinfectant concentration each time and at the same sampling site that a bacteriological sample is collected, as specified in §290.109 of this title (relating to Microbial Contaminants) in addition to the residual disinfectant concentration monitoring requirements as described in this subsection and chapter.

(E) All public water systems with a chloramine residual must monitor the total chlorine residual downstream of any chlorine and ammonia injection points, in conjunction with the chloramine effectiveness sampling in paragraph (5)(C) of this subsection, in the distribution system weekly and whenever the chemical dose is changed.

(5) Chloramine effectiveness sampling. Public water systems with a chloramine residual shall monitor to ensure that monochloramine is the prevailing chloramine species and that nitrification is controlled. Sample sites and procedures used for chloramine effectiveness sampling must be documented in the system's nitrification action plan (NAP) required by §290.46(z) of this title (relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems). Sample results determined by monitoring required under this paragraph will not be used to determine compliance with the maximum contaminant levels, MRDLs, action levels, or treatment techniques of this subchapter.

(A) Source water. Public water systems must monitor source water (including raw and treated purchased water) to establish baseline ammonia, nitrite, and nitrate levels (all as nitrogen) at least once to determine the availability of ammonia for chloramine formation and to provide a reference for downstream nitrite and nitrate levels that may indicate nitrification. If any source has more than 0.5 mg/L free ammonia (as nitrogen) in the initial sample, then raw water ammonia (as nitrogen) shall be monitored monthly for six months to determine the baseline free ammonia level.

(B) Water entering distribution system. All public [~~Public~~] water systems that have chloramines present shall perform sampling to represent the water entering the distribution system.

(i) Total chlorine, free ammonia (as nitrogen) and monochloramine shall be monitored weekly at all entry points to the distribution system or at a location before the first customer.

(ii) Nitrite and nitrate (as nitrogen) levels at the first customer shall be monitored monthly for at least six months to determine baseline nitrite and nitrate levels in the water prior to consumption. Nitrite and nitrate samples collected at the first customer will not be used for compliance with §290.106 of this title (relating to Inorganic Contaminants).

(iii) Nitrite and nitrate (as nitrogen) shall be monitored quarterly at the first customer after establishing the baseline. Nitrite and nitrate samples collected at entry points for compliance with §290.106 of this title may be used for these quarterly samples.

(C) Treatment sampling. Public water systems that inject chlorine at any location to form chloramines or to convert from chloramines to free chlorine must monitor to ensure that chemical addition is effective and the proper chlorine to ammonia (as nitrogen) ratio is achieved. Samples must be collected and analyzed weekly and whenever the chemical dosage is changed.

(i) Sampling must be performed upstream of the chlorine or ammonia chemical injection point, whichever is furthest upstream.

(ii) Sampling must be performed downstream of all the chlorine and ammonia chemical injection points.

(iii) The residual of the chemical injected upstream must be determined to properly dose the downstream chemical where sample taps are present or required under §290.42(e)(7)(C)(ii) of this title (relating to Water Treatment).

(iv) The total chlorine, ammonia (as nitrogen), and monochloramine residuals must all be monitored if the treatment occurs before the entry point.

(v) The ammonia (as nitrogen) and monochloramine residuals must all be monitored if the treatment occurs in the distribution system. The monitoring must occur at the same time as a compliance sampling required under paragraph (4)(E) of this subsection.

(D) Distribution system. Public water systems that distribute water and have a chloramine residual must ensure the efficacy of disinfection within the distribution system.

(i) Monochloramine and free ammonia (as nitrogen) must be monitored weekly at the same time as a compliance sample required under paragraph (4) of this subsection.

(ii) Nitrite and nitrate (as nitrogen) must be monitored quarterly.

(d) Analytical requirements. All monitoring required by paragraphs (1) and (2) of this subsection must be conducted at a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title (relating to Analytical Procedures). All monitoring for chloramine effectiveness required by paragraphs (3) - (6) of this subsection must be analyzed to the accuracy provided therein.

(1) The free chlorine or chloramine residual (measured as total chlorine) must be measured to a minimum accuracy of plus or minus 0.1 mg/L. Color comparators may be used for distribution system samples only. When used, a color comparator must have current reagents, an unfaded and clear color comparator, a sample cell that is not discolored or stained, and must be properly stored in a cool, dark location where it is not subjected to conditions that would result in staining. The color comparator must be used in the correct range. If a sample reads at the top of the range, the sample must be diluted with chlorine-free water, then a reading taken and the resulting residual calculated.

(2) The chlorine dioxide residual must be measured to a minimum accuracy of plus or minus 0.05 mg/L using a method that conforms to the requirements of §290.119 of this title. The DPD-glycine method using a colorimeter or spectrophotometer may be utilized only with the written permission of the executive director. [~~one of the following methods:~~]

[~~(A) the amperometric titration method using a titrator with platinum-platinum electrodes;~~]

[~~(B) the spectrophotometric Lissamine Green B method; or~~]

[~~(C) with the written permission of the executive director, the DPD-glycine method using a colorimeter or spectrophotometer.~~]

(3) The free ammonia level must be measured to a minimum accuracy of plus or minus 0.1 mg/L.

(4) The monochloramine level must be measured to a minimum accuracy of plus or minus 0.15 mg/L using a procedure that has the ability to distinguish between monochloramine and other forms of chloramine.

(5) The nitrate (as nitrogen) level must be measured to a minimum accuracy of plus or minus 0.1 mg/L.

(6) The [~~the~~] nitrite (as nitrogen) level must be measured to a minimum accuracy of plus or minus 0.01 mg/L.

(e) Reporting requirements. Any owner or operator of a public water system subject to the provisions of this section is required to report to the executive director the results of any test, measurement, or analysis required by this section.

(1) Public water systems [~~Systems~~] exceeding the MRDL for chlorine dioxide in subsection (b)(3) of this section must report the exceedance to the executive director within 24 hours of the event.

(2) Public water systems that use surface water sources or groundwater sources under the direct influence of surface water must submit a Surface Water Monthly Operating Report (commission Form 0102C), a Surface Water Monthly Operating Report (commission Form 0102D) for alternative technologies, or a Surface Water Monthly Operational Report for Plants That Do Not Have a Turbidimeter on Each Filter (commission Form 0103) each month.

(3) Public water systems that use chlorine dioxide must submit a Chlorine Dioxide Monthly Operating Report (commission Form 0690) each month.

(4) Public water systems that use purchased water or groundwater sources only must complete a Disinfection Level Quarterly Operating Report (commission Form 20067) each quarter.

(A) Community and nontransient, noncommunity public water systems must submit the Disinfection Level Quarterly Operating Report each quarter, by the tenth day of the month following the end of the quarter.

(B) Transient, noncommunity public water systems must retain the Disinfection Level Quarterly Operating Reports and must provide a copy if requested by the executive director.

(5) Systems that use chloramines must retain their NAP required under §290.46(z) of this title and must provide a copy upon request by the executive director.

(6) Monthly and quarterly reports required by this section must be submitted to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 by the tenth day of the month following the end of the reporting period.

(f) Compliance determinations. Compliance with the requirements of this section shall be determined using the following criteria.

(1) All samples used for compliance must be obtained at sampling sites designated in the monitoring plan.

(A) All samples collected at sites designated in the monitoring plan as microbiological and disinfectant residual monitoring sites shall be included in the compliance determination calculations.

(B) Samples collected at sites in the distribution system not designated in the monitoring plan shall not be included in the compliance determination calculations.

(2) A public water system that fails to conduct the monitoring tests required by this section commits a monitoring violation.

(3) A public water system that fails to report the results of the monitoring tests required by this section commits a reporting violation.

(4) A public water system that uses surface water sources or groundwater sources under the direct influence of surface water and fails to meet the requirements of subsection (b)(2) of this section for a period longer than four consecutive hours commits a nonacute treatment technique violation. A public water system that fails to conduct the additional testing required by subsection (c)(1)(B)(iii) of this section also commits a nonacute treatment technique violation.

(5) A public water system that uses chlorine dioxide and exceeds the level specified in subsection (b)(3) of this section violates the MRDL for chlorine dioxide.

(A) If a public water system violates the MRDL for chlorine dioxide and any of the three additional distribution samples exceeds the MRDL, the system commits an acute MRDL violation for chlorine dioxide.

(B) If a public water system violates the MRDL for chlorine dioxide and fails to collect each of the three additional distribution samples required by subsection (c)(3) of this section, the system commits an acute MRDL violation for chlorine dioxide.

(C) If a public water system violates the MRDL for chlorine dioxide but none of the three additional distribution samples violates the MRDL, the system commits a nonacute MRDL violation for chlorine dioxide.

(6) A public water system that fails to meet the requirements of subsection (b)(4) of this section, in more than 5.0% of the samples collected each month, for any two consecutive months, commits a nonacute treatment technique violation. Specifically, the system commits a nonacute violation if the value "V" in the following formula exceeds 5.0% per month for any two consecutive months:
Figure: 30 TAC §290.110(f)(6) (No change.)

(7) A public water system violates the MRDL for chlorine or chloramine (measured as total chlorine) if, at the end of any quarter, the running annual average of monthly averages exceeds the level specified in subsection (b)(5) of this section.

(8) Public water systems [~~Notwithstanding the MRDLs listed in subsection (b) of this section, operators~~] shall increase residual disinfectant levels of free chlorine, or chloramines[~~,~~] measured as total chlorine, (but not chlorine dioxide) in the distribution system to a level and for a time necessary to protect public health to address specific microbiological contamination problems caused by circumstances such as distribution line breaks, storm runoff events, source water contamination, or cross-connections. Public water systems shall consult with the executive director upon increasing residual disinfectant levels in the distribution system in order to maintain compliance with the MRDLs listed in subsection (b) of this section.

(9) If a public water system's failure to monitor makes it impossible to determine compliance with the MRDL for chlorine or chloramines (measured as total chlorine), the system commits an MRDL violation for the entire period covered by the annual average.

(10) A public water system that fails to issue a required public notice or certify that it has issued that notice commits a violation.

(g) Public notification requirements. The owner or operator of a public water system that violates the requirements of this section must notify the executive director and the people served by the system.

(1) A public water system that fails to meet the requirements of subsection (b)(3) of this section, shall notify the executive director within 24 hours of the event and the customers in accordance with the requirements of §290.122 of this title (relating to Public Notification).

(A) A public water system that has an acute violation of the MRDL for chlorine dioxide must notify the customers in accordance with the requirements of §290.122(a) of this title.

(B) A public water system that has a non-acute violation of the MRDL for chlorine dioxide must notify the customers in accordance with the requirements of §290.122(b) of this title.

(2) A public water system that uses surface water sources or groundwater sources under the direct influence of surface water and fails to meet the minimum disinfection requirements of subsection (b)(2) of this section shall notify the executive director by the end of the next business day and the customers in accordance with the requirements of §290.122(b) of this title.

(3) A public water system that fails to meet the requirements of subsection (b)(4) of this section in more than 5.0% of the samples collected each month for two consecutive months must notify its customers in accordance with the requirements of §290.122(b) of this title.

[~~(A) A public water system that uses surface water or groundwater under the direct influence of surface water must notify its customers in accordance with the requirements of §290.122(b) of this title.~~]

[~~(B) A public water system that uses only groundwater or purchased water must notify its customers when it issues its annual consumer confidence report.~~]

(4) A public water system that fails to meet the requirements of subsection (b)(5) of this section shall notify the executive director by the end of the next business day and the customers in accordance with the requirements of §290.122(b) of this title.

(5) A public water system which fails to conduct the monitoring required by subsection (c)(1) - (4) of this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(6) A public water system that uses chloramines shall notify their retail and wholesale customers of the use of chloramines.

(A) This notification must contain the exact wording included in Appendix H of §290.47 of this title (relating to Appendices).

(B) Prior to initially providing the chloraminated water to its existing customers, the water system must provide notification by mail or direct delivery at least 14 days before the change.

(C) Additionally, the notification must be provided to the news media, hospitals, renal disease facilities, dialysis clinics, physicians, local health departments, and entities which maintain live fish directly by letter, e-mail, or hand delivery.

(D) New customers must also be notified before they begin receiving water from the water system.

(E) Where appropriate, the notice must be multilingual.

§290.111. Surface Water Treatment.

(a) Applicability. A public water system that treats surface water or groundwater under the direct influence of surface water must comply with the requirements of this section.

(1) A public water system that treats surface water must comply with the requirements of this section beginning on the effective date of the rule.

(2) A public water system that treats groundwater under the direct influence of surface water must comply with the requirements of this section beginning on a date specified by the executive director. This compliance date shall not exceed 18 months from the date that the executive director first notifies the system that the groundwater source is under the direct influence of surface water.

(3) A public water system that treats both surface water and groundwater under the direct influence of surface water must meet the compliance date in paragraph (1) of this subsection at plants that treat any surface water and must meet the compliance date in paragraph (2) of this subsection at plants that treat only groundwater under the direct influence of surface water.

(b) Raw surface water monitoring. A public water system that treats surface water or groundwater under the direct influence of surface water must conduct at least two rounds of special raw surface water monitoring at each surface water intake and at each well producing groundwater under the direct influence of surface water for the purpose of establishing minimum treatment technique requirements for *Cryptosporidium* and other pathogens. The executive director may waive the raw surface water monitoring requirements for an intake or a well if the combination of pathogen removal and disinfection processes used to treat the raw water achieves at least a 5.5-log total removal and inactivation of *Cryptosporidium parvum.*

(1) Raw water monitoring plans. A system must submit a proposed raw surface water monitoring plan when requested by the executive director. The proposed plan must identify all of the system's intakes and wells; provide the location of each raw water sampling point; include the parameters that will be monitored and the frequency and dates that samples will be collected; and specify the laboratories that will perform the analyses. Raw surface water monitoring must be conducted in accordance with a monitoring plan that has been approved by the executive director. The executive director shall not approve a raw surface water monitoring plan unless it indicates that the system will meet the requirements of 40 Code of Federal Regulations (CFR) §§141.701 - 141.707.

(2) Sampling location. A system must collect each raw water sample at a location approved by the executive director. Samples must be collected from the raw water line prior to any treatment and before the first point where a recycled stream is returned to the treatment process.

(3) Sampling parameters and frequency. A system must collect raw water samples at a frequency approved by the executive director.

(A) Unless the executive director approves an alternate sampling regimen, a system must monitor turbidity, *Escherichia coli (E. coli),* and *Cryptosporidium* levels in the raw water at least once each month for a period of not less than 24 consecutive months if the system:

(i) serves at least 10,000 people; or

(ii) is part of combined distribution system in which one or more systems serve at least 10,000 people and the system with the well or intake regularly provides water to another public water supply.

(B) A system that is not required to monitor under subparagraph (A) of this paragraph must either monitor in accordance with the requirements of subparagraph (A) of this paragraph or monitor *E. coli* levels in their raw water at least once every two weeks for a period of not less than 12 consecutive months. A system that does not initially monitor for *Cryptosporidium* and has elevated *E. coli* levels must conduct additional raw water monitoring.

(i) A system must conduct additional monitoring if the average *E. coli* level exceeds 100 colony-forming units per 100 milliliters in the raw water produced by a surface water intake located on a river or flowing stream or the raw water from a well producing groundwater under the direct influence of surface water located closest to a river or flowing stream.

(ii) A system must conduct additional monitoring if the average *E. coli* level exceeds 100 colony-forming units per 100 milliliters in the raw water from a surface water intake not located on a river or flowing stream or the raw water produced by a well producing groundwater under the direct influence of surface water not located on a river or flowing stream.

(iii) A system that must conduct additional monitoring must monitor *Cryptosporidium* levels in the raw water at least twice each month for a period of not less than 12 consecutive months, or at least once each month for a period of not less than 24 consecutive months.

(C) The executive director may approve an alternate sampling frequency for intakes and wells that operate only part of the year.

(4) Sampling schedule and dates. A system must collect raw water samples in accordance with a schedule approved by the executive director.

(A) Except as provided in subparagraph (B) of this paragraph, a system must begin each round of raw source water monitoring no later than the date shown in the following table titled "Raw Source Water Monitoring Schedule."
Figure: 30 TAC §290.111(b)(4)(A) (No change.)

(B) If a system installs a new well or intake after the date the first round of raw source water monitoring must begin, the system must:

(i) submit a proposed monitoring schedule for the first round of special raw surface water monitoring no later than three months after first placing the new source in operation; and

(ii) begin the second round of special raw surface water monitoring no later than six years after initial bin classification.

(C) A system must collect a raw water sample no sooner than two days before the date approved by the executive director and no later than two days after the approved date, unless an extreme condition or situation exists that poses a danger to the sample collector.

(D) A system which is unable to collect a sample within this five-day period must collect the sample as close as possible to the approved date and must notify the executive director in writing why the sample was not collected on the approved date.

(5) Replacement samples. If, for any reason, the laboratory is unable to report a valid analytical result for a scheduled sample, the system must submit a replacement sample on a date approved by the executive director.

(6) Analytical requirements. Raw water samples collected pursuant to this subsection must be analyzed at an United States Environmental Protection Agency (EPA) approved or a Texas Commission on Environmental Quality accredited laboratory.

(A) *Cryptosporidium* samples must be analyzed using one of the methods approved in 40 CFR §141.704(a) and by a laboratory that is approved under EPA's Laboratory Quality Assurance Evaluation Program for Analysis of *Cryptosporidium* in Water.

(B) *E. coli* samples must be analyzed using one of the methods approved in 40 CFR §136.3(a) for the enumeration of *E. coli* in source water and by a laboratory that is accredited by the executive director.

(i) Systems must ensure that samples are maintained between 0 degrees Celsius and 10 degrees Celsius during storage and transportation to the laboratory.

(ii) The time between sample collection and the initiation of the analysis may not exceed 30 hours without the prior approval of the executive director.

(iii) The executive director may allow up to 48 hours between sample collection and the initiation of the analysis if the analysis is conducted by the Colilert reagent version of Standard Method 9223B.

(C) Turbidity samples must be analyzed using a method and at a laboratory approved by the executive director.

(7) Reporting requirements for raw surface water sample results. The owner or operator of a public water system must provide to the executive director with a copy of the results of any test, measurement, or analysis required by this subsection.

(A) Results must be submitted using the Raw Surface Water Sampling Report (commission Form 20358) or in another format that is approved by the executive director and contains the information required by 40 CFR §141.706(e).

(i) If the sample was not collected within the five-day window described in paragraph (4)(C) of this subsection, the result must be accompanied by the information required in paragraph (4)(D) of this subsection.

(ii) If the laboratory report indicates that a valid analytical result could not be reported, the laboratory report must be accompanied by a request to collect a replacement sample.

(B) The results must be submitted within ten days of their receipt by the public water system and no later than ten days after the end of the first month following the month that the sample was collected.

(C) The results and any additional information must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(c) Treatment technique requirements. A system that treats surface water or groundwater under the direct influence of surface water must meet minimum treatment technique requirements before the water reaches the entry point to the distribution system.

(1) The combination of pathogen removal and disinfection processes used by a public water system must achieve at least a 4.0-log removal/inactivation of viruses.

(2) The combination of pathogen removal and disinfection processes used by a public water system must achieve at least a 3.0-log removal/inactivation of *Giardia lamblia.*

(3) A public water system that is required by subsection (b) of this section to conduct raw surface water monitoring must comply with the requirements of this paragraph.

(A) The average *Cryptosporidium* level and bin classification shall be determined in accordance with the requirements established by 40 CFR §141.710.

(i) For systems that collect a total of at least 48 *Cryptosporidium* samples, the average concentration is equal to the arithmetic mean of all sample concentrations.

(ii) For systems that collect a total of at least 24 samples, but not more than 47 *Cryptosporidium* samples, the average concentration is equal to the highest arithmetic mean of all sample concentrations in any 12 consecutive months during which *Cryptosporidium* samples were collected.

(iii) For systems that serve fewer than 10,000 people and monitor for *Cryptosporidium* for only one year (i.e., collect 24 samples in 12 months), the average concentration is equal to the arithmetic mean of all sample concentrations.

(iv) For systems with plants operating only part of the year that monitor fewer than 12 months per year under 40 CFR §141.701(e), the bin concentration is equal to the highest arithmetic mean of all sample concentrations during any year of *Cryptosporidium* monitoring.

(v) If the monthly *Cryptosporidium* sampling frequency varies, systems must first calculate a monthly average for each month of monitoring. Systems must then use these monthly average concentrations, rather than individual sample concentrations, in the applicable calculation for bin classification in paragraphs.

(B) Unless otherwise specified in this paragraph, the combination of pathogen removal and disinfection processes must achieve the removal/inactivation of *Cryptosporidium parvum* specified in the following table titled "Treatment Technique Requirements for *Cryptosporidium,*" beginning 36 months after being assigned a bin classification by the executive director.
Figure: 30 TAC §290.111(c)(3)(B) (No change.)

(i) A system that conducts the first round of special raw surface water monitoring according to the schedule contained in subsection (b)(4)(A) of this section must comply with the requirements of this paragraph no later than the date shown in the following table, titled "Compliance Date for Existing Sources."
Figure: 30 TAC §290.111(c)(3)(B)(i) (No change.)

(ii) A system that conducts the first round of special raw surface water monitoring according to the schedule contained in subsection (b)(4)(B)(i) of this section must comply with the requirements of this paragraph no later than six years after beginning the first round of monitoring on the new source.

(iii) The executive director may allow a system making capital improvements an additional two years to comply with the treatment requirement of this paragraph.

(C) A system that has been assigned to Bin 3 or Bin 4 must achieve at least 1.0-log removal/inactivation of *Cryptosporidium* using one or a combination of the following: bag filters, cartridge filters, chlorine dioxide, membranes, ozone, or ultraviolet light (UV).

(D) Prior to the effective date of subparagraph (B) of this paragraph, the combination of disinfection and filtration processes used by a public water system to treat for *Cryptosporidium* must achieve at least a 2.0-log removal/inactivation of *Cryptosporidium parvum.*

(4) The combination of disinfection and filtration processes at plants that do not monitor each source in accordance with the requirements of subsection (b) of this section must achieve at least a 5.5-log removal/inactivation of *Cryptosporidium parvum.*

(5) The executive director may require additional levels of treatment in cases of poor source water quality.

(6) The executive director may establish minimum design, operational, and reporting requirements for watershed control programs and treatment processes used to meet the treatment technique requirements of this subsection.

(d) Microbial inactivation requirements. A system that treats surface water or groundwater under the direct influence of surface water must meet minimum disinfection requirements before the water is supplied to any consumer.

(1) Inactivation table. The disinfection process must achieve the minimum microbial inactivation levels shown in the following table.
Figure: 30 TAC §290.111(d)(1) (No change.)

(A) The disinfection process at treatment plants not described in the Microbial Inactivation Requirements table must provide the level of disinfection required by the executive director.

(B) The executive director may require additional levels of treatment in cases of poor source water quality.

(C) The executive director may reduce the inactivation requirement for plants that meet the individual filter effluent performance criteria contained in subsection (g)(1) of this section and have been assigned a Bin 1 classification under the provisions of subsection (c)(3) of this section.

(D) A system that fails to meet the inactivation requirements of this section for a period of longer than four consecutive hours commits a nonacute treatment technique violation. A system that fails to conduct the additional testing required by paragraph (2)(C) of this subsection also commits a nonacute treatment technique violation.

(E) A system that has a plant assigned a Bin 2, 3, or 4 classification under the provisions of subsection (c)(3) of this section and uses UV disinfection facilities to meet the treatment technique requirements for *Cryptosporidium* must meet the inactivation requirements of this subsection in at least 95% of the water treated each month.

(2) Monitoring requirements for chemical disinfectants. Public water systems must monitor the performance of the disinfection facilities to ensure that appropriate disinfectant levels are maintained. All monitoring conducted pursuant to the requirements of this subsection must be conducted at sites designated in the public water system's monitoring plan.

(A) The disinfectant residual, pH, temperature, and flow rate of the water in each disinfection zone must be measured at least once each day during a time when peak hourly raw water flow rates are occurring.

(B) Disinfection contact time will be based on tracer study data or a theoretical analysis submitted by the system owner or their designated agent and approved by the executive director and the actual flow rate that is occurring at the time that monitoring occurs.

(C) Treatment plants that fail to demonstrate an appropriate level of treatment must repeat these tests at four-hour or shorter intervals until compliance has been reestablished.

(3) Monitoring requirements for UV disinfection facilities. Public water systems must monitor the performance of the UV disinfection facilities.

(A) A system must continuously monitor and record UV intensity as measured by a UV sensor, lamp status, the flow rate through the unit, and other parameters prescribed by the executive director to ensure that the units are operating within validated conditions.

(B) A system with a plant that has been assigned a Bin 2, 3, or 4 classification under the provisions of subsection (c)(3) of this section must also monitor and record the amount of water treated by each UV unit each month and the amount of water produced each month when the unit was not operating within validated conditions.

(4) Analytical requirements. All monitoring required by this subsection must be conducted at a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title (relating to Analytical Procedures).

(A) The pH analysis must be conducted using a pH meter with a minimum accuracy of plus or minus 0.1 pH units.

(B) The temperature of the water must be measured using a thermometer or thermocouple with a minimum accuracy of plus or minus 0.5 degrees Celsius.

(C) The free chlorine or chloramine residual (measured as total chlorine) must be measured to a minimum accuracy of plus or minus 0.1 milligrams per liter (mg/L). Color comparators may be used for distribution system samples only. When used, a color comparator must have current reagents, an unfaded and clear color comparator, a sample cell that is not discolored or stained, and must be properly stored in a cool, dark location where it is not subjected to conditions that would result in staining. The color comparator must be used in the correct range. If a sample reads at the top of the range, the sample must be diluted with chlorine-free water, then a reading taken and the resulting residual calculated.

(D) The chlorine dioxide residual must be measured to a minimum accuracy of plus or minus 0.05 mg/L using a method that conforms to the requirements of §290.119 of this title. The DPD-glycine method using a colorimeter or spectrophotometer may be utilized only with the written permission of the executive director. [~~one of the following methods:~~]

~~*[(i)* Amperometric titrator with platinum-platinum electrodes; or]~~

~~*[(ii)* Lissamine Green B.]~~

(E) The ozone residual must be measured to a minimum accuracy of plus or minus 0.05 mg/L using the Indigo Method and using a colorimeter or spectrophotometer.

(F) The UV dose must be measured by a calibrated sensor approved by the executive director.

(e) Filtration requirements for conventional filters. A system that uses granular media filters to treat surface water or groundwater under the direct influence of surface water must meet minimum filtration requirements before the water is supplied to any consumer.

(1) Treatment technique requirements for combined filter effluent. Treatment plants using conventional media filtration must meet the following turbidity requirements.

(A) The turbidity level of the combined filter effluent must never exceed 1.0 nephelometric turbidity unit (NTU).

(B) The turbidity level of the combined filter effluent must be 0.3 NTU or less in at least 95% of the samples tested each month.

(2) Performance criteria for individual filter effluent. The filtration techniques must ensure the public water system meets the following performance criteria.

(A) The turbidity from each individual filter effluent should never exceed 1.0 NTU.

(B) At a public water system that serves 10,000 people or more, the turbidity from each individual filter effluent should not exceed 0.5 NTU at four hours after the individual filter is returned to service after backwash or shutdown.

(3) Routine turbidity monitoring requirements. A system must monitor the performance of its filtration facilities.

(A) A system that serves fewer than 500 people and continuously monitors the turbidity level of each individual filter must measure and record the turbidity level of the combined filter effluent at least once each day that the plant is in operation.

(B) A system that serves at least 500 people and continuously monitors the turbidity level of each individual filter must measure and record the turbidity level of the combined filter effluent at least every four hours that the system serves water to the public.

(C) Except as provided in subparagraph (D) of this paragraph, a system must continuously monitor the filtered water turbidity at the effluent of each individual filter and record the turbidity value every 15 minutes.

(D) A system that serves fewer than 10,000 people and monitors combined filter effluent turbidity in lieu of individual filter effluent turbidity under the provisions of §290.42(d)(11)(E)(ii) of this title (relating to Water Treatment) must:

(i) continuously monitor the turbidity of the combined filter effluent and record the turbidity value every 15 minutes; and

(ii) measure and record the turbidity level at the effluent of each filter at least once each day the plant is in operation.

(4) Special investigation requirements. A system which fails to produce water with acceptable turbidity levels or if the level of removal/inactivation of pathogens is inadequate or cannot be determined, the system must investigate the cause of the problem and take appropriate corrective action. The executive director can waive these special monitoring requirements for systems that have a corrective action schedule approved by the executive director.

(A) A public water system that fails to meet the turbidity criteria specified in paragraph (2) of this subsection must conduct additional monitoring.

(i) Each time a filter exceeds an applicable filtered water turbidity level specified in paragraph (2) of this subsection for two consecutive 15-minute readings, the public water system must either identify the cause of the exceedance or produce a filter profile on the filter within seven days of the exceedance.

(ii) Each time a filter exceeds the filtered turbidity level specified in paragraph (2)(A) of this subsection for two consecutive 15-minute readings on three separate occasions during any consecutive three-month period, the public water system must conduct a filter assessment on the filter within 14 days of the third exceedance.

(iii) Each time the filtered water turbidity level for a specific filter or any combination of individual filters exceeds 2.0 NTU on two consecutive 15-minute readings during two consecutive months, the public water system must participate in a third-party comprehensive performance evaluation (CPE). If the system serves at least 10,000 people, the CPE must be conducted within 90 days of the first exceedance in the second month. If the system serves fewer than 10,000 people, the CPE must be conducted within 120 days of the first exceedance in the second month.

(iv) A public water system that uses conventional filters may be required to participate in a special investigation conducted by the executive director if, during two consecutive months, the public water system fails to report individual filter effluent turbidity levels on a day when the combined filter effluent turbidity level exceeds 1.0 NTU.

(B) A system that serves fewer than 10,000 people, monitors combined filter effluent turbidity in lieu of individual filter effluent turbidity, and fails to meet the turbidity criteria in paragraph (1)(A) of this subsection must conduct additional monitoring. The executive director may waive these special monitoring requirements for systems that have a corrective action schedule approved by the executive director.

(i) Each time the combined filter effluent turbidity level exceeds 1.0 NTU for two consecutive 15-minute readings, the public water system must either identify the cause of the exceedance or complete a filter profile on the combined filter effluent within seven days of the exceedance.

(ii) Each time the combined filter effluent turbidity level exceeds 1.0 NTU for two consecutive 15-minute readings on three separate occasions during any consecutive three-month period, the public water system must conduct a filter assessment on each filter within 14 days of the third exceedance.

(iii) Each time the combined filter effluent turbidity level exceeds 2.0 NTU on two consecutive 15-minute readings during two consecutive months, the public water system must participate in a third-party CPE within 120 days of the first exceedance in the second month.

(C) A public water system may be required to participate in a special investigation conducted by the executive director when documentation or lack of documentation from a public water system indicates that the pathogen removal/inactivation levels are inadequate or cannot be determined.

(5) Analytical requirements for turbidity. All monitoring required by this subsection must be conducted by a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title. Equipment used for compliance measurements must be maintained and calibrated in accordance with §290.46(s) of this title (relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems).

(A) Turbidity must be measured with turbidimeters that use a method that conforms with the requirements as described in §290.119 of this title. [~~one of the following methods:~~]

~~[*(i)* EPA Method 180.1 and Standard Method 2130B;]~~

~~[*(ii)* Great Lakes Instruments Method 2; or]~~

~~[*(iii)* Hach FilterTrak Method 10133.]~~

(B) A system monitoring the performance of individual filters with on-line turbidimeters and recorders may monitor combined filter effluent turbidity levels by either continuously monitoring turbidity levels with an on-line turbidimeter or measuring the turbidity level in grab samples with a bench-top turbidimeter.

(C) Continuous turbidity monitoring must be conducted using a continuous, on-line turbidimeter and a device that records the turbidity level reading at least once every 15 minutes.

(i) Turbidity data may be recorded electronically by a supervisory control and data acquisition system (SCADA) or on a strip chart. The recorder must be designed so that the operator can accurately determine the turbidity level readings at 15-minute intervals.

(ii) If there is a failure in the continuous turbidity monitoring equipment at a system serving 10,000 people or more, the system must conduct grab sampling every four hours in lieu of continuous monitoring, but for no more than five working days following the failure of the equipment.

(iii) If the continuous turbidity monitoring equipment at a system serving fewer than 10,000 people malfunctions, the system must conduct grab sampling every four hours in lieu of continuous monitoring, but for no more than 14 working days following the failure of the equipment.

(D) A system that monitors combined filter effluent turbidity in lieu of individual filter effluent turbidity under §290.42(d)(11)(E)(ii) of this title must monitor the performance of individual filters using a bench-top turbidimeter.

(E) Combined filter effluent and individual filter effluent turbidity monitoring equipment and all associated data recording devices shall read and record turbidity levels to adequately determine compliance with the requirements as described in this subchapter. The turbidity equipment and all associated recording devices shall read and record levels:

(i) at least 10% higher than the turbidity level needed to determine compliance with the highest applicable regulatory requirement as described in this subchapter;

(ii) at the lowest method detection limit of the approved turbidimeter; and

(iii) at the precision and accuracy necessary to determine compliance with the requirements as described in this subchapter.

(f) Filtration requirements for other filters. A system that uses cartridge filters, membrane filters, or other unconventional filtration systems to treat surface water or groundwater under the direct influence of surface water must meet minimum filtration requirements before the water is supplied to any consumer.

(1) Treatment technique requirements. A system that uses unconventional filtration technologies such as membrane filters or cartridge filters must meet treatment technique requirements prescribed by the executive director.

(A) The filtration facilities must meet combined filter effluent and individual filter effluent turbidity limits established by the executive director.

(B) The filtration facilities must be operated and maintained in accordance with requirements that the executive director determines are needed to demonstrate the amount of *Giardia* and *Cryptosporidium* removal achieved.

(2) Monitoring requirements. A system must monitor the performance of its filtration facilities.

(A) A system that serves fewer than 500 people and continuously monitors the turbidity level of each individual cartridge or membrane unit must measure and record the turbidity level of the combined effluent at least once each day that the plant is in operation.

(B) A system that serves at least 500 people and continuously monitors the turbidity level of each individual cartridge or membrane unit must measure and record the turbidity level of the combined effluent at least every four hours that the system serves water to the public.

(C) A system using membranes must use a method approved by the executive director to continuously monitor the quality of the water produced by each membrane unit and record the monitoring results at least once every five minutes. The executive director may approve monitoring parameters other than turbidity and decrease the frequency to once every 15 minutes if the approved operating parameters will allow consecutive readings to be obtained between backwash or backflush cycles.

(D) A system using membranes must conduct direct integrity testing on each membrane unit using a procedure approved by the executive director.

(i) Direct integrity tests must be conducted in a manner that will detect a membrane defect of 3 microns or smaller and demonstrates a removal efficiency equal to or greater than the removal credit awarded to the membrane filtration process by the executive director.

(ii) Direct integrity test method must calculate the log removal value for a 3-micron size particle and establish an upper control limit which assures that the unit is capable of meeting the removal credit approved by the executive director.

(iii) A system that has been assigned a Bin 1 classification under the provisions of subsection (c)(3)(B) of this section must conduct direct integrity tests at least once every seven days. The executive director may reduce the testing requirements for other membrane units.

(iv) A system that has been assigned a Bin 2, 3, or 4 classification under the provisions of subsection (c)(3)(B) of this section must conduct direct integrity tests at least once each day that the membrane unit is used for filtration. The executive director may approve less frequent testing, based on demonstrated process reliability, the use of multiple barriers effective for *Cryptosporidium* removal or inactivation, or reliable process safeguards.

(v) A system must immediately conduct a direct integrity test on any membrane unit that produces filtered water with turbidity level above 0.15 NTU on two consecutive readings. The executive director must establish alternate site-specific control limits for systems that use other approved technology in lieu of turbidimeters to continuously monitor the performance of membrane units.

(vi) A system must immediately remove any membrane unit that fails a direct integrity test from service until the membrane modules in that unit are inspected and, if necessary, repaired. A membrane unit that has been removed from service may not be returned to service until it has passed a direct integrity test.

(E) A system that uses cartridge filters must continuously monitor the performance of the filtration process in a manner approved by the executive director.

(3) Analytical requirements. All monitoring required by this subsection must be conducted by a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title. Equipment used for compliance measurements must be maintained and calibrated in accordance with §290.46(s) of this title.

(A) Turbidity of the combined effluent must be measured with turbidimeters that meet the requirements of subsection (e)(5)(A) of this section.

(B) The turbidity of the water produced by each membrane unit must be measured using the Hach FilterTrak Method 10133. The executive director may approve the use of alternative technology to monitor the quality of the water produced by each membrane unit.

(C) A system continuously monitoring the performance of individual cartridges or membrane units may monitor combined ef-

fluent turbidity levels by either continuously monitoring turbidity levels with an on-line turbidimeter, or by measuring the turbidity level in grab samples with a bench-top turbidimeter.

(D) Data collected from on-line instruments may be recorded electronically by a SCADA system or on a strip chart recorder. The recorder must be designed so that the operator can accurately determine the value of readings at the monitoring interval approved by the executive director.

(i) If there is a failure in the continuous monitoring equipment at a system serving 10,000 people or more, the system must conduct grab sampling every four hours in lieu of continuous monitoring, but for no more than five working days following the failure of the equipment.

(ii) If there is a failure in the continuous monitoring equipment at a system serving fewer than 10,000 people, the system must conduct grab sampling every four hours in lieu of continuous monitoring, but for no more than 14 working days following the failure of the equipment.

(E) A system that uses cartridge filters and does not continuously monitor the turbidity of each filter unit must monitor the performance of individual filters at least once each day using a bench-top turbidimeter.

(F) Combined filter effluent and individual filter effluent turbidity monitoring equipment and all associated data recording devices shall read and record turbidity levels to adequately determine compliance with the requirements as described in this subchapter. The turbidity equipment and all associated recording devices shall read and record levels:

(i) at least 10% higher than the turbidity level needed to determine compliance with the highest applicable regulatory requirement as described in this subchapter;

(ii) at the lowest method detection limit of the approved turbidimeter; and

(iii) at the precision and accuracy necessary to determine compliance with the requirements as described in this subchapter.

(4) Special investigation requirements. A system which fails to produce water with acceptable turbidity levels, or if the level of removal/inactivation of pathogens is inadequate or cannot be determined, the system shall investigate the cause of the problem and take appropriate corrective action. The executive director can waive these special monitoring requirements for systems that have a corrective action schedule approved by the executive director.

(A) A public water system that utilizes membrane filters for pathogen removal may be required to participate in a special investigation conducted by the executive director if, during two consecutive months, the system fails to report all required direct integrity test results for a specific membrane unit.

(B) A public water system that utilizes membrane filters for pathogen removal may be required to participate in a special investigation conducted by the executive director if, during two consecutive months, a specific membrane unit fails at least one direct integrity test and continues to produce water.

(C) A public water system may be required to participate in a special investigation conducted by executive director when documentation or lack of documentation from a public water system indicates that the pathogen removal/inactivation levels are inadequate or cannot be determined.

(g) Other treatment credits for systems in Bins 2 through 4. The executive director may grant additional pathogen removal and inactivation credit to systems that meet enhanced design, operational, maintenance, and reporting requirements.

(1) Individual filter effluent. The executive director may approve an additional 1.0-log removal credit for *Giardia* and *Cryptosporidium* to a treatment plant that uses conventional granular media filters.

(A) The executive director will approve the additional credit for a plant if:

(i) the system continuously monitored the filtered water turbidity at the effluent of each individual filter and recorded the turbidity value every 15 minutes that the filter was sending water to the clearwell;

(ii) the turbidity level at each individual filter effluent is less than or equal to 0.15 NTU in at least 95% of the measurements recorded during the month; and

(iii) no individual filter produced water with turbidity level above 0.3 NTU in two consecutive 15-minute readings.

(B) The executive director may also approve the additional credit for a plant that does not meet the requirements of subparagraph (A) of this paragraph if:

(i) the executive director determines that the failure to meet the requirements of subparagraph (A) of this paragraph could not have been prevented through optimizing plant operations, design, or maintenance; and

(ii) the system has experienced no more than two such failures within the most recent 12 months.

(2) Combined filter effluent. The executive director may approve an additional 0.5-log removal credit for *Cryptosporidium* to a treatment plant that uses conventional granular media filters if:

(A) the system continuously monitored the filtered water turbidity at the effluent of each individual filter and recorded the turbidity value every 15 minutes that the filter was sending water to the clearwell;

(B) the turbidity level at the combined filter effluent is less than or equal to 0.15 NTU in at least 95% of the measurements recorded during the month; and

(C) the plant does not receive additional treatment credit under paragraph (1) of this subsection.

(3) Second stage filtration. The executive director will approve an additional 0.5-log removal credit for *Giardia* and *Cryptosporidium* to a treatment plant that uses a second, separate stage of conventional granular media filters if:

(A) the filters in both stages meet minimum design criteria approved by the executive director;

(B) all of the water produced by the plant passes through both stages of filtration;

(C) the system continuously monitored the filtered water turbidity at the effluent of each individual filter in the first stage of filtration and recorded the turbidity value every 15 minutes that the filter was sending water to the clearwell; and

(D) no individual filter in the first stage of filtration produced water with turbidity level above 1.0 NTU in two consecutive 15-minute readings.

(4) Other pathogen control strategies. The executive director may approve an additional removal or inactivation credit for other pre-filtration, filtration, or post-filtration strategies that can demonstrate effective, consistent levels of enhanced pathogen control.

(A) The alternative strategy must achieve a quantifiable reduction in the risk of waterborne disease in all of the treated water produced by the plant.

(B) The alternative strategy must conform to any applicable requirement of 40 CFR §§141.715 - 141.720.

(C) The executive director may establish minimum site-specific design, operational, maintenance, and reporting requirements for any alternative strategy used to meet minimum treatment technique requirements of subsection (c) of this section.

(D) The executive director may not approve additional removal credit under the provisions of this paragraph to any strategy that includes a treatment process has been assigned additional removal or inactivation credit under any other provision of this subsection.

(h) Reporting requirements. Public water systems must properly complete and submit periodic reports to demonstrate compliance with this section.

(1) A system that has a turbidity level exceeding 1.0 NTU in the combined filter effluent must consult with the executive director within 24 hours.

(2) A system that treats surface water sources or groundwater sources under the direct influence of surface water must submit a Surface Water Monthly Operating Report each month for each plant.

(A) A system that uses alternative treatment technologies or has been assigned a Bin 2, Bin 3, or Bin 4 classification under subsection (c)(3)(B) of this section must submit a Surface Water Monthly Operating Report (commission Form 0102D) for alternative technologies.

(B) A system that continuously monitors the performance of individual filters, but is not required to submit commission Form 0102D, must submit a Surface Water Monthly Operating Report (commission Form 0102C).

(C) A system that is allowed by the executive director to submit combined filter effluent turbidity in lieu of individual filter effluent turbidity under §290.42(d)(11)(E)(ii) of this title must submit a Surface Water Monthly Operational Report for Plants That Do Not Have a Turbidimeter on Each Filter (commission Form 0103) each month for each plant that treats surface water or groundwater under the direct influence of surface water.

(3) A system that must complete the additional monitoring required by subsection (e)(4)(A)(i) or (B)(i) of this section must submit a Filter Profile Report for Individual Filters (commission Form 10276) with its Surface Water Monthly Operating Report.

(4) A system that must complete the additional monitoring required by subsection (e)(4)(A)(ii) or (B)(ii) of this section must submit a Filter Assessment Report for Individual Filters (commission Form 10277) with its Surface Water Monthly Operating Report.

(5) A system that must complete the additional monitoring required by subsection (e)(4)(A)(iii) or (B)(iii) of this section must submit a Comprehensive Performance Evaluation Request Form (commission Form 10278) with its Surface Water Monthly Operating Report.

(6) A system must submit any additional reports required by the executive director to verify the level of pathogen removal or inactivation achieved by the system's treatment plants.

(7) A system must submit its *Cryptosporidium* bin classification.

(8) A system must submit reports required by subsection (b)(7) of this section.

(9) Periodic reports required by this section must be submitted to the Water Supply Division, Texas Commission on Environmental Quality, MC 155, P.O. Box 13087, Austin, Texas 78711-3087 by the tenth day of the month following the end of the reporting period.

(i) Compliance determination. Compliance with the requirements of this section must be determined using the criteria of this subsection.

(1) A public water system that fails to complete source water monitoring or conduct the routine monitoring tests and any applicable special investigations required by this section commits a monitoring violation.

(2) A public water system that fails to submit a report required by subsection (h) of this section commits a reporting violation.

(3) A public water system that has one or more of the following conditions as specified in subparagraphs (A) - (E) of this paragraph commits an acute treatment technique violation and is required to issue a public notice and a boil water notice within 24 hours in accordance with §290.122(a) of this title (relating to Public Notification). [~~A public water system using conventional filters that has a turbidity level exceeding 5.0 NTU in the combined filter effluent commits an acute treatment technique violation.~~]

(A) A public water system using conventional filters that has a turbidity level exceeding 5.0 NTU in the combined filter effluent.

(B) A public water system using conventional filters that has a combine filter effluent (CFE) turbidity level exceeding 2.0 NTU at plants that are required to have individual filter effluent (IFE) turbidimeters and failed to properly monitor or record IFE turbidity data during the period when the CFE turbidity level was above 2.0 NTU.

(C) A public water system using conventional filters that has a CFE turbidity level exceeding 2.0 NTU at a plant that has only two filters, is not required to continuously monitor the IFE turbidity level at the effluent of each filter, and did not collect IFE turbidity grab samples during the period when CFE levels were above 2.0 NTU.

(D) A public water system that fails to submit a report required by subsection (h) of this section for two consecutive months.

(E) A public water system using membrane or cartridge filters that has a turbidity level exceeding 1.0 NTU in the combined filter effluent.

(4) A public water system using conventional filters that has one or more of the following conditions as specified in subparagraphs (A) - (D) of this paragraph, and has not met the conditions as specified in paragraph (3) of this subsection, commits an acute treatment technique violation and is required to issue a public notice within 24 hours in accordance with §290.122(a) of this title. [~~A public water system using membrane filters that has a turbidity level exceeding 1.0 NTU in the combined filter effluent commits an acute treatment technique violation.~~]

(A) A CFE turbidity level exceeding 1.0 NTU during a period when the disinfection protocol did not achieve an inactivation ratio of at least 2.0 for both *Giardia* and viruses.

(B) A CFE turbidity level exceeding 1.0 NTU during a period that IFE turbidity levels were above 2.0 NTU at one or more filters.

(C) A CFE turbidity level exceeding 1.0 NTU occurring at a plant that is required to have IFE turbidimeters and fails to properly monitor or record IFE turbidity data during the period when the CFE turbidity level was above 1.0 NTU.

(D) A CFE turbidity level exceeding 1.0 NTU occurred at a plant that has only two filters, is not required to continuously monitor the IFE turbidity level at the effluent of each filter, and did not collect IFE turbidity grab samples during the period when CFE levels were above 1.0 NTU.

(5) Except as provided in paragraphs (3) and (4) of this subsection, a public water system that violates the requirements of subsections (c), (d)(1), (e)(1), and (f)(1) of this section commits a nonacute treatment technique violation.

(6) A system that fails to request a bin classification within six months of completing a round of source water monitoring commits a treatment technique violation.

(7) A system that fails to correct the performance-limiting factors identified in a comprehensive performance evaluation conducted under the requirements of subsection (e)(4)(A)(iii) or (B)(iii) of this section commits a violation.

(8) A system that fails to properly issue a public notice required by subsection (j) of this section commits a violation.

(j) Public notification. The owner or operator of a public water system that violates the requirements of this section must notify the executive director and the people served by the system.

(1) A public water system that commits an acute treatment technique violation must notify the executive director and the water system customers of the acute violation within 24 hours in accordance with the requirements of §290.46(q) of this title and §290.122(a) of this title (relating to Public Notification).

(2) A public water system that has a turbidity level exceeding 1.0 NTU in the combined filter effluent must consult with the executive director within 24 hours of the violation.

(A) Based on the results of the consultation, the executive director will determine whether the water system must notify its customers in accordance with the requirements of §290.122(a) or (b) of this title.

(B) A water system that fails to consult with the executive director as required by this paragraph must notify its customers in accordance with the requirements of §290.122(a) of this title.

(3) Except as provided in paragraphs (1) and (2) of this subsection, a public water system that fails to meet the treatment technique requirements of subsections (c), (d)(1), (e)(1), or (f)(1) of this section must notify the executive director by the end of the next business day and the water system customers in accordance with the requirements of §290.122(b) of this title.

(4) A public water system that fails to conduct the monitoring required by this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

§290.112. Total Organic Carbon (TOC).

(a) Applicability. A water treatment plant must meet the provisions of this section if the plant:

(1) serves a community or nontransient, noncommunity public water system;

(2) treats surface water or groundwater under the direct influence of surface water; and

(3) uses a series of treatment processes that includes coagulation, flocculation, sedimentation or clarification, and filtration as part of the overall treatment protocol.

(b) Treatment technique. Systems must achieve the Step 1 removal requirements in paragraph (1) of this subsection, meet one of the alternative compliance criteria described in paragraph (2) of this subsection, or apply for the alternative Step 2 removal requirements described in paragraph (3) of this subsection.

(1) Systems must determine their ability to meet the Step 1 removal requirements given in the following table. A water treatment plant's Step 1 total organic carbon (TOC) required percent removal is based upon plant's source water TOC and alkalinity. Step 1 TOC percent removal requirements are indicated in the following table. Systems practicing softening are evaluated based on the Step 1 TOC removal in the far-right column (Source water alkalinity >120 milligrams per liter (mg/L)) for the specified source water TOC.
Figure: 30 TAC §290.112(b)(1) (No change.)

(2) Systems may determine their ability to meet one of the eight alternative compliance criteria listed in this paragraph.

(A) A system meets alternative compliance criteria Number 1 if the system's source water TOC level is less than 2.0 mg/L, calculated quarterly as a running annual average.

(B) A system meets alternative compliance criteria Number 2 if the system's treated water TOC level is less than 2.0 mg/L, calculated quarterly as a running annual average.

(C) A system meets alternative compliance criteria Number 3 if: the system's source water TOC level is less than 4.0 mg/L, calculated quarterly as a running annual average; the source water alkalinity is greater than 60 mg/L (as calcium carbonate (CaCO3), calculated quarterly as a running annual average; and the total trihalomethanes (TTHM) and haloacetic acid-group of five (HAA5) running annual averages are no greater than 0.040 mg/L and 0.030 mg/L, respectively.

(D) The system meets alternative compliance criteria Number 4 if the TTHM and HAA5 running annual averages are no greater than 0.040 mg/L and 0.030 mg/L, respectively, and the system uses only chlorine for primary disinfection and maintenance of a residual in the distribution system.

(E) The system meets alternative compliance criteria Number 5 if the system's source water specific ultraviolet absorbance (SUVA), prior to any treatment, measured monthly, is less than or equal to 2.0 liters per milligram-meter (L/mg-m), calculated quarterly as a running annual average.

(F) The system meets alternative compliance criteria Number 6 if the system's finished water SUVA, measured monthly at a point prior to any disinfection, is less than or equal to 2.0 L/mg-m, calculated quarterly as a running annual average.

(G) The system meets alternative compliance criteria Number 7 if the system practices softening, cannot achieve the Step 1 TOC removals required by paragraph (1) of this subsection, and has treated water alkalinity less than 60 mg/L (as CaCO3) and calculated quarterly as a running annual average.

(H) The system meets alternative compliance criteria Number 8 if the system practices softening, cannot achieve the Step 1 TOC removals required by paragraph (1) of this subsection, and has magnesium hardness removal greater than or equal to 10 mg/L (as

CaCO3), measured monthly calculated quarterly as a running annual average.

(3) If a system fails to meet the Step 1 TOC removal requirement required by paragraph (1) of this subsection and does not meet one of eight alternative compliance criteria described in paragraph (2) of this subsection, the system must apply to the executive director for approval of Step 2 removal requirements.

(A) The plant must perform Step 2 jar testing to determine the coagulant dose at which the removal of TOC is less than 0.3 mg/L for an increase in coagulant of 10 mg/L alum or its equivalent. This dose is referred to as the point of diminishing returns (PODR).

(B) The system must submit the results of the Step 2 jar testing to the executive director for approval of the alternative removal requirements at least 15 days before the end of the applicable quarter.

(C) The executive director may approve Step 2 alternative removal requirements.

(i) If approved, the removal achieved at the PODR becomes the alternative full-scale TOC removal requirement for the plant.

(ii) The alternate removal requirements may be applied to the quarter in which the jar test results are received and for the following quarter.

(c) TOC monitoring requirements. Systems must conduct required TOC monitoring during normal operating conditions at sites and at the frequency designated in the system's monitoring plan.

(1) Systems must monitor for TOC and alkalinity in the source water prior to any treatment. Between one and eight hours after taking the source water sample, systems must measure each treatment plant TOC after filtration in the combined filter effluent stream. These samples (source water alkalinity, source water TOC, and treated water TOC) are referred to as a TOC sample set.

(2) Systems must take one TOC sample set monthly (every 30 days) at a time representative of normal operating conditions and influent water quality. With the executive director's approval, a system may reduce monitoring according to subparagraphs (A) - (C) of this paragraph.

(A) Systems with a running annual average treated water TOC of less than 2.0 mg/L for two consecutive years may reduce monitoring to one TOC sample set per plant per quarter (every 90 days). The system must revert to routine monitoring in the month following the quarter when the running annual average treated water TOC is greater than or equal to 2.0 mg/L.

(B) Systems with a running annual average treated water TOC of less than 1.0 mg/L for one year may reduce monitoring to one TOC sample set per plant per quarter (every 90 days). The system must revert to routine monitoring in the month following the quarter when the running annual average treated water TOC is greater than or equal to 2.0 mg/L.

(C) Systems with a running annual average source water TOC at each plant of less than or equal to 4.0 mg/L based on the running annual average of the most recent four quarters of monitoring may reduce source TOC monitoring to one source TOC sample per quarter (every 90 days) if they also meet criteria for reduced disinfection byproduct monitoring. In order to remain on quarterly source TOC monitoring, the system must also meet the criteria for reduced trihalomethane and haloacetic acid monitoring given in §290.113(c)(4) of this title (relating to Stage 1 Disinfection Byproducts (TTHM and HAA5)) until the date shown in table §290.113(a)(2) of this title. After the date shown in §290.115(a)(2) of this title (relating to Stage 2 Disinfection Byproducts (TTHM and HAA5)), the system must also meet the criteria for reduced trihalomethane and haloacetic acid monitoring in §290.115(c)(3) of this title in order to remain on quarterly source TOC monitoring. The system must revert to routine monitoring in the first month following the quarter when the running annual average source water TOC is greater than 4.0 mg/L, or the system no longer meets the reduced monitoring criteria for disinfection byproducts.

(3) A public water system attempting to meet the treatment technique requirements for TOC using alternative compliance criteria Number 5 (as defined in subsection (b)(2)(E) of this section) must monitor for SUVA in the source water prior to any treatment at least once each month.

(4) A public water system attempting to meet the treatment technique requirements for TOC using alternative compliance criteria Number 7 (as defined in subsection (b)(2)(G) of this section) must monitor for alkalinity in the treated water at any point prior to distribution system at least once each month.

(5) A public water system attempting to meet the treatment technique requirements for TOC using alternative compliance criteria Number 8 (as defined in subsection (b)(2)(H) of this section) must monitor for magnesium in both the source water prior to any treatment at and the treated water at any point prior to the distribution system least once each month.

(d) Analytical requirements for TOC treatment. Analytical procedures required by this section must be conducted at a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title (relating to Analytical Procedures).

(e) Reporting requirements for TOC. Systems treating surface water or groundwater under the direct influence of surface water shall properly complete and submit periodic reports to demonstrate compliance with this section.

(1) The reports must be submitted to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 by the tenth day of the month following the end of the reporting period.

(2) Public water systems must submit a Monthly Operational Report for Total Organic Carbon (commission Form 0879) each month.

(3) A system that does not meet the Step 1 removal requirements must submit a Request for Alternate TOC Requirements at least 15 days before the end of the quarter.

(A) If the system meets alternative compliance criterion Number 3, subsection (b)(2)(C) of this section, the system must report the running annual average TTHM and HAA5 concentrations as determined under the requirements of §290.113 of this title.

(B) If the system meets alternative compliance criterion Number 4, subsection (b)(2)(D) of this section, the system must report the running annual average TTHM and HAA5 concentrations as determined under the requirements of §290.113 or §290.115 of this title, and report all disinfectants used by the system during last 12 months.

(C) If the system meets alternative compliance criterion Number 5, subsection (b)(2)(E) of this section, the system must report the average source water SUVA for each of the preceding 12 months.

(D) If the system meets alternative compliance criterion Number 6, subsection (b)(2)(F) of this section, the system must report the average treated water SUVA for each of the preceding 12 months.

(E) If the system practices softening and meets alternative compliance criterion Number 8, subsection (b)(2)(H) of this section, the system must report the source water and treated water magnesium concentrations and the average percent removal of magnesium obtained during each of the preceding 12 months.

(F) A system that does not meet any of the alternative compliance criteria must apply for the Step 2 alternative removal requirements and must submit the results of Step 2 jar testing.

(f) Compliance determination. Compliance with the requirements of this section shall be based on the following criteria:

(1) A system that fails to conduct the monitoring tests required by this section commits a monitoring violation. Failure to monitor will be treated as a violation for the entire period covered by the annual average.

(2) A system that fails to report the results of monitoring tests required by this section commits a reporting violation. Systems may use only data collected under the provisions of this section to qualify for reduced monitoring.

(3) A system that does not meet any of the alternative compliance criteria and does not achieve the required TOC removal commits a treatment technique violation. Compliance shall be determined quarterly by determining an annual average removal ratio using the following method:

(A) The actual monthly TOC percent removal must be determined for each month. The actual removal for a TOC sample set is equal to (1 - (treated water TOC/source water TOC)) [~~(1 - treated water TOC/source water TOC)~~]. The actual monthly percent removal is calculated as the average of all actual removals [~~by taking average removal~~] for all TOC sample sets collected in the month, expressed as [~~and expressing that value as~~] a percent.

(B) The required monthly Step 1 or Step 2 TOC percent removal must be determined as provided in subsection (b) of this section. The executive director will approve or disapprove Step 2 requirements based on jar or pilot data. Until the executive director approves the Step 2 TOC removal requirements, the system must meet the Step 1 TOC removals contained in subsection (b)(1) of this section.

(C) The monthly removal ratio must be determined. The monthly removal ratio is determined by dividing the actual monthly TOC percent removal for each month by the required monthly Step 1 or approved Step 2 TOC percent removal for the month. The alternative compliance criteria may be used on a monthly basis as described in clauses (i) - (iv) of this subparagraph.

(i) If the monthly average source or treated water TOC is less than 2.0 mg/L, a monthly removal ratio value of 1.0 may be assigned (in lieu of the value calculated in subparagraph (C) of this paragraph) when calculating compliance under the provisions of this section.

(ii) If the monthly average water source or treated SUVA level is less than 2.0 L/mg-m, a monthly removal ratio value of 1.0 may be assigned (in lieu of the value calculated in subparagraph (C) of this paragraph) when calculating compliance under the provisions of this section.

(iii) In any month that a softening system lowers alkalinity below 60 mg/L (as CaCO3), a monthly removal ratio value of 1.0 may be assigned (in lieu of the value calculated in subparagraph (C) of this paragraph) when calculating compliance under the provisions of this section.

(iv) In any month that a softening system removes at least 10 mg/L of magnesium hardness (as CaCO3) a monthly value of 1.0 may be assigned (in lieu of the value calculated in subparagraph (C) of this paragraph) when calculating compliance under the provisions of this section.

(D) The annual average [~~yearly~~] removal ratio must be determined. The annual average [~~yearly~~] removal ratio is the [~~running annual~~] average of all [~~the quarterly averages of the~~] monthly removal ratios over the most recent 12-month period [~~averages~~]. To determine the annual average removal ratio, determine the sum of all [~~this value, for each quarter in the compliance year, determine the~~] monthly removal ratios in the most recent 12-month period, and divide that sum by 12 [~~ratio, add the removal ratios and divide by three. Then, add the quarterly removal ratio and divide by four~~].

(E) If the annual average [~~yearly~~] removal ratio is less than 1.00, the system commits a treatment technique violation.

(4) A public water system that fails to do a required public notice or certify that the public notice has been performed commits a public notice violation.

(g) Public Notification. A public water system that violates the treatment technique requirements of this section must notify the executive director and the system's customers.

(1) A public water system that commits a TOC treatment technique violation shall notify the executive director and the water system customers in accordance with the requirements of §290.122(b) of this title (relating to Public Notification).

(2) A public water system which fails to conduct the monitoring required by this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

§290.113. Stage 1 Disinfection Byproducts (TTHM and HAA5).

(a) Applicability for total trihalomethanes (TTHM) and haloacetic acids (group of five) (HAA5). All community and nontransient, noncommunity water systems shall comply with the requirements of this section.

(1) Systems must comply with the Stage 1 requirements in this section until the date shown in the table entitled "Date to Start Stage 2 Compliance."

(2) Until the date shown in the table in Figure: 30 TAC §290.113(a)(2) of this paragraph [~~paragraph (1) of this subsection~~], systems must continue to monitor according to this section.
Figure: 30 TAC §290.113(a)(2) (No change.)

(b) Maximum contaminant level (MCL) for TTHM and HAA5. The running annual average concentration of TTHM and HAA5 shall not exceed the MCLs.

(1) The MCL for TTHM is 0.080 milligrams/liter (mg/L).

(2) The MCL for HAA5 is 0.060 mg/L.

(c) Monitoring requirements for TTHM and HAA5. Systems must take all TTHM and HAA5 samples during normal operating conditions. Monitoring shall be performed at locations and frequency specified in the system's monitoring plan.

(1) The minimum number of samples required to be taken shall be based on the number of treatment plants used by the system, except that multiple wells drawing raw water from a single aquifer shall be considered as one treatment plant for determining the minimum number of samples.

(2) All samples taken within one sampling period shall be collected within a 24-hour period.

(3) Systems must routinely sample at the frequency and locations given in the following table entitled "Stage 1 Routine Monitoring Frequency and Locations for TTHM and HAA5."
Figure: 30 TAC §290.113(c)(3) (No change.)

(4) The executive director may reduce the monitoring frequency for TTHM and HAA5 as indicated in the following table entitled "Stage 1 Reduced Monitoring Frequency and Locations for TTHM and HAA5."
Figure: 30 TAC §290.113(c)(4) (No change.)

(A) The executive director may not reduce the routine monitoring requirements for TTHM and HAA5 until a system has completed one year of routine monitoring in accordance with the provisions of paragraph (3) of this subsection.

(B) A system that is on reduced monitoring and collects quarterly samples for TTHM and HAA5 may remain on reduced monitoring as long as the running annual average of quarterly averages for TTHM and HAA5 is no greater than 0.060 mg/L and 0.045 mg/L, respectively, and as long as it meets the requirements in subparagraph (D) of this paragraph.

(C) A system that is on a reduced monitoring and monitors no more frequently than once each year may remain on reduced monitoring as long as TTHM and HAA5 concentrations are no greater than 0.060 mg/L and 0.045 mg/L, respectively, and as long as it meets the requirements in subparagraph (D) of this paragraph.

(D) To remain on reduced TTHM and HAA5 monitoring, systems that treat surface water or groundwater under the direct influence of surface water must also maintain a source water annual average total organic carbon (TOC) level, before any treatment, less than or equal to 4.0 mg/L (based on the most recent four quarters of monitoring) on a continuing basis at each plant.

(5) The executive director may require a system to return to the routine monitoring frequency described in paragraph (3) of this subsection.

(A) A system that does not meet the requirements of paragraph (4)(B), (C) or (D) of this subsection must return to routine monitoring in the quarter immediately following the quarter in which the results exceed 0.060 mg/L or 0.045 mg/L for TTHMs and HAA5, respectively, or when the source water annual average TOC level, before any treatment, exceeds 4.0 mg/L at any plant.

(B) A system that is on reduced monitoring and makes any significant change to its source of water or treatment program shall return to routine monitoring in the quarter immediately following the quarter when the change was made.

(C) If a system is returned to routine monitoring, routine monitoring shall continue for at least one year before a reduction in monitoring frequency may be considered.

(D) The executive director may return a system on reduced monitoring to routine monitoring at any time.

(6) Systems monitoring no more frequently than once each year must increase their monitoring frequency to quarterly if either the TTHM annual average is >0.080 mg/L or the HAA5 annual average is >0.060 mg/L. The system must begin monitoring quarterly immediately following the monitoring period in which the system exceeds 0.080 mg/L or 0.060 mg/L for TTHMs or HAA5, respectively.

(d) Analytical requirements for TTHM and HAA5. Analytical procedures required by this section shall be performed in accordance with §290.119 of this title (relating to Analytical Procedures). Testing for TTHM and HAA5 shall be performed at a laboratory accredited by the executive director.

(e) Reporting requirements for TTHM and HAA5. The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~of the request or within ten days of their receipt by the public water system, whichever is later~~]. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(f) Compliance determination for TTHM and HAA5. Compliance with the provisions of this section shall be determined as follows.

(1) A system that fails to monitor in accordance with this section commits a monitoring violation. Failure to monitor will be treated as a violation for the entire period covered by the annual average.

(2) A public water system that fails to report the results of the monitoring tests required by subsection (e) of this section commits a reporting violation.

(3) Compliance with the MCLs for TTHM and HAA5 shall be based on the running annual average of all samples collected during the preceding 12 months.

(A) A public water system that samples for TTHM and HAA5 each quarter must calculate the running annual average of the quarterly averages.

(B) A public water system that samples for TTHM and HAA5 no more frequently than once each year must calculate the annual average of all samples collected during the year.

(C) All samples collected at the sampling sites designated in the public water system's monitoring plan shall be used to compute the quarterly and annual averages unless the analytical results are invalidated by the executive director for technical reasons.

(4) A public water system violates the MCL for TTHM if the running annual average for TTHM exceeds the MCL specified in subsection (b)(1) of this section.

(5) A public water system violates the MCL for HAA5 if the running annual average for HAA5 exceeds the MCL specified in subsection (b)(2) of this section.

(6) If a public water system is routinely sampling in accordance with the requirements of subsection (c)(3) of this section and an individual sample or quarterly average will cause the system to exceed the MCL for TTHM or HAA5, the system is in violation of the respective MCL at the end of that quarter.

(7) If a public water system's failure to monitor makes it impossible to determine compliance with the MCL for TTHM or HAA5, the system commits an MCL violation for the entire period covered by the annual average.

(g) Public Notification Requirements for TTHM and HAA5. A public water system that violates the treatment technique requirements of this section must notify the executive director and the system's customers.

(1) A public water system that violates an MCL given in subsection (b)(1) or (2) of this section shall report to the executive di-

rector and the water system customers in accordance with the requirements of §290.122(b) of this title (relating to Public Notification).

(2) A public water system which fails to conduct the monitoring required by subsection (c) of this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(h) Best available technology for TTHM and HAA5. Best available technology for treatment of violations of MCLs in subsection (b) of this section are listed in 40 Code of Federal Regulations §141.64(b)(1)(ii).

§290.114. Other Disinfection Byproducts (Chlorite and Bromate).

(a) Chlorite. All public water systems that use chlorine dioxide must comply with the requirements of this subsection.

(1) Maximum contaminant level (MCL) for chlorite. The chlorite concentration in the water in the distribution system shall not exceed an MCL of 1.0 milligrams per liter (mg/L).

(2) Monitoring requirements for chlorite. Public water systems shall measure the chlorite concentration at locations and intervals specified in the system's monitoring plan. All samples must be collected during normal operating conditions.

(A) Each plant using chlorine dioxide must monitor the chlorite concentration in the water entering the distribution system at least once each day. The monitoring frequency at the entry point to the distribution system may not be reduced.

(B) Each plant using chlorine dioxide must monitor the chlorite concentration in the water within the distribution system at each of the following three locations: at a location near the first customer of a plant using chlorine dioxide; at a location representative of the average residence time in the distribution system; and at a location reflecting maximum residence time in the distribution system. The group of three samples must be collected on the same day and is called a "three-sample set."

(i) Each system must collect at least one three-sample set each month.

(ii) If the chlorite concentration entering the distribution system exceeds 1.0 mg/L, the system must collect a three-sample set within 24 hours.

(iii) The frequency of chlorite monitoring in the distribution system may be reduced to one three-sample set per quarter if none of the entry point or distribution system samples tested during the preceding 12 months contained a chlorite concentration above 1.0 mg/L. A system must revert to the monthly monitoring frequency if the chlorite concentration exceeds 1.0 mg/L in any sample.

(3) Analytical requirements for chlorite. Analytical procedures required by this section shall be performed in accordance with the requirements of §290.119 of this title (relating to Analytical Procedures).

(A) The chlorite concentration of the water entering the distribution system must be analyzed at a facility approved by the executive director. The analysis must have a minimum accuracy of 0.05 mg/L. [~~and use one of the following methods:~~]

[~~*(i)* amperometric titration using a unit with platinum-platinum electrodes; or~~]

[~~*(ii)* ion chromatography.~~]

(B) The chlorite concentration of the water within the distribution system must be analyzed using ion chromatography at a facility accredited by the executive director.

(4) Reporting requirements for chlorite. Public water systems that are subject to the provisions of this subsection must provide the executive director with the results of any test, measurement, or analysis required by this section.

(A) Systems using chlorine dioxide must submit a Chlorine Dioxide Monthly Operating Report (commission Form 0690) by the tenth day of the month following the end of the reporting period.

(B) Except where a shorter period is specified in this section, a public water system [~~Upon the request of the executive director, systems~~] shall provide the executive director with a copy of the results of any chlorite test, measurement, or analysis required by paragraph (2)(B) of this subsection within the first ten days following the end of the required monitoring period or ten days following receipt of the results of such test, measurement, or analysis whichever occurs first.

(C) Reports and analytical results must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(5) Compliance determination for chlorite. Compliance with the requirements of this subsection shall be based on the following criteria.

(A) A public water system that fails to conduct the monitoring tests required by this subsection commits a monitoring violation.

(B) A public water system that fails to report the results of the monitoring tests required by this subsection commits a reporting violation.

(C) A public water system commits an MCL violation if the arithmetic average of any three-sample set collected in the distribution system exceeds the MCL for chlorite.

(D) A public water system that fails to do a required public notice or certify that the public notice has been performed commits a public notice violation.

(6) Public notification requirements for chlorite. A public water system that violates the requirements of this subsection must notify the executive director and the system's customers.

(A) A public water system that violates the MCL for chlorite shall notify the executive director by the end of the next business day and the customers in accordance with the requirements of §290.122(b) of this title (relating to Public Notification).

(B) A public water system which fails to conduct the monitoring required by this subsection must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(b) Bromate. Community and nontransient, noncommunity public water systems that use ozone must comply with the requirements of this subsection beginning on January 1, 2002.

(1) MCL for bromate. The concentration of bromate at the entry point to the distribution system shall not exceed an MCL of 0.010 mg/L.

(2) Monitoring requirements for bromate. Each plant using ozone must measure the bromate concentration in the water entering the distribution system at least once each month. The monitoring frequency at the entry point to the distribution system may not be reduced. Samples shall be collected when the ozonation system is operating under normal conditions and at locations and intervals specified in the system's monitoring plan.

(3) Analytical requirements for bromate. Analytical procedures required by this section shall be performed in accordance with §290.119 of this title. Testing for bromate shall be performed at a laboratory certified by the executive director.

(4) Reporting requirements for bromate. The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever occurs first [~~of the request or within ten days of their receipt by the public water system, whichever is later~~]. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(5) Compliance determination for bromate. Compliance with the requirements of this subsection shall be determined using the following criteria.

(A) A system that fails to monitor in accordance with this section commits a monitoring violation. Failure to monitor will be treated as a violation for the entire period covered by the annual average.

(B) A public water system that fails to report the results of the monitoring tests required by this subsection commits a reporting violation.

(C) A public water system violates the MCL for bromate if, at the end of any quarter, the running annual average of monthly averages, computed quarterly, exceeds the maximum contaminant level specified in paragraph (1) of this subsection.

(D) A public water system that fails to do a required public notice or certify that the public notice has been performed commits a public notice violation.

(E) A public water system that fails to complete 12 consecutive months' monitoring, compliance with the MCL for the last four-quarter compliance period must be based on an average of the available data.

(6) Public notification requirements for bromate. A public water system that violates the requirements of this subsection must notify the water system's customers and the executive director.

(A) A public water system that violates the MCL for bromate shall notify the customers in accordance with the requirements of §290.122(b) of this title.

(B) A public water system which fails to conduct the monitoring required by this subsection must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

§290.115. Stage 2 Disinfection Byproducts (TTHM and HAA5).

(a) Applicability for total trihalomethanes (TTHM) and haloacetic acids (group of five) (HAA5). All community and nontransient, noncommunity water systems shall comply with the requirements of this section for TTHM and HAA5.

(1) Systems must comply with the initial monitoring requirements starting on the dates given in subsection (c) of this section.

(2) Systems must comply with all of the additional requirements in this section starting on the date shown in the table entitled "Date to Start Stage 2 Compliance."
Figure: 30 TAC §290.115(a)(2) (No change.)

(A) Systems required to conduct quarterly monitoring, must begin monitoring in the first full calendar quarter that includes the compliance date in the table titled "Date to Start Stage 2 Compliance."

(B) Systems required to conduct routine monitoring less frequently than quarterly must begin monitoring in the calendar month approved by the executive director in their Initial Distribution System Evaluation (IDSE) report or revised monitoring plan identifying Stage 2 sample sites.

(3) Systems must complete their monitoring plan for the additional Stage 2 TTHM and HAA5 requirements according to §290.121 of this title (relating to Monitoring Plans) before the date shown in the table entitled "Date to Start Stage 2 Compliance."

(b) Maximum contaminant levels (MCL) and operational evaluation levels (OELs) for TTHM and HAA5. Systems shall comply with MCLs and OELs.

(1) The locational running annual average (LRAA) concentration of TTHM and HAA5 shall not exceed the MCLs [~~maximum contaminant levels~~]. A public water system that exceeds a MCL shall determine compliance as described in subsection (f) of this section.

(A) The MCL for TTHM is 0.080 milligrams/liter (mg/L).

(B) The MCL for HAA5 is 0.060 mg/L.

(2) The OEL at any monitoring location is the sum of the two previous quarters' results plus twice the current quarter's result, divided by 4 to determine an average. A public water system that exceeds an OEL shall perform operation evaluation monitoring and reporting described in subsection (e) of this section.

(A) The OEL for TTHM is 0.080 mg/L.

(B) The OEL for HAA5 is 0.060 mg/L.

(c) Monitoring requirements for TTHM and HAA5. Monitoring shall be performed at locations and frequency specified in the system's monitoring plan as approved by the executive director. The executive director may require changes to a system's sampling locations. The executive director may require sampling at additional sampling locations.

(1) Monitoring locations. Systems must establish Stage 2 compliance monitoring sites throughout the distribution system at locations with the potential for relatively high disinfection byproduct formation. Systems must determine Stage 2 compliance monitoring locations by the dates shown in the table titled "Date to Establish Stage 2 Sites."
Figure: 30 TAC §290.115(c)(1) (No change.)

(A) Systems that perform IDSE sampling in accordance with paragraph (5) of this subsection must use the IDSE and Stage 1 results to set Stage 2 compliance monitoring sites.

(B) Systems that do not perform IDSE sampling must set Stage 2 compliance monitoring sites through consultation with the executive director in accordance with this subparagraph.

(i) Systems required to sample at the same number of sites under Stage 1 and Stage 2, can use the Stage 1 sites for Stage 2 compliance monitoring.

(ii) Systems required to sample at more sites under Stage 2 than Stage 1 must identify Stage 2 sites in addition to the existing Stage 1 sites. Systems must identify additional sites representing areas of the distribution system with potentially high TTHM or HAA5 levels and provide the rationale for identifying these locations as having

high levels of TTHM or HAA5. The required number of compliance monitoring locations must be identified.

(iii) Systems required to sample at fewer sites under Stage 2 than Stage 1 must identify which locations will be used for Stage 2. Stage 2 sites will be selected by alternating selection of Stage 1 locations representing the highest TTHM levels and highest HAA5 levels until the required number of compliance monitoring locations have been identified.

(C) The protocol given in [~~Title~~] 40 Code of Federal Regulations ([~~40~~] CFR) §141.605(c) - (e) for selecting Stage 2 sample sites is hereby adopted by reference.

(D) To change monitoring locations, a system must replace existing compliance monitoring locations with the lowest LRAA with new locations that reflect the current distribution system locations with expected high TTHM or HAA5 levels. Changes must be approved by the executive director and included in the monitoring plan.

(2) Monitoring frequency and number of sample sites. Routine sampling frequency and number of sample sites are given in the following table, titled "Routine Stage 2 Monitoring Frequency and Number of Sites." Systems must take all routine compliance TTHM and HAA5 samples during normal operating conditions.
Figure: 30 TAC §290.115(c)(2) (No change.)

(3) Reduced monitoring for TTHM and HAA5. Monitoring may be reduced when the LRAA is less than or equal to 0.040 mg/L for TTHM and less than or equal to 0.030 mg/L for HAA5 at all Stage 2 compliance monitoring locations. The Stage 2 reduced sampling frequency and number of sample sites are given in the following table, titled "Reduced Stage 2 Monitoring Frequency and Number of Sites."
Figure: 30 TAC §290.115(c)(3) (No change.)

(A) Only data collected under the provisions of §290.113 of this title (relating to Stage 1 Disinfection Byproducts (TTHM and HAA5)) and under this section may be used to qualify for reduced monitoring.

(B) In order to remain on reduced monitoring, a system must meet the applicable conditions of this subparagraph.

(i) Systems with annual or less frequent reduced monitoring qualify to remain on reduced monitoring as long as each TTHM sample is less than or equal to 0.060 mg/L and each HAA5 sample is less than or equal to 0.045 mg/L.

(ii) Systems on quarterly reduced monitoring qualify to remain on reduced monitoring as long as the TTHM LRAA is less than or equal to 0.040 mg/L and the HAA5 LRAA is less than or equal to 0.030 mg/L at each monitoring location.

(iii) To qualify for and remain on reduced monitoring, the source water annual average Total Organic Carbon (TOC) level, before any treatment, must be less than or equal to 4.0 mg/L at each treatment plant treating surface water or groundwater under the direct influence of surface water, based on monitoring conducted under §290.112(c)(2)(C) of this title (relating to Total Organic Carbon (TOC)).

(C) Systems will be returned to routine monitoring:

(i) if the LRAA at any monitoring location exceeds either 0.040 mg/L for TTHM or 0.030 mg/L for HAA5 based on quarterly monitoring, or

(ii) if the annual (or triennial) sample at any location exceeds either 0.060 mg/L for TTHM or 0.045 mg/L for HAA5, or

(iii) if the source water annual average TOC level, before any treatment, exceeds 4.0 mg/L at any treatment plant treating surface water or groundwater under the direct influence of surface water.

(D) The executive director may return a system on reduced monitoring to routine monitoring at any time.

(E) A system that is on reduced Stage 1 monitoring in accordance with §290.113(c)(4) of this title that has monitoring locations for Stage 2 different from those under Stage 1 must initiate routine monitoring in accordance with paragraph (2) of this subsection on the schedule given in subsection (a) of this section.

(F) A system that is on reduced monitoring in accordance with §290.113(c)(4) of this title may remain on reduced monitoring after the dates identified in subsection (a)(2) of this section only if the system:

(i) received a very small system (VSS) IDSE waiver under paragraph (5)(A) of this subsection or received a 40/30 IDSE waiver under paragraph (5)(B) of this subsection, [~~and~~]

(ii) meets the reduced monitoring criteria in subparagraph (B) of this paragraph, and

(iii) is approved to use the same monitoring locations under Stage 1 and Stage 2.

(G) The executive director may choose to perform calculations and determine whether the system is eligible for reduced monitoring in lieu of having the system report that information.

(4) Increased monitoring for TTHM and HAA5. The executive director may increase monitoring in accordance with this paragraph.

(A) A system required to routinely monitor at a particular location annually or less frequently than annually under paragraph (2) of this subsection must increase monitoring to quarterly dual sample sets (every 90 days) at all locations if any TTHM compliance sample is greater than 0.080 mg/L or if any HAA5 compliance sample is greater than 0.060 mg/L at any location.

(B) The executive director may return a system on increased quarterly monitoring to routine monitoring after at least four consecutive quarters if the LRAA for every monitoring location is less than or equal to 0.060 mg/L for TTHM and less than or equal to 0.045 mg/L for HAA5.

(C) A system that is on increased monitoring under §290.113 of this title must remain on increased monitoring until the system qualifies for a return to routine monitoring under subparagraph (B) of this paragraph. The increased monitoring schedule must be conducted at the Stage 2 monitoring locations approved under paragraph (1) of this subsection, beginning on the date identified in subsection (a)(2) of this section.

(5) IDSE [~~Initial Distribution System Evaluation (IDSE)~~] requirements. All community systems of any size and nontransient, noncommunity systems that serve at least 10,000 people must comply with these IDSE requirements.

(A) The executive director may grant a VSS IDSE monitoring waiver to systems that serve fewer than 500 people. Systems that receive a VSS IDSE monitoring waiver are not required to do IDSE monitoring. Systems must be compliant with all of the Stage 1 monitoring requirements of §290.113 of this title to be eligible for a VSS IDSE waiver.

(B) The executive director may grant a 40/30 IDSE monitoring waiver to IDSE monitoring to systems with levels for TTHM less than 0.040 mg/L and levels for HAA5 less than 0.030 mg/L. Systems that receive a 40/30 IDSE monitoring waiver are not required to do IDSE monitoring. Systems must be compliant with all of the Stage 1 monitoring requirements of §290.113 of this title to be eligible for a 40/30 IDSE waiver. The timing of samples that all need to be less than 0.040 mg/L and 0.030 mg/L respectively for TTHM and HAA5 are given in the following table, titled "Timing of Stage 1 Samples Evaluated for 40/30 Initial Distribution System Evaluation (IDSE) Waiver."
Figure: 30 TAC §290.115(c)(5)(B) (No change.)

(i) To qualify for a 40/30 IDSE waiver a system must certify to the executive director that every individual sample taken under §290.113 of this title were less than 0.040 mg/L for TTHM and less than 0.030 mg/L for HAA5, and must have not had any TTHM or HAA5 monitoring violations during the period specified in subsection (a) of this section.

(ii) To qualify for a 40/30 IDSE waiver, a system must submit compliance monitoring results, distribution system schematics, and recommended Stage 2 compliance monitoring locations to the executive director upon request. The executive director may require a system that fails to submit the requested information to perform IDSE sampling.

(iii) The executive director may still require a system that meets the 40/30 IDSE waiver or VSS IDSE waiver requirements to do IDSE sampling under subparagraph (C) of this paragraph.

(C) Systems that must perform IDSE sampling must submit any needed documentation for waivers, produce an IDSE Plan, do IDSE sampling, and report the IDSE results to the executive director on the schedule in the following table titled "Initial Distribution Schedule Evaluation (IDSE) [~~"IDSE~~] Schedule."
Figure: 30 TAC §290.115(c)(5)(C) (No change.)

(i) The IDSE plan has required elements.

(I) The IDSE plan must include a schematic of the distribution system (including distribution system entry points and their sources, and storage facilities), with notes indicating locations and dates of all projected standard monitoring, and also Stage 1 compliance monitoring under §290.113 of this title.

(II) The IDSE plan must include justification of IDSE monitoring location selection and a summary of data used to justify IDSE monitoring location selection.

(III) The IDSE plan must include the system type and population served by the system.

(ii) Systems must do required IDSE sampling in accordance with this clause.

(I) Systems must monitor at the number and type of sites indicated in the following table titled "Number and Type of Initial Distribution System Evaluation (IDSE) [~~IDSE~~] Sample Sites:"
Figure: 30 TAC §290.115(c)(5)(C)(ii)(I) (No change.)

(II) Systems must collect dual sample sets at each monitoring location. One sample in the dual sample set must be analyzed for TTHM. The other sample in the dual sample set must be analyzed for HAA5.

(III) IDSE sample locations must be different than the existing Stage 1 monitoring locations established under §290.113 of this title.

(IV) IDSE sample locations must be distributed throughout the distribution system.

(V) Systems must monitor at the frequency indicated in the following table titled "Frequency of Initial Distribution System Evaluation (IDSE) [~~IDSE~~] Monitoring:"
Figure: 30 TAC §290.115(c)(5)(C)(ii)(V) (No change.)

(VI) The IDSE monitoring frequency and locations may not be reduced.

(iii) The IDSE report must comply with the elements in this clause.

(I) The IDSE report must include all TTHM and HAA5 analytical results from Stage 1 compliance monitoring under §290.113 of this title and all IDSE sample results and locational running annual averages presented in a tabular or spreadsheet format acceptable as described in Texas Commission on Environmental Quality [~~TCEQ~~] regulatory guidance number 384: "How to Develop a Monitoring Plan for a Public Water System."

(II) If changed from the IDSE plan submitted under clause (ii) of this subparagraph, the IDSE report must also include an updated distribution system map, documentation verifying the population served, and an updated list of sources including their water type.

(III) The IDSE report must include an explanation of any deviations from the approved IDSE plan.

(IV) The IDSE report must recommend and justify Stage 2 compliance monitoring locations consistent with paragraph (1) of this subsection. The recommended Stage 2 compliance monitoring locations must be listed in a Stage 2 sample plan as part of the system's monitoring plan.

(V) The IDSE report must include recommendations and justification for when Stage 2 samples should be collected.

(iv) The executive director may approve a system specific study that meets the requirements in 40 CFR §141.602 to comply with IDSE sampling requirements. The commission hereby adopts the requirements of 40 CFR §141.602 by reference.

(D) The executive director may require a system to perform IDSE sampling or a system specific study for any reason. The executive director may require a system to perform IDSE sampling or a system specific study even if the system meets the criteria for an IDSE waiver. The executive director may require new systems and systems with a change in population or system type to perform IDSE sampling or a system specific study.

(d) Analytical requirements for TTHM and HAA5. Analytical procedures required by this section shall be performed in accordance with §290.119 of this title (relating to Analytical Procedures). Testing for TTHM and HAA5 shall be performed at a laboratory accredited by the executive director.

(e) Reporting requirements for TTHM and HAA5. Public water systems must submit reports related to TTHM and HAA5 to the executive director. Reports must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

(1) The [~~Upon the request of the executive director, the~~] owner or operator of a public water system must provide the executive director with a copy of the results of any test, measurement, or analysis required by this subsection. The copies must be submitted within the first ten days following the month in which the result is received by the public water system, or the first ten days following the end of the required monitoring period as provided by this subsection, whichever

occurs first [~~of the request or within ten days of their receipt by the public water system, whichever is later~~].

(A) The owner or operator of a public water system is responsible for reporting the following information for each monitoring location to the executive director within ten days of the end of any quarter in which monitoring is required:

(i) number of samples taken during the last quarter;

(ii) date and results of each sample taken during the last quarter;

(iii) arithmetic average of quarterly results for the last four quarters for each monitoring location (LRAA), beginning at the end of the fourth calendar quarter that follows the compliance date and at the end of each subsequent quarter;

(iv) whether the MCL was violated at any monitoring location; and

(v) any OELs that were exceeded during the quarter and, if so, the location and date, and the calculated TTHM and HAA5 levels.

(B) If the LRAA based on fewer than four quarters would cause the MCL to be exceeded regardless of the monitoring results of subsequent quarters, the system must report a potential MCL violation as part of the first report due following the compliance date or anytime thereafter that this determination is made. A system required to conduct monitoring at a frequency that is less than quarterly must make compliance calculations beginning with the first compliance sample taken after the compliance date, unless the system is required to conduct increased monitoring under subsection (c)(4) of this section.

(C) A system that treats surface water or groundwater under the direct influence of surface water that seeks to qualify for or remain on reduced TTHM and HAA5 monitoring must measure and report TOC monthly in accordance with §290.112 of this title and distribution system disinfection levels in accordance with §290.110 of this title (relating to Disinfectant Residuals).

(2) A system that exceeds an OEL described in subsection (b)(2) of this section must conduct an operation evaluation and submit a written operation evaluation report that meets the requirements of this paragraph.

(A) The operation evaluation report must be submitted to the executive director no later than 90 days after being notified of the analytical result that causes the exceedance of the OEL.

(B) The operation evaluation report must document an examination of system treatment and distribution operation practices that may contribute to TTHM and HAA5 formation, including:

(i) storage tank operations;

(ii) excess storage capacity;

(iii) distribution system flushing;

(iv) changes in sources or source water quality;

(v) treatment changes or problems; and

(vi) what steps could be considered to minimize future exceedances.

(C) If the cause of the OEL exceedance is identifiable the scope of the report may be limited with the approval of the executive director. A request to limit the scope of the evaluation does not extend the schedule in subparagraph (A) of this paragraph for submitting the written report. The executive director's approval to limit the scope of the operation evaluation report must be in writing. The system must keep a copy of the executive director's approval with the completed operation evaluation report.

(D) The operation evaluation report must be submitted and approved in writing.

(f) Compliance determination for TTHM and HAA5. Compliance with the provisions of this section shall be determined as follows.

(1) A public water system violates the MCL for TTHM if any locational running annual average for TTHM exceeds an MCL specified in subsection (b)(1)(A) of this section. A public water system violates the MCL for HAA5 if any locational running annual average for HAA5 exceeds the MCL specified in subsection (b)(1)(B) of this section.

(A) Compliance with the MCLs for TTHM and HAA5 shall be based on the LRAA of all samples collected during four consecutive quarters of monitoring. If a single quarterly sample would cause an LRAA exceedance regardless of the results of subsequent quarters, compliance may be based on fewer than four quarters of data. Should a system fail to collect all required samples, compliance will be based on the available data. All samples collected at the sampling sites designated in the public water system's monitoring plan shall be used to compute the quarterly and annual averages unless the analytical results are invalidated by the executive director for technical reasons.

(B) Stage 2 MCL compliance determination with LRAAs will start after Stage 2 samples are collected.

(i) For systems required to conduct routine quarterly monitoring, compliance calculations will be made starting at the end of the fourth calendar quarter that follows the compliance date in subsection (a)(2) of this section and at the end of each subsequent quarter.

(ii) For systems on quarterly monitoring, where the LRAA based on fewer than four quarters would exceed the MCL regardless of the monitoring results of subsequent quarters, compliance will be calculated beginning with the first sample that causes that exceedance.

(iii) For systems that are required to monitor less frequently than quarterly, compliance shall be calculated beginning with the first compliance sample taken after the compliance date.

(iv) For systems monitoring annually or triennially that start monitoring quarterly in the quarter following an LRAA exceedance, compliance shall be calculated based on the results of all available samples.

(C) If a public water system's failure to monitor makes it impossible to determine compliance with the MCL for TTHM or HAA5, the system commits an MCL violation for the entire period covered by the annual average.

(D) The executive director may choose to perform calculations and determine MCL exceedances in lieu of having the system report that information.

(E) IDSE results will not be used for the purpose of determining compliance with MCLs.

(2) A system that fails to monitor in accordance with this section commits a monitoring violation. A system on a quarterly monitoring schedule is in violation of the monitoring requirements for each quarter that it fails to monitor.

(3) A system that fails to perform a required operation evaluation under subsection (e)(2) of this section commits a monitoring violation.

(4) A public water system that fails to report the results of the monitoring tests required by subsection (e) of this section commits a reporting violation.

(5) A system that fails to submit an operation evaluation report as required under subsection (e)(2) of this section commits a reporting violation.

(6) A system that fails to perform a required public notification commits a public notification violation.

(g) Public notification requirements for TTHM and HAA5. A public water system that violates the treatment technique requirements of this section must notify the executive director and the system's customers.

(1) A public water system that commits an MCL violation described in subsection (f)(1) of this section shall report to the executive director and the water system customers in accordance with the requirements of §290.122(b) of this title (relating to Public Notification).

(2) A public water system which fails to conduct the monitoring required by subsection (c) of this section must notify its customers of the violation in accordance with the requirements of §290.122(c) of this title.

(3) Any IDSE compliance documents required under subsection (c)(5) of this section must be made available to the executive director or the public upon request.

(4) Any operation evaluation report required under subsection (e)(2) of this section must be made available to the executive director or the public upon request.

(h) Best available technology for TTHM and HAA5. Best available technology for treatment of violations of MCLs in subsection (b) of this section are listed in 40 CFR §141.64(b)(2)(ii) and (iii).

§290.116. Groundwater Corrective Actions and Treatment Techniques.

(a) Applicability. All public water systems that use groundwater, except public water systems that combine all of their groundwater with surface water or with groundwater under the direct influence of surface water prior to treatment as described in §290.111 of this title (relating to Surface Water Treatment) [~~including such systems that use surface water or groundwater under the direct influence of surface water (mixed systems)~~], must comply with one or more of the treatment techniques and corrective actions of this section if a raw groundwater source sample collected under §290.109(d)(4)(B), (C), or (E) of this title (relating to Microbial Contaminants) was positive for fecal indicators, or if a significant deficiency was identified, or if the system is not required to conduct raw groundwater source monitoring because it provides at least 4-log treatment of viruses at each groundwater source. At the discretion of the executive director, a public water system not excluded under this subsection, shall comply with the requirements of this section after exceeding a treatment technique trigger as described in accordance with §290.109 of this title. A public water system shall comply with provisions of this section except in cases where the executive director determines that the significant deficiency is in a portion of the distribution system that is served solely by surface water or groundwater under the direct influence of surface water.

(1) A groundwater system must provide written notification to the executive director that it is not required to meet the raw groundwater source monitoring requirements under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title [~~(relating to Microbial Contaminants)~~] because it provides at least 4-log treatment of viruses for the specified groundwater source and must begin compliance monitoring in accordance with subsection (c) this section. The notification must include engineering, operational, and other information required by the executive director to evaluate the submission. If the executive director determines and documents in writing that 4-log treatment of viruses is no longer necessary for a specified groundwater source or if the system discontinues 4-log treatment of viruses before the first connection for any groundwater source, the system must document this in writing and conduct raw groundwater source sampling as required under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title. If the public water system discontinues 4-log treatment it shall receive prior approval in writing from the executive director that 4-log treatment is no longer necessary for that groundwater source.

(2) A groundwater system that places a groundwater source in service after November 30, 2009, that is not required to meet the raw source monitoring requirements under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title because the system provides at least 4-log treatment of viruses for a specified groundwater source must begin compliance monitoring within 30 days of placing the source in service in accordance with subsection (c) of this section. The system must provide written notification to the executive director that it provides at least 4-log treatment of viruses before the first connection for the specified groundwater source. The notification must include engineering, operational, and other information required by the executive director to evaluate the submission. The system must conduct triggered source monitoring under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title until the executive director provides written approval of the system's request to provide the 4-log treatment. If the system discontinues 4-log treatment of viruses before the first connection for a groundwater source, the system must conduct raw groundwater source sampling as required under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title. If the public water system discontinues 4-log treatment it shall receive prior approval in writing from the executive director that 4-log treatment is no longer necessary for that groundwater source.

(b) Groundwater corrective action plan. All public water systems using groundwater must submit a corrective action plan and implement corrective action if a raw groundwater source sample was positive for fecal indicators or if a significant deficiency was identified.

(1) If a groundwater source sample was found to be fecal indicator positive or if a significant deficiency was identified, the system must consult with the executive director regarding appropriate corrective action and have an approved corrective action plan in place within 30 days of receiving written notification from a laboratory of the fecal indicator positive source sample collected under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title or within 30 days of receiving written notification from the executive director of the identification of a significant deficiency.

(2) Within 120 days of receiving written notification from a laboratory of the fecal indicator positive source sample or receiving written notification from the executive director of a significant deficiency, the system must have completed corrective action or be in compliance with an approved corrective action plan and schedule.

(3) Any changes to the approved corrective action plan or schedule must be approved by the executive director.

(4) The executive director may require interim measures for the protection of public health pending approval of the corrective action plan. The system must comply with these interim measures as well as with any schedules specified by the executive director.

(5) Systems that are required to complete corrective action must implement one or more of the procedures in this paragraph and the details of the implementation must be specified in the approved corrective action plan. If subparagraph (A) or (F) of this paragraph is

selected as part of the corrective action plan, then subparagraph (B), (C), (D), or (E) of this paragraph must also be selected.

(A) The system may disinfect the groundwater source where the fecal indicator positive source sample was collected following the American Water Works Association (AWWA) standards for well disinfection and start monthly fecal indicator sampling at that source within 30 days after well disinfection. The executive director may discontinue the monthly source sampling requirement if corrective action is sufficient.

(B) The system may eliminate the groundwater source that was found to be fecal indicator positive and provide an alternate groundwater source if necessary. Eliminated groundwater sources must be disconnected from the distribution system until the contamination is corrected and the executive director approves it for use.

(C) The system may identify and eliminate the source of fecal contamination followed by well disinfection according to AWWA well disinfection standards and begin monthly fecal indicator sampling within 30 days after well disinfection. The executive director may allow the system to discontinue the monthly source sampling requirement after making a determination that corrective action is sufficient.

(D) The system may provide treatment that reliably achieves at least 4-log treatment of viruses using inactivation, removal or an executive director-approved combination of inactivation and removal before the first connection of the groundwater source.

(E) Correct all significant deficiencies.

(F) Assessment source monitoring for a period of 12 months or a time period specified by the executive director from the raw groundwater source in accordance with §290.109(d)(4)(E) [~~§290.109(c)(4)(E)~~] of this title.

(c) Microbial inactivation and removal requirements. A public water system that treats groundwater in response to a fecal indicator positive source sample or[~~,~~] significant deficiency, instead of conducting [~~or in lieu of the~~] raw groundwater source monitoring, shall meet minimum [~~disinfection~~] requirements demonstrating at least 4-log treatment of viruses before the water is distributed to the first connection of the specified groundwater source.

(1) Monitoring requirements for chemical disinfectants. Groundwater systems shall monitor the performance of the disinfection facilities to ensure that appropriate disinfectant levels are maintained every day the specified source serves the public. All monitoring conducted pursuant to the requirements of this section must be conducted at sites designated in the system's monitoring plan in accordance with §290.121 of this title (relating to Monitoring Plans).

(A) Groundwater systems serving a population greater than 3,300 must continuously monitor the residual disinfectant concentration in accordance with the analytical methods specified in 40 Code of Federal Regulations (CFR) §141.74(a)(2) at a location approved by the executive director and must record the lowest residual disinfectant concentration every day the groundwater source serves the public.

(i) The groundwater system must maintain the executive director-approved minimum specified disinfectant residual every day the groundwater system serves water from the specified groundwater source to the public. If there is a failure in the continuous monitoring equipment, the groundwater system must conduct grab sampling every four hours until the continuous monitoring equipment is returned to service.

(ii) The system must resume continuous residual disinfectant monitoring within 14 days.

(B) Groundwater systems serving a population of 3,300 or fewer must monitor the disinfectant residual in accordance with the analytical methods specified in 40 CFR §141.74(a)(2) in each disinfection zone at least once each day that water from the specified groundwater source is served to the public during either a time when peak hourly raw water flow rates are occurring or at another time specified by the executive director. The system must record and maintain the disinfectant residual every day the system serves water from the groundwater source to the public. The system must collect a daily grab sample during the hour of peak flow or at another time specified by the executive director. If any daily grab sample measurement falls below the executive director-approved minimum specified disinfectant residual, the groundwater system must collect follow-up samples every four hours until the residual disinfectant concentration is restored to the executive director-approved level. Alternatively, a groundwater system that serves 3,300 or fewer people may monitor the residual disinfectant concentration continuously and meet the requirements of subparagraph (A) of this paragraph.

(C) Disinfection contact time will be based on tracer study data or a theoretical analysis submitted by the system owner or their designated agent and approved by the executive director.

(D) Groundwater treatment plants that fail to demonstrate an appropriate level of treatment must repeat these tests at four-hour or shorter intervals until compliance has been reestablished.

(2) Monitoring and operating requirements for commission-approved alternative treatment, including ultraviolet light (UV) disinfection facilities, membrane systems, and other methods that can obtain 4-log inactivation or removal of viruses [~~and can be properly validated. Public water systems shall monitor the UV intensity as measured by a UV sensor, lamp status, the flow rate through the unit, and other parameters prescribed by the executive director as specified in §290.42(g)(5) of this title (relating to Water Treatment) to ensure that the units are operating within validated conditions~~].

(A) Public water systems shall monitor the UV intensity as measured by a UV sensor, lamp status, the flow rate through the unit, and other parameters prescribed by the executive director as specified in §290.42(g)(5) of this title (relating to Water Treatment) to ensure that the units are operating within validated conditions.

(B) Public water systems shall monitor and record membrane system performance in accordance with executive director specified requirements.

(3) Analytical requirements. All monitoring required by this section must be conducted at a facility approved by the executive director and using methods that conform to the requirements of §290.119 of this title (relating to Analytical Procedures).

(A) The pH analysis must be conducted using a pH meter with a minimum accuracy of plus or minus 0.1 pH units.

(B) The temperature of the water must be measured using a thermometer or thermocouple with a minimum accuracy of plus or minus 0.5 degrees Celsius.

(C) The free chlorine or chloramine residual (measured as total chlorine) must be measured to a minimum accuracy of plus or minus 0.1 milligrams per liter (mg/L). Color comparators may be used for distribution system samples only. When used, a color comparator must have current reagents, an unfaded and clear color comparator, a sample cell that is not discolored or stained, and must be properly stored in a cool, dark location where it is not subjected to conditions that would result in staining. The color comparator must be used in the correct range. If a sample reads at the top of the range, the sample

must be diluted with chlorine-free water, then a reading taken and the resulting residual calculated.

(D) The chlorine dioxide residual must be measured to a minimum accuracy of plus or minus 0.05 mg/L using one of the following methods:

(i) Amperometric titrator with platinum-platinum electrodes; or

(ii) Lissamine Green B.

(E) The ozone residual must be measured to a minimum accuracy of plus or minus 0.05 mg/L using an indigo method that uses a colorimeter or spectrophotometer.

(F) Membrane system integrity monitoring shall be conducted in accordance with executive director specified requirements.

(4) Recordkeeping requirements for microbial inactivation and removal treatment. Groundwater systems, including wholesale, and consecutive[, ~~and mixed~~] systems, regulated under this subsection must comply with §290.46 of this title (relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems).

(d) Reporting requirements. Groundwater systems conducting 4-log treatment instead of conducting [~~in lieu of the~~] raw groundwater source monitoring or required [~~to conduct~~] corrective action in response to a fecal indicator positive source sample, or a significant deficiency, must report to the executive director in accordance with this subsection.

(1) A groundwater system required to conduct compliance monitoring for chemical disinfectants must complete a Groundwater Treatment Monthly Operating Report (commission Form 20362) for groundwater disinfection facilities monthly. Groundwater systems must maintain the reports on site and make them available to the executive director upon request.

(2) A groundwater system must provide written notification to the executive director that it is not required to meet the raw groundwater source monitoring requirements under §290.109(d)(4) [~~§290.109(e)(4)~~] of this title because it provides at least 4-log treatment of viruses for a specified groundwater source and must begin compliance monitoring in accordance with subsection (c) of this section. The notification must include engineering, operational, and other information required by the executive director to evaluate the submission.

(3) A groundwater system required to complete corrective action under subsection (b) of this section must notify the executive director within 30 days of completing the corrective action.

(4) If a groundwater system is subject to the triggered source monitoring requirements of §290.109(d)(4)(A) [~~§290.109(e)(4)(A)~~] of this title and does not conduct source monitoring, the system must provide written documentation that it was providing 4-log treatment of viruses for the specified groundwater source or that it met the criteria set out in §290.109(d)(4)(D) [~~§290.109(e)(4)(D)~~] of this title within 30 days of the positive distribution coliform sample.

(5) A groundwater system conducting compliance monitoring under subsection (a) of this section must notify the executive director any time the system fails to meet any executive director-specified requirements (including, but not limited to, minimum residual disinfectant concentration, and alternative treatment operating criteria) if the operation in accordance with the criteria or requirements is not restored within four hours. The system must notify the executive director as soon as possible, but no later than the end of the next business day.

(6) A groundwater system required to conduct integrity monitoring for membrane systems shall complete the executive director specified reports. The reports shall be maintained in accordance with executive director specified requirements.

(e) Compliance determination. In accordance with this subsection, the executive director shall determine compliance for groundwater systems required to conduct corrective action within 120 days, or pursuant to a groundwater corrective action plan.

(1) A groundwater system is in violation of the treatment technique requirement if it does not complete corrective action in accordance with the executive director-approved corrective action plan or any interim measures required by the executive director.

(2) A groundwater system is in violation of the treatment technique requirement if it is not in compliance with the executive director-approved corrective action plan and schedule.

(3) A groundwater system subject to the requirements of subsection (c) of this section that fails to maintain at least 4-log treatment of viruses is in violation of the treatment technique requirement if the failure is not corrected within four hours. The groundwater system must notify the executive director as soon as possible but no later than the next business day if there is a failure in maintaining the 4-log treatment for more than four hours.

(4) A groundwater system that fails to conduct the disinfectant or membrane system integrity monitoring required under subsection (c) of this section commits a monitoring violation.

(5) A groundwater system that fails to report the results of the disinfectant or membrane system integrity monitoring required under subsection (c) of this section commits a reporting violation.

(6) A groundwater system that fails to issue a required public notice or certify that the public notice has been performed commits a public notice violation.

(f) Public notification. A groundwater system that commits a treatment technique, monitoring, or reporting violation or situation as identified in this section must notify its customers of the violation in accordance with the requirements of §290.122 of this title (relating to Public Notification).

(1) Special notice to the public of significant deficiencies or source water fecal contamination for community systems. In addition to the applicable public notice requirements of §290.122(a) of this title, a community groundwater system that receives notice from the executive director of a significant deficiency or notification of a fecal indicator positive [~~indicator-positive~~] groundwater source sample that is not invalidated under §290.109(e)(2) [~~§290.109(d)(2)~~] of this title must inform the public served by the water system of the fecal indicator positive [~~indicator-positive~~] source sample or of any significant deficiency that has not been corrected in its Consumer Confidence Report as specified in §290.272(g)(7) and (8) of this title (relating to Content of the Report). The system shall continue to inform the public annually until the significant deficiency is corrected or the fecal contamination in the groundwater source is determined by the executive director to be corrected under subsection (b)(2) of this section.

(2) Special notice to the public of significant deficiencies or source water fecal contamination for noncommunity systems. In addition to the applicable public notice requirements of §290.122(a) of this title, a noncommunity groundwater system that receives notice from the executive director of a significant deficiency or notification of a fecal indicator positive [~~indicator-positive~~] groundwater source sample

that is not invalidated under §290.109(e)(2) [~~§290.109(d)(2)~~] of this title must inform the public served by the water system of any significant deficiency that has not been corrected within 12 months of being notified by the executive director, or earlier if directed by the executive director. The system must continue to inform the public annually until the significant deficiency is corrected. The information must include:

(A) posting the notice in conspicuous locations throughout the distribution system frequented by persons served by the system, or by mail or direct delivery to each customer and service connection; and

(B) any other method reasonably calculated to notify other persons served by the system, if they would not normally be notified by the methods set out in subparagraph (A) of this paragraph. Such persons may include those who may not see a posted notice because the notice is not in a location they routinely frequent. Other methods may include publication in a local newspaper, newsletter, or e-mail; or, delivery of multiple copies in central locations (e.g., community centers).

(C) If directed by the executive director, a noncommunity groundwater system with significant deficiencies that have been corrected must inform its customers of the significant deficiencies, how deficiencies were corrected, and the dates of correction.

§290.117. Regulation of Lead and Copper.

(a) Applicability. The requirements of this section apply to community and nontransient, noncommunity public water systems. These regulations establish requirements for monitoring, reporting, corrosion control studies and treatment, source water treatment, lead service line replacement, and public education. Public water systems must control the levels of lead and copper in drinking water by controlling the corrosivity of the water. New water systems will be required to meet the requirements of this section when notified by the executive director.

(b) Compliance levels and ranges. Community and nontransient, noncommunity systems must meet designated lead and copper levels and water quality parameter ranges.

(1) Lead and copper action levels. Public water systems must meet action levels for lead and copper in drinking water.

(A) Lead action level. The lead action level is 0.015 milligrams per liter (mg/L). The action level is exceeded if the "90th percentile" lead level exceeds 0.015 mg/L in any monitoring period. The 90th percentile lead level is exceeded when more than 10% of tap water samples have a concentration over the action level.

(B) Copper action level. The copper action level is 1.3 mg/L. The action level is exceeded if the concentration of copper in more than 10% of tap water samples collected during any monitoring period is greater than 1.3 mg/L.

(2) Reduced lead and copper monitoring levels. Systems with levels of lead and copper less than the reduced monitoring levels may be eligible for reduced monitoring under subsections (c) - (e) of this section.

(A) The reduced monitoring level for lead is 0.005 mg/L.

(B) The reduced monitoring level for copper is 0.65 mg/L.

(C) A system with 90th percentile levels of lead and copper less than or equal to the reduced monitoring levels in two consecutive six-month initial or routine tap sampling periods may be eligible for reduced monitoring under subsections (c) - (e) of this section.

(3) Lead and copper Practical Quantitation Levels (PQLs). The PQLs for lead and copper are defined by this paragraph.

(A) The PQL for lead is 0.005 mg/L.

(B) The PQL for copper is 0.050 mg/L.

(4) Optimal water quality parameter (OWQP) ranges. The executive director shall set approved OWQP ranges for systems based on corrosion control studies described in subsection (f)(1) of this section. All systems that exceed an action level for lead or copper based on the 90th percentile are required to have approved OWQP ranges. Systems that serve more than 50,000 people that exceed the PQL for lead based on the 90th percentile are required to have approved OWQP ranges. Systems with approved water quality parameter ranges shall operate within the approved OWQP ranges at all times.

(A) OWQP ranges shall include all elements contained in this subparagraph.

(i) OWQPs shall include a minimum value or a range of values for negative log of hydrogen ion concentration (pH) measured at each entry point to the distribution system.

(ii) OWQPs shall include a minimum pH value, measured in all tap samples. Such value shall be equal to or greater than 7.0, unless the executive director determines that meeting a pH level of 7.0 is not technologically feasible or is not necessary for the system to optimize corrosion control.

(iii) If a corrosion inhibitor is used, OWQPs shall include a minimum concentration or a range of concentrations for the inhibitor, measured at each entry point to the distribution system and in all tap samples, that the executive director determines is necessary to form a passivating film on the interior walls of the pipes of the distribution system.

(iv) If alkalinity is adjusted as part of optimal corrosion control treatment, OWQPs shall include a minimum concentration or a range of concentrations for alkalinity, measured at each entry point and in all distribution samples.

(v) If calcium carbonate stabilization is used as part of corrosion control, OWQPs shall include a minimum concentration or a range of concentrations for calcium, measured in all distribution samples.

(B) Systems that must perform corrosion controls studies under subsection (f) of this section shall submit proposed system-specific OWQP ranges in writing for the executive director's approval.

(C) The executive director shall review and designate OWQPs in writing within six months after receipt of the system's recommended OWQPs.

(5) Deemed to have optimized corrosion control. A system may be considered deemed to have optimized corrosion control if it meets the requirements of this paragraph.

(A) A system that serves 50,000 or fewer people may be deemed to have optimized corrosion control if the system meets the lead and copper action levels in two consecutive initial or routine monitoring periods.

(B) A system that serves more than 50,000 people may be deemed to have optimized corrosion control if the difference between the 90th percentile lead level and the highest entry point lead level is less than the PQL and the system meets the copper action levels in two consecutive initial or routine monitoring periods.

(C) Those systems whose highest source water lead level is below the method detection limit may also be deemed to have

optimized corrosion control under this paragraph if the 90th percentile tap water lead level is less than or equal to the PQL for lead for two consecutive six-month monitoring periods.

(D) Any water system may be deemed by the executive director to have optimized corrosion control treatment if the system demonstrates, to the satisfaction of the executive director, that it has conducted activities equivalent to the corrosion control requirements of this section, including all applicable monitoring requirements.

(E) Any system that fails to perform required monitoring or reporting, operates outside any approved OWQP ranges, or exceeds a lead or copper action level shall no longer be deemed to have optimized corrosion control.

(6) Maximum permissible levels (MPLs) for source water lead. The executive director shall designate MPLs for lead and copper at entry points to the distribution system for systems that are required to install source water treatment under subsection (g) of this section. Such MPLs shall reflect the contaminant-removal capability of the source water treatment properly operated and maintained. The executive director shall determine MPLs based on source water samples taken by the water system before and after the system installs the approved source water treatment. The executive director will set MPLs in writing, explaining the basis of that decision, within six months after the system completes follow-up tap sampling for lead and copper after source water treatment installation under subsection (g) of this section.

(c) Lead and copper tap sampling locations and frequency. Community and nontransient, noncommunity public water systems shall sample at sites approved by the executive director and at a frequency set by the executive director. Systems shall conduct initial tap sampling until the system either exceeds the lead or copper action level or becomes eligible for reduced monitoring.

(1) Lead and copper tap sampling locations. Systems shall sample at sites approved by the executive director and documented in the system's monitoring plan required under §290.121 of this title (relating to Monitoring Plans).

(A) Number of tap sample sites. The minimum number of sample sites required for initial, routine, or reduced lead and copper tap sampling are listed in the following table, entitled "Required Number of Lead and Copper Tap Sample Sites:"
Figure: 30 TAC §290.117(c)(1)(A) (No change.)

(B) Suitable sample taps. All sites from which lead and copper tap samples are collected shall be selected from a pool of targeted sampling sites identified through a materials survey of the distribution system. Sample sites shall be selected first at tier 1, then tier 2, then tier 3 locations as defined in subparagraph (D) of this paragraph. Sampling sites may not include faucets that have point-of-use or point-of-entry treatment devices designed to remove inorganic chemicals.

(C) Material survey and sample site selection form. Sample sites shall be representative of the distribution system and specifically represent areas of the system most vulnerable to corrosion of lead and copper into the water. The system must maintain a current copy of their Material Survey Form with the monitoring plan.

(i) Material survey. Systems shall perform a materials survey to select sample appropriate tap sampling sites using the Material Survey Form and Instructions (TCEQ Form Number 20467). The material survey shall be submitted in writing for executive director review and approval. In performing the material survey, the system shall review the sources of information listed in this clause in order to identify sampling sites. In addition, the system shall seek to collect such information where possible in the course of its normal operations (for example, while checking service line materials when reading water meters or performing maintenance activities). Sources of information that must be reviewed include:

(I) all [~~All~~] plumbing codes, permits, and records in the files of the building department(s) which indicate the plumbing materials that are installed within publicly and privately owned structures connected to the distribution system; [~~and~~]

(II) all [~~All~~] inspections and records of the distribution system that indicate the material composition of the service connections that connect a structure to the distribution system; [~~and~~]

(III) all [~~All~~] existing water quality information, which includes the results of all prior analyses of the system or individual structures connected to the system, indicating locations that may be particularly susceptible to high lead or copper concentrations; [~~and~~]

(IV) a [~~A~~] water system shall use the information on lead, copper, and galvanized steel that it is required to collect when performing a corrosion control study that is required under subsection (f) of this section.

(ii) Sample site selection form. After completing sample site selection, the system will submit the Lead and Copper Sample Site Selection form (TCEQ Form Number 20467) to the executive director for approval. Systems shall identify routine and reduced monitoring sites on their Lead and Copper Sample Site Selection form.

(I) Selecting tier 1, 2, and 3 sites. Systems shall identify tier 1, tier 2, and tier 3 sites as described in subparagraph (D) of this paragraph.

(II) Sites for community systems with insufficient tier 1, 2, or 3 sites. A community water system with insufficient tier 1, tier 2, and tier 3 sampling sites shall complete its sampling pool with representative sites throughout the distribution system.

(III) Sites for nontransient, noncommunity systems with insufficient tier 1, 2, or 3 sites. A nontransient, noncommunity water system with insufficient tier 1 sites shall complete its sampling pool with sampling sites that contain copper pipes with lead solder installed before 1983. If additional sites are needed to complete the sampling pool, the nontransient, noncommunity water system shall use representative sites throughout the distribution system.

(IV) Sites for systems with lead service lines. Any water system whose distribution system contains lead service lines shall draw 50% of the samples it collects during each monitoring period from sites that contain lead pipes, or copper pipes with lead solder, and 50% of the samples from sites served by a lead service line. A water system that cannot identify a sufficient number of sampling sites served by a lead service line shall collect first-draw samples from all of the sites identified as being served by such lines.

(V) Supplemental information with Site Selection Form. Systems shall submit supplemental explanatory information as part of the sample site selection documentation.

(D) Tier 1, 2, and 3 sites. Tier 1, 2, and 3 sites representing potential for leaching lead or copper under corrosive conditions shall be defined as described in this subparagraph.

(i) Definition of community tier 1. The sampling sites selected for a community water system's sampling pool, called "tier l sampling sites," shall consist of single family structures that:

(I) contain [~~Contain~~] copper pipes with lead solder installed after 1982 or contain lead pipes; or

(II) are [~~Are~~] served by a lead service line. When multiple-family residences comprise at least 20% of the structures served by a water system, the system may include these types of structures in its sampling pool.

(ii) Definition of community tier 2. Any community water system with insufficient tier 1 sampling sites shall complete its sampling pool with "tier 2 sampling sites", consisting of buildings, including multiple-family residences that:

(I) contain [~~Contain~~] copper pipes with lead solder installed after 1982 or contain lead pipes; or

(II) are [~~Are~~] served by a lead service line.

(iii) Definition of community tier 3. Any community water system with insufficient tier 1 and tier 2 sampling sites shall complete its sampling pool with tier 3 sampling sites consisting of single family structures that contain copper pipes with lead solder installed before 1983.

(iv) Definition of community "other representative sites". A representative site is a site in which the plumbing materials used at that site would commonly be found at other sites served by the water system.

(v) Definition of nontransient, noncommunity tier 1 sites. Tier 1 sampling sites selected for a nontransient, noncommunity water system shall consist of buildings that:

(I) contain [~~Contain~~] copper pipes with lead solder installed after 1982 or contain lead pipes; or

(II) are [~~Are~~] served by a lead service line.

(vi) Nontransient, noncommunity representative sites. For the purpose of this paragraph, a representative site is a site in which the plumbing materials used at that site would be commonly found at other sites served by the water system.

(E) Sites for systems missing first-draw sites. A water system may request approval of non-first-draw sample sites if it meets the requirements in this paragraph. The executive director will use all written documentation provided by the system in reviewing the request.

(i) Type of system for non-first-draw sites. In order to request use of non-first-draw sites, the system must be either a nontransient, noncommunity system, or a community system where:

(I) the [~~The~~] system is a facility, such as a prison or a hospital, where the population served is not capable of or is prevented from making improvements to plumbing or installing point of use treatment devices; and

(II) the [~~The~~] system provides water as part of the cost of services provided and does not separately charge for water consumption.

(ii) The request for approval of non-first-draw sites must provide written documentation identifying standing times and locations for enough non-first-draw samples to make up its sampling pool. A system must update their sample sites when system conditions changes, such as changes in population and destruction of previously used sites.

(F) Sites for systems with less than five taps. A public water system that has fewer than five drinking water taps that can be used for human consumption may request a five-tap waiver to collect samples at fewer than five locations. The executive director may allow these public water systems to collect a number of samples less than the number of sites specified in paragraph (1) of this subsection, provided that all taps that can be used for human consumption are sampled. The system must request this reduction of the minimum number of sample sites in writing based on a request from the system or on-site verification. In no case can the system reduce the number of samples required below the minimum of one sample per available tap.

(G) Use of same taps each round. A water system must collect tap samples from the same sampling sites in each sampling round.

(i) If a water system changes a sampling site for any reason allowed in this section, the water system must provide the executive director with a written explanation showing which sampling site will be abandoned and the sampling site that replaces the abandoned sampling site. The water system's report shall include an explanation as to why a sampling site was changed from the previous round of sampling,

(ii) If a water system cannot collect a sample from a previously used site, the water system shall provide a written explanation to the executive director. The water system must select an alternate sampling site from the system's sampling pool which meets similar criteria and is within reasonable proximity to the original sampling site.

(2) Lead and copper tap sampling frequency. Water systems shall collect at least one sample from the number of sites listed the table in paragraph (1) of this subsection during each monitoring period. Systems shall sample on the schedule determined by the executive director.

(A) Initial and routine tap sampling. New systems, systems that exceed any action level, systems that install corrosion control treatment, systems that exceed a reduced monitoring level, and systems that operate outside an approved OWQP range shall collect tap samples in two consecutive six-month monitoring periods at the initial/routine number of sample sites.

(i) Initial tap sampling. New systems shall collect tap samples in two consecutive six-month monitoring periods at the initial/routine number of sample sites. A new community or nontransient, noncommunity water system begins the first six-month initial monitoring period in the year after it becomes active. Initial tap sampling shall be conducted after the executive director has determined that a system has had sample sites approved based on the materials survey and sample site selection form required by subsection (b)(2) of this section.

(ii) Routine tap sampling. Systems on reduced monitoring may be required to return to routine sampling in two consecutive six-month periods.

(I) Systems that exceed the lead action level during any 4-month monitoring period shall return to routine tap sample monitoring.

(II) Systems required to perform biweekly water quality parameter (WQP) [~~WQP~~] sampling that have WQP levels that are outside the system's approved OWQP range for more than nine days in any six-month period shall return to routine tap sample monitoring.

(III) Systems that are required to return to routine tap sampling because of an action level, reduced monitoring level, or OWQP range exceedance shall start the two consecutive six-month periods in the next calendar year after the exceedance or event that triggers routine monitoring.

(IV) Within 36 months after the executive director designates optimal corrosion control treatment, systems that serve fewer than 50,000 people shall return to routine tap sampling.

(V) Any system that installs corrosion control treatment shall return to routine tap sampling.

(VI) Any system that installs source treatment shall return to routine tap sampling.

(B) Reduced annual tap sampling. Systems that meet the requirements of this paragraph shall collect tap samples every year. Systems on annual reduced monitoring shall collect tap samples at the number of sites in the table entitled "Required Number of Lead and Copper Tap Sample Sites" in paragraph (1) of this subsection. Systems shall collect samples at sites approved by the executive director and documented in the monitoring plan. Reduced annual monitoring shall be performed during June, July, August, or September. This annual sampling shall begin during the calendar year immediately following the end of the second consecutive six-month monitoring period. The executive director shall notify each water system if it is eligible for reduced annual tap sample monitoring.

(i) Systems serving more than 50,000 people that meet the lead action levels, and operate within any approved OWQP ranges, during two consecutive six-month periods may have their sampling frequency reduced to once a year.

(ii) Systems serving 50,000 or fewer people that meet the lead and copper action levels during two consecutive six-month periods may have their sampling frequency reduced to once a year.

(iii) Systems serving 50,000 or fewer people that meet the lead action level, and operate within any approved OWQP ranges, during two consecutive six-month periods may have their sampling frequency reduced to once a year.

(iv) Systems that meet the action levels, but whose 90th percentile levels exceed 0.005 mg/L for lead or 0.65 for copper during two consecutive six-month initial or routine sampling periods must perform two consecutive years of annual monitoring.

(v) Systems monitoring annually, that have been collecting samples during the months of June through September and that receive approval from the executive director to alter their sample collection period under subparagraph (E) of this paragraph must collect their next round of samples during a time period that ends no later than 21 months after the previous round of sampling.

(vi) Systems with approved OWQP ranges that operate outside those ranges are not eligible for reduced annual monitoring.

(C) Reduced three-year tap sampling. Systems which meet the requirements of this paragraph, shall collect tap samples every three years. Systems on reduced three-year monitoring shall collect tap samples at the reduced number of sites in the table entitled "Required Number of Lead and Copper [~~Lead/Copper~~] Tap Sample Sites" in paragraph (1) of this subsection. Systems shall collect samples at the sites approved by the executive director and documented in the monitoring plan. Reduced three-year monitoring shall be performed during June, July, August, or September, unless the executive director has designated a different four-month period under subparagraph (E) of this paragraph.

(i) Any system that demonstrates during two consecutive six-month initial or routine monitoring periods that the 90th percentile lead level is less than or equal to 0.005 mg/L and the 90th percentile copper level is less than or equal to 0.65 mg/L shall have the required frequency of sampling reduced to once every three years.

(ii) A system that serves 50,000 or fewer people that meets the lead and copper action levels during three consecutive years of monitoring may reduce the frequency of monitoring for lead and copper from annually to once every three years.

(iii) A system with approved OWQP ranges must operate within those ranges to remain eligible for reduced three-year monitoring.

(iv) Samples collected once every three years shall be collected no later than every third calendar year.

(v) Systems on reduced three-year monitoring that have been collecting samples during the months of June through September, and receive approval from the executive director to alter the sampling collection period as per subparagraph (E) of this paragraph must collect their next round of samples during a time period that ends no later than 45 months after the previous round of sampling.

(D) Reduced nine-year tap sampling. Systems that meet the requirements of the United States Environmental Protection Agency's (EPA's) Lead and Copper Rule Minor Revisions, this paragraph, and serve 3,300 or fewer people shall be eligible for reduced nine-year tap sampling. Systems on reduced monitoring shall collect tap samples at the number of sites in the table entitled "Required Number of Lead and Copper Tap Sample Sites" in paragraph (1) of this subsection. Systems shall collect samples at the sites approved by the executive director and documented in the monitoring plan. Reduced nine-year tap sampling [~~monitoring~~] shall be performed during June, July, August, or September, unless the executive director has designated a different four-month period under subparagraph (E) of this paragraph. The executive director shall notify a system that it is eligible for reduced monitoring.

(i) Initiation of reduced nine-year tap sampling. The first round of reduced nine-year [~~reduced~~] tap sampling shall be completed no later than nine years after the last time the system monitored for lead and copper at the tap.

(ii) Materials requirement for reduced nine-year tap sampling. In order to be eligible for reduced nine-year tap sampling [~~monitoring~~], a system must provide the executive director with an updated materials survey certifying that the system meets the requirements of this clause.

(I) The water system must demonstrate on the Materials Survey and Lead/Copper Sample Site Selection form (TCEQ Form Number 20467) that its distribution system, service lines, and all drinking water supply plumbing, including plumbing conveying drinking water within all residences and buildings connected to the system, are free of lead-containing materials and/or copper-containing materials to demonstrate the risk from lead and/or copper exposure is negligible throughout the water system.

(II) To qualify for reduced nine-year [~~reduced~~] tap sampling [~~monitoring~~], the water system must certify in writing and provide supporting documentation that the system is free of all lead-containing materials. The system must contain no plastic pipes that contain lead plasticizers, or plastic service lines that contain lead plasticizers. The system must be free of lead service lines, lead pipes, lead soldered pipe joints, and leaded brass or bronze alloy fittings and fixtures, unless such fittings and fixtures meet the specifications of any standard established pursuant to 42 United States Code, §300g-6(e) (Safe Drinking Water Act, §1417(e)).

(III) To qualify for reduced nine-year tap sampling [~~reduced monitoring~~] the water system must provide certification and supporting documentation to the executive director that the system contains no copper pipes or copper service lines.

(IV) The executive director shall not issue any "partial waivers" for lead and copper monitoring.

(iii) Lead and copper levels for reduced nine-year tap sampling eligibility. To qualify for reduced nine-year tap sampling [~~reduced monitoring~~], the public water system must have completed at least one six-month period of initial tap water monitoring. Also, all of the system's 90th percentile lead and copper levels must have been less than or equal to 0.005 mg/L for lead and 0.65 for copper in all sampling performed by the system.

(iv) Conditions for reduced nine-year tap sampling eligibility. As a condition of the reduced nine-year tap sampling schedule [~~waiver~~], the executive director may require the system to perform specific activities to avoid the risk of lead or copper concentration of concern in tap water. For example, additional monitoring, periodic outreach to customers to remind them to avoid installation of materials that might void the reduced nine-year tap sampling schedule [~~waiver~~], or other activities may be required.

(v) Reduced nine-year [~~Nine-year~~] tap sampling revocation. If a water system with a nine-year tap sampling schedule [~~waiver~~] adds a new source of water, changes any water treatment, or no longer meets the requirements of this subparagraph, the water system must notify the executive director in writing within 60 days of the change as required by §290.39(j) of this title (relating to General Provisions). The executive director has the authority to [~~add or~~] modify the reduced nine-year tap sampling schedule [~~monitoring waiver conditions~~] to address changes.

(vi) Notification of change in lead or copper materials. If a system on reduced nine-year tap sampling becomes aware that the system is no longer free of lead-containing or copper-containing materials, the system shall notify the executive director in writing no later than 60 days after becoming aware of such a change. If the system met both the lead and the copper action levels in all previous lead and copper tap sampling results, the system must return to three-year tap sampling schedule contained in subparagraph (C) of this paragraph.

~~*[(vii)* Grandfathered nine-year tap sampling. Systems with nine-year tap sampling waivers approved in writing by the executive director prior to January 1, 2002 shall remain in effect if the system continues to meet the requirements of this paragraph.]~~

(vii) [~~(viii)~~] Tap sampling frequency sequence. Subsequent rounds of sampling, after a return to routine monitoring, must be collected once a year, every three years, or every nine years, as required by this section.

(E) Alternate months for reduced lead and copper tap sampling. The executive director may approve a different period, other than June through September, for systems conducting reduced lead and copper tap sampling. Such a period shall be no longer than four consecutive months and must represent a time of normal operation where the highest levels of lead are most likely to occur. For a nontransient, noncommunity water system that does not operate during the months of June through September, and for which the period of normal operation where the highest levels of lead are most likely to occur is not known, the executive director shall designate a period that represents a time of normal operation for the system. This sampling shall begin during the period designated by the executive director in the calendar year immediately following the end of the second consecutive six-month monitoring period for systems initiating annual monitoring and during the three-year period following the end of the third consecutive calendar year of annual monitoring for systems initiating three-year reduced monitoring.

(F) Tap sampling monitoring period. For systems on annual or less frequent schedules, the end of the monitoring period is September 30 of the calendar year in which the sampling occurs, or if the executive director has established an alternate monitoring period, the last day of that period.

(G) Return to initial/routine tap sampling frequency. The executive director shall determine whether a system continues to meet the requirements to remain on reduced annual, three-year, or nine-year monitoring. A system on reduced monitoring may be required to return to routine monitoring as described in subparagraph (A)(i) of this paragraph. Systems required to return to routine monitoring shall sample at the number of routine sites listed in the table entitled "Required Number of Lead and Copper [~~Lead/Copper~~] Tap Sample Sites" under paragraph (1) of this subsection.

(H) Replacement tap samples. The water system must collect replacement samples for any samples invalidated under subsection (h) of this section. Any such replacement samples must be collected as soon as possible, but no later than twenty days after receiving notification of sample invalidation approval from the executive director. If a water system discovers that a sample has been collected at an inappropriate sampling site, the water system may request in writing that the sample be invalidated. The replacement samples shall be taken at the same locations as the invalidated samples or, if that is not possible, at locations other than those with valid results for the monitoring period.

(I) Nontransient, noncommunity systems with less than five taps. A nontransient, noncommunity system that has fewer than five drinking water taps meeting the sample site criteria of this paragraph must collect at least one sample from each tap and then must collect additional samples from those same taps on different days during the monitoring period to meet the required number of samples unless the system has received a five-tap waiver from the executive director under paragraph (1)(F) of this subsection.

(3) Consumer sampling for lead action level exceeders. Water systems that exceed the lead action level must arrange to sample the tap water of any customer who requests it. Analytical costs may be borne by the consumer.

(d) Lead and copper entry point sampling. Systems must perform entry point lead and copper sampling after the system exceeds a lead or copper action level, installs source water treatment, or exceeds any MPLs set by the executive director. Systems must routinely monitor lead and copper in conjunction with monitoring for inorganic contaminants other than asbestos or nitrate under section §290.106 of this title (relating to Inorganic Contaminants).

(1) Lead and copper entry point sampling locations. Systems required to perform entry point sampling under this subsection shall sample at every entry point to the distribution system including purchased water entry points. The system shall take each subsequent sample at the same sampling point unless conditions make another sampling point more representative of each source or treatment plant. The system must seek executive director approval to modify an entry point sample location, and must revise its monitoring plan.

(2) Lead and copper entry point sampling frequency. If a system draws water from more than one source and the sources are combined before distribution, the system must sample at an entry point to the distribution system during periods of normal operating conditions when water is representative of all sources being used.

(A) Entry point lead and copper sampling after an action level exceedance. Any system which exceeds the lead or copper action level shall collect one sample from each entry point no later than 180 days after the end of the monitoring period during which the lead or copper action level was exceeded. For systems on annual or less frequent schedules, the end of the monitoring period is September 30

of the calendar year in which the sampling occurs, or if the executive director has established an alternate monitoring period, the last day of that period.

(B) Entry point lead and copper sampling for systems that meet the action levels. A system is not required to conduct entry point lead and copper sampling if the system meets the lead and copper action levels during the entire entry point sampling period.

(C) Entry point lead and copper monitoring frequency after installing source water treatment. Any system that installs source water lead or copper removal treatment shall collect entry point samples during two consecutive six-month periods within 36 months after source water treatment begins.

(D) Entry point lead and copper sampling frequency after specification of MPLs. A system shall monitor at the frequency specified below.

(i) Starting the year after the executive director specifies MPLs, water systems using any surface water shall collect annual samples once during each calendar year.

(ii) Starting the year after the executive director specifies MPLs, a water system using only groundwater shall collect samples once during the three-year compliance period in effect at that time. Such systems shall collect samples once during each subsequent compliance period. Triennial samples shall be collected every third calendar year.

(iii) A water system using only groundwater may sample entry points every ninth year if the system meets one of the following criteria.

(I) The entry point lead and copper levels are below the lead and copper MPLs during at least three consecutive compliance periods; or

(II) The executive director has determined that source water treatment is not needed and the system demonstrates that, during at least three consecutive annual or three-year compliance periods, the concentration of lead in source water was less than or equal to 0.005 mg/L and the concentration of copper in source water was less than or equal to 0.65 mg/L.

(iv) A water system using surface water (or a combination of surface water and ground water) may reduce the lead and copper entry point monitoring frequency to once during every ninth year if the system meets one of the following criteria:

(I) The entry point lead and copper levels are below the MPLs for lead and copper for at least three consecutive years; or

(II) The executive director has determined that source water treatment is not needed and the concentration of lead at all entry points was less than or equal to 0.005 mg/L and the concentration of copper at all entry points was less than or equal to 0.65 mg/L during at least three consecutive years.

(v) A water system that uses a new source of water is not eligible for reduced entry point monitoring for lead and copper until concentrations in samples collected from the new source during three consecutive monitoring periods are below the lead and copper MPLs.

(vi) Where the results of sampling indicate an exceedance of a lead or copper MPL, one additional sample must be collected within two weeks after the initial sample was taken at the same entry point. Samples will be averaged for compliance determination.

(E) All water systems shall notify the executive director in writing of any proposed change in treatment or the addition or deletion of a source of water. The executive director may require any such system to conduct additional monitoring or to take other action to ensure that the system maintains minimal levels of corrosion in the distribution system.

(e) WQP monitoring requirements. Systems shall monitor WQPs to determine the potential for corrosion. [~~The WQP monitoring requirements are summarized in the table entitled "WQP Entry Point and Distribution Monitoring Summary."~~] All systems that serve more than 50,000 people shall monitor in accordance with this subsection. Systems that serve 50,000 or fewer people that exceed a lead or copper action level shall monitor in accordance with this subsection [~~section~~], during the monitoring period in which the system exceeds the action level. Sites shall be submitted to the executive director for approval in conjunction with the system's monitoring plan.

(1) WQP monitoring locations. Systems that are required to monitor WQPs shall take two samples at all entry points, distribution, and raw water WQP sites, as specified in paragraph (1)(A) - (C) of this subsection, where applicable, and at the number of distribution sites shown in Figure: 30 TAC §290.117(e)(1). [~~must sample at all entry points and at the number of distribution sites shown in the table entitled "Number of WQP Distribution Sample Sites." Distribution sample sites must represent the entire distribution system.~~] Systems on initial or routine monitoring, as described in paragraph (2) of this subsection, must sample at the number of sample sites in the column entitled "Initial and Routine Number of WQP Distribution Sites." Systems on reduced monitoring must sample at the number of sites in the column entitled "Reduced Number of WQP Distribution Sites."
Figure: 30 TAC §290.117(e)(1) (No change.)

(A) Entry point WQP sites. Systems that are required to perform entry point WQP monitoring under this subsection must perform monitoring at every entry point to the distribution system. The executive director may allow systems using only groundwater to forego entry point monitoring, and monitor only at representative distribution system locations according to paragraph (6) of this subsection.

(B) Distribution WQP sites. Sites normally used for bacteriological monitoring or other appropriate sites may be used for WQP sampling. Samples need not be collected inside a customer's home. These sites shall represent water quality throughout the entire distribution system.

(C) Raw water WQP sites. A raw water source sample shall be collected from the raw water line prior to any treatment and at a location approved by the executive director.

(2) Initial and routine WQP monitoring. New systems must perform at least one initial WQP monitoring round in the year following the year that the system is identified as active. Systems that exceed lead or copper action levels shall perform two consecutive six-month periods of routine WQP monitoring. Systems must monitor in accordance with subparagraph (A) and (B) of this paragraph. [~~the table entitled "Initial or Routine WQP Entry Point and Distribution Monitoring."~~]
Figure: 30 TAC §290.117(e)(2)
[~~Figure: 30 TAC §290.117(e)(2)~~]

(A) Locations for initial and routine WQP monitoring. Systems must conduct WQP monitoring at the locations specified in paragraph (1)(A) - (C) of this subsection, where applicable, and at the number of distribution sites specified in Figure: 30 TAC §290.117(e)(1). [~~at all entry points and at the number of distribution sites specified in paragraph (1) of this subsection, entitled "Number of WQP Distribution Sample Locations."~~]

(B) Frequency of initial and routine WQP monitoring. Systems serving 50,000 or fewer people shall measure the WQPs listed in this paragraph during each six-month monitoring period in which the system exceeds the lead or copper action level. Systems serving more than 50,000 people must perform two consecutive six-month periods of sampling. Public water systems shall collect WQP samples on a quarterly basis as described in Figure: 30 TAC §290.117(e)(2) to reflect seasonal variability in water quality conditions.

(3) WQP monitoring after installation of corrosion control treatment. Any system that installs optimal corrosion control treatment as required by subsection (f) of this section shall measure the list of WQPs at the locations and frequencies as specified in Figure: 30 TAC §290.117(e)(3). [~~the table entitled "WQP Entry Point and Distribution Monitoring After Installing Corrosion Control."~~] Any system serving more than 50,000 people that installs optimal corrosion control treatment shall monitor once during each six-month period. Any system serving 50,000 or fewer people that installs corrosion control treatment shall monitor during each six-month monitoring period specified in which the system exceeds the lead or copper action level.
Figure: 30 TAC §290.117(e)(3)
[~~Figure: 30 TAC §290.117(e)(3)~~]

(A) Frequency of WQP monitoring after installation of corrosion control treatment. After a system installs corrosion control treatment, it must collect least one sample every two weeks (biweekly) at every entry point to the distribution system, except as provided under paragraph (6) of this subsection.

(B) Documentation for WQP sample locations after installation of corrosion control treatment. Prior to the starting date of the monitoring period for any monitoring under this paragraph, the system shall provide the executive director with an updated list of entry points and their sources, a list of distribution sites, and information on seasonal variability of water usage to demonstrate that the sites are representative of water quality and treatment conditions throughout the system. The system shall submit this information to the executive director upon request or when circumstances change and retain a copy of the submittal and approval with the system's monitoring plan.

(C) Additional monitoring when determining optimal corrosion control treatment. The executive director may require the system to conduct additional WQP monitoring in to assist in evaluating the system's sample sites.

(4) WQP monitoring after designation of OWQP ranges. After the executive director approves OWQP ranges, systems shall measure the list of WQPs at the frequency and locations as described in Figure: 30 TAC §290.117(e)(4). [~~in the table entitled "WQP Entry Point and Distribution Monitoring After OWQP Determination."~~]
Figure: 30 TAC §290.117(e)(4) (No change.)

(A) After the executive director approves OWQP ranges, systems serving more than 50,000 people shall measure the WQPs listed in this paragraph and determine compliance with the OWQP ranges quarterly starting with the first six-month period after the executive director specifies the OWQPs beginning on either January 1 or July 1, whichever comes first.

(B) Any system serving 50,000 or fewer people shall conduct WQP monitoring during each six-month period specified in this paragraph in which the system exceeds the lead or copper action level. If the system is eligible for reduced lead and copper tap sampling, the system shall collect WQPs during the same monitoring periods that it collects lead and copper tap samples.

(C) The system shall complete follow-up sampling within 36 months after the executive director designates optimal corrosion control treatment.

(D) Systems shall measure WQPs at every entry point to the distribution system, except as allowed under paragraph (6) of this subsection.

(5) Reduced WQP monitoring. The executive director may reduce monitoring for systems that demonstrate a low risk of corrosion of lead and copper into the drinking water. Water systems on reduced schedules shall monitor the list of WQPs at the locations and frequency given in the table entitled "Reduced Water Quality Parameter (WQP) [~~WQP~~] Entry Point and Distribution Monitoring."
Figure: 30 TAC §290.117(e)(5) (No change.)

(A) Reduced quarterly WQP distribution monitoring. A system that operates within approved OWQP ranges in all samples taken during two consecutive six-month initial or routine monitoring periods under paragraph (2) of this subsection may collect tap samples for applicable WQPs from the reduced number of sites quarterly. A water system sampling quarterly shall collect samples evenly throughout the year so as to reflect seasonal variability.

(B) Reduced annual WQP distribution monitoring. Any water system that operates within approved OWQP ranges during three consecutive years of quarterly monitoring may reduce the frequency with which it collects distribution WQP samples to annually. Annual WQP sampling shall begin during the calendar year immediately following the end of the monitoring period in which the third consecutive year of quarterly monitoring occurs. A water system sampling annually shall collect samples evenly throughout the year so as to reflect seasonal variability.

(C) Reduced triennial WQP distribution monitoring. The executive director may reduce the WQP monitoring frequency to once every three years if a system meets the criteria of this subparagraph. Triennial monitoring shall be done no later than every third calendar year.

(i) A system that operates within approved OWQP ranges during three consecutive years of annual monitoring is eligible to reduce the frequency of distribution WQP monitoring to once in every third year. This sampling shall begin no later than the third calendar year following the end of the monitoring period in which the third consecutive year of monitoring occurs.

(ii) A system that demonstrates during two consecutive six-month periods that the entry point 90th percentile lead level is less than or equal to the PQL for lead in subsection (b)(3) of this section, and that operates within approved OWQP ranges during that time may reduce the frequency of distribution monitoring to once every third year. This sampling shall begin no later than the third calendar year following the end of the year in which the second consecutive six-month period occurs.

(D) Return to routine WQP monitoring. The executive director may return a system to monitoring at the routine frequency and routine number of sample sites. Any water system on reduced monitoring that fails to operate within the approved OWQP range for more than nine days in any six-month monitoring period shall resume routine WQP distribution system sampling in accordance with the number and frequency requirements in paragraph (2) of this subsection. Any system required to return to routine frequency for lead and copper tap sampling under subsection (c)(2)(A)(ii) of this section shall also return to routine WQP monitoring.

(E) Entry point WQP monitoring. Systems on reduced WQP monitoring shall measure WQPs at every entry point to the dis-

tribution system, except as provided under paragraph (6) of this subsection.

(6) Distribution system sampling for systems using only groundwater. The executive director may allow a system using only groundwater to perform WQP sampling required by paragraphs (3), (4), or (5) of this subsection to sample only at representative distribution system sites, and to forego sampling at entry points. Prior to foregoing entry point monitoring, the system shall provide written information identifying the selected entry points and documentation, including information on seasonal variability, sufficient to demonstrate that the sites are representative of water quality and treatment conditions throughout the system to the executive director for approval.

(f) Corrosion control. Systems may be required to perform corrosion control studies to determine whether treatment is necessary to reduce the corrosivity of the water. Systems may be required to install optimal corrosion control treatment in order to control corrosion in the system. The executive director may modify the designated corrosion control treatment or parameters. A system's request for changes and executive director response pursuant to modification shall be in writing.

(1) Corrosion control studies. Systems may be required to perform corrosion control studies to determine whether treatment is necessary to reduce the corrosivity of the water.

(A) Corrosion control studies applicability. Systems that meet the conditions in this subparagraph are required to perform corrosion control studies.

(i) Corrosion control studies for systems serving more than 50,000 people. Systems serving more than 50,000 people are required to conduct corrosion control studies unless the executive director has determined that the system is currently deemed to have optimized corrosion control, as defined in subsection (b)(5) of this section.

(I) Systems serving more than 50,000 people that exceed either the lead or copper action level during any a reduced tap sampling monitoring round must perform a corrosion control study within six months.

(II) Systems serving more than 50,000 people that have not been deemed at any previous time that exceed lead or copper action levels must conduct a demonstration study as described in subparagraph (C) of this paragraph.

(III) The corrosion control study must be conducted and submitted within 12 months after the end of the monitoring period in which the system exceeded the action level.

(ii) Corrosion control studies for systems serving 50,000 or fewer people. Any system serving 50,000 or fewer people that exceeds the lead or copper action level must perform a corrosion control study to identify optimal corrosion control treatment for the system. The system must conduct the study within 12 months after the end of the monitoring period in which the system exceeded the action level.

(B) Scope of corrosion control study. A system required to perform a corrosion control study shall include evaluation of treatment methods and potential constraints to treatment.

(i) Corrosion control treatment methods. Any public water system performing a corrosion control study shall evaluate the effectiveness of each of the following treatments (or combinations of treatments) to identify the optimal control treatment:

(I) alkalinity [~~Alkalinity~~] and pH adjustment;

(II) calcium [~~Calcium~~] hardness adjustment; and

(III) the [~~The~~] addition of a phosphate or silicate based corrosion inhibitor at a concentration sufficient to maintain an effective residual concentration in all test tap samples.

(ii) Potential constraints to corrosion control treatment methods. The system shall identify all chemical or physical constraints that limit or prohibit the use of a particular corrosion control treatment. The system shall evaluate the effect of the chemicals used for corrosion control treatment on other water quality treatment processes. The system shall document treatment considerations with at least one of the following:

(I) data [~~Data~~] and documentation showing that a particular corrosion control treatment has adversely affected other water treatment processes when used by another water system with comparable water quality characteristics, or

(II) data [~~Data~~] and documentation demonstrating that the water system has previously attempted to evaluate a particular corrosion control treatment and has found that the treatment is ineffective or adversely affects other water quality treatment processes.

(C) Demonstration corrosion control study requirements. The water system shall conduct this evaluation using pipe rig/loop tests, metal coupon tests, or partial systems tests called a demonstration study. The water system shall measure the parameters in this clause in any tests conducted under this subparagraph before and after evaluating the corrosion control treatments listed in subparagraph (B) of this paragraph [~~above~~]:

(i) lead [~~Lead~~];

(ii) copper [~~Copper~~];

(iii) pH;

(iv) alkalinity [~~Alkalinity~~];

(v) calcium [~~Calcium~~];

(vi) conductivity [~~Conductivity~~];

(vii) orthophosphate [~~Orthophosphate~~] (when an inhibitor containing a phosphate compound is used);

(viii) silicate [~~Silicate~~] (when an inhibitor containing a silicate compound is used); and

(ix) water [~~Water~~] temperature.

(D) Desk-top corrosion control study requirements. A desk-top corrosion control study shall recommend treatment and OWQPs based on data for treatments in documented analogous systems called a desk-top study. Analogous system means a system of similar size, water chemistry, and distribution system configuration. The water system shall evaluate each of the corrosion control treatments in subparagraph (B)(i) of this paragraph.

(2) Setting approved OWQP ranges based on corrosion control study data. On the basis of the corrosion control study evaluation, the water system shall recommend to the executive director, in writing, an OWQP range based on normal system operating conditions. Systems must recommend OWQPs consistent with subsection (b)(4) of this section. The executive director will review the study and designate OWQPs. The executive director shall designate OWQP ranges based on the results of lead, copper, and WQP monitoring by the system, both before and after the system installs optimal corrosion control treatment. The executive director may designate values for additional water quality control parameters determined to reflect optimal corrosion control for the system. The executive director shall notify the system in writing of these determinations and will provide the basis for the decision.

(3) Optimal corrosion control treatment designation. A system exceeding the action level for lead or copper based on the 90th percentile level shall submit recommendations for optimal corrosion control treatment within six months after the end of the monitoring period during which it exceeds one of the action levels. The executive director shall designate the optimal corrosion control treatment method.

(A) On the basis of the corrosion control study in paragraph (1) of this subsection, lead and copper tap sampling, and WQP sampling the water system shall recommend to the executive director, in writing, the treatment option that constitutes optimum corrosion control. The system shall submit all corrosion control data and shall provide sufficient documentation as required by the executive director to establish the validity of the evaluation procedure.

(B) The executive director shall designate optimal corrosion control treatment. The executive director shall either approve the corrosion control treatment option recommended by the system, or designate alternative corrosion control treatment(s) from among those listed in paragraph (1)(B)(i) of this subsection. When designating optimal treatment the executive director shall consider the effects that additional corrosion control treatment will have on water quality parameters and on other water quality treatment processes. If the executive director requests additional information, the water system shall provide the information.

(C) Upon its own initiative or in response to a request by a water system or other interested party, the executive director may modify the determination of the optimal corrosion control treatment. A request for modification by a system or other interested party shall be in writing, explain why the modification is appropriate, and provide supporting documentation. The executive director may modify the determination when the change is necessary to ensure that the system continues to optimize corrosion control treatment. A revised determination shall be made in writing, set forth the new treatment requirements, explain the basis for the decision, and provide an implementation schedule for completing the treatment modifications.

(D) The executive director shall notify the system of the decision on optimal corrosion control treatment in writing and will provide the basis for this determination. The executive director will review the study and designate optimal corrosion control treatment and water quality parameters.

(i) For systems serving more than 50,000 customers, optimal corrosion control treatment and OWQPs shall be designated within six months of submittal.

(ii) For systems serving 3,300 to 50,000 customers, optimal corrosion control treatment and OWQPs shall be designated within 18 months of submittal.

(iii) For systems serving fewer than 3,300, optimal corrosion control treatment and OWQPs shall be designated within 24 months of submittal.

(4) Installation of optimal corrosion control treatment. A system shall perform corrosion control activities identified in their approved corrosion control study. A system shall install optimal corrosion control treatment within 24 months after the executive director designates optimal corrosion control treatment and notifies the water system. All applicable water systems shall operate optimal corrosion control treatment in a manner that minimizes lead and copper concentrations at users' taps while ensuring that the treatment does not cause the system to violate any other drinking water standard.

(5) Operation of corrosion control treatment. All systems optimizing corrosion control shall continue to operate and maintain optimal corrosion control treatment, including operating within approved OWQP ranges and complying with all other requirements of this section.

(A) The executive director shall evaluate the results of all lead and copper tap samples and WQP samples submitted by the water system to determine whether the corrosion control treatment was properly installed and if the system is properly operating the designated optimal corrosion control treatment.

(B) The system shall operate in such a manner as to meet any requirements that the executive director determines appropriate to ensure optimal corrosion control treatment is maintained.

(6) Small system activities cessation. A system serving 50,000 or fewer people that is required to perform corrosion control activities because of an action level exceedance may cease the corrosion control activities if it conducts two consecutive six-month lead and copper monitoring rounds and meets the lead and copper action levels based on the 90th percentile in both rounds.

(g) Treatment of source water lead and copper. Systems may be required to perform treatment to remove lead or copper from source water. Any system exceeding the lead or copper action level shall implement all applicable source water treatment requirements specified by the executive director under this subsection. The executive director will determine whether such treatment is required.

(1) Determination of need for source water treatment. Any system which exceeds the lead or copper action level shall recommend in writing to the executive director the installation and operation of ion exchange, reverse osmosis, lime softening or coagulation/filtration. The executive director shall evaluate all entry point water sample results, along with the corrosion control study, to determine if source water treatment is necessary. If source water treatment is required by the executive director, the system must install the treatment in accordance with the scheduling requirements specified in this subsection.

(A) The system shall submit the results for all source water samples to aid in the executive director's evaluation of whether source water treatment is necessary.

(B) The executive director may approve the treatment recommended by the system or may require installation and operation of another source water treatment from among the following: ion exchange, reverse osmosis, lime softening or coagulation/filtration.

(C) If the executive director requests additional information to aid in its review, the water system shall provide the information by the date specified by the executive director in the request.

(D) A system may recommend that no treatment be installed based upon a demonstration that source water treatment is not necessary to minimize lead and copper levels at users' taps.

(E) The executive director shall notify the system in writing of the determination and will provide the basis for the decision.

(2) Schedule for installation of treatment of source water lead and copper. If source water treatment is required, the system must install the treatment in accordance with the scheduling requirements specified in this subsection.

(A) A system exceeding the lead or copper action level shall recommend treatment to the executive director no later than 180 days after the end of the monitoring period during which the lead or copper action level was exceeded.

(B) The executive director shall make a determination regarding source water treatment within six months after the system

submits the treatment recommendation and supporting data under subparagraph (A) of this paragraph.

(C) The system shall properly install and operate the source water treatment approved by the executive director within 24 months after the executive director's determination under subparagraph (B) of this paragraph.

(D) The system shall complete follow-up tap sampling under subsection (c) of this section and entry point monitoring under subsection (d) of this section within 36 months after the executive director's determination of source water treatment under subparagraph (B) of this paragraph.

(3) Operation of source water lead and copper treatment. If source water treatment is required, the system shall properly operate the treatment in compliance with the specified MPLs for lead and copper and continue entry point monitoring under subsection (d) of this section.

(A) A water system shall operate the source water treatment in a manner that maintains lead and copper levels below the MPLs designated by the executive director at each entry point.

(B) The executive director may review the system's data and determine whether the system has properly installed and operated the source water treatment.

(4) Modification of source water treatment decisions. Upon its own initiative or in response to a request by a water system or other interested party, the executive director may modify the determination of the source water treatment under paragraph (1) of this subsection, or MPLs for lead and copper at entry points under subsection (b)(6) of this section. A request for modification by a system or other interested party shall be in writing, explain why the modification is appropriate, and provide supporting documentation. The executive director may modify the determination when the change is necessary to ensure that the system continues to minimize lead and copper concentrations in water entering the distribution system. A revised determination shall be made in writing, set forth the new treatment requirements, explain the basis for the executive director's decision, and provide an implementation schedule for completing the treatment modifications.

(h) Analytical methods, sample collection, and sample invalidation. All methods used for analysis under this section shall be consistent with 40 Code of Federal Regulations (CFR) Part 141, Subpart I, concerning Lead and Copper.

(1) Lead and copper tap sample collection method. A first draw tap sample means a one liter or one quart sample of tap water collected from a cold water, frequently used interior tap, after the water has been standing in the plumbing for at least six hours without first flushing the tap. The kitchen cold water faucet is the preferred sampling tap at residential sites. It is recommended that the water not be allowed to stand in the plumbing for more than 18 hours prior to a sample collection. A sample collection may be conducted by either water system personnel or the residents. If the resident is allowed to collect samples for lead and copper monitoring, the water system must provide written instructions for sample collection procedures.

(2) Lead and copper tap sample analytical methods. Analysis for lead and copper shall be conducted using methods stated in 40 CFR §141.89, in laboratories accredited by the executive director. Analysis for pH, conductivity, calcium, alkalinity, orthophosphate, silica, and temperature may be conducted in any laboratory approved by the executive director under §290.121 of this title utilizing the EPA [~~United States Environmental Protection Agency (EPA)~~] methods prescribed in 40 CFR §141.89.

(A) The PQLs and the method detection limits [~~Method Detection Limits~~] (MDLs) must comply with 40 CFR §141.89. The laboratory accredited for the analysis of lead and copper tap samples must achieve the MDL of 0.001 mg/L for lead if composited entry point water samples are analyzed for lead.

(B) The executive director may allow the use of previously collected monitoring data if the data were collected in accordance with 40 CFR §141.89.

(C) All lead levels measured between the PQL and MDL must either be reported as measured or reported as one-half the PQL. All levels below the lead MDLs must be reported as zero.

(D) All copper levels measured between the PQL and the MDL must be either reported as measured or reported as one-half the PQL. All levels below the copper MDL must be reported as zero.

(E) First-draw-tap samples must be received in the laboratory within 14 days after the collection date.

(3) Lead and copper tap sample invalidation. The executive director may invalidate a lead or copper tap sample if one of the conditions in subparagraphs (A) - (D) of this paragraph is met:

(A) The laboratory establishes that improper sample analysis caused erroneous results.

(B) The executive director determines that the sample was taken from an inappropriate site.

(C) The sample was damaged in transit.

(D) The executive director determines that the sample was subject to tampering, as based on substantial documentation.

(E) The executive director shall not invalidate a sample based solely on the fact that a follow-up sample result is higher or lower than the original sample. [~~n~~]

(F) The water system must provide written documentation to the executive director for samples the water system believes should be invalidated. The executive director must document any decision to invalidate a sample in writing.

(4) Water quality parameter analytical methods. Water quality parameter testing must be conducted at a laboratory that uses the methods described in 40 CFR §141.89, and it is the responsibility of the water system to collect, submit, and report these values.

(A) Analyses for lead, copper, pH, conductivity, calcium, alkalinity, orthophosphate, silica, and temperature shall be conducted in accordance with 40 CFR §141.23(k)(1).

(B) Analyses for alkalinity, calcium, conductivity, orthophosphate and phosphate compounds, pH, silica, and temperature must be performed by a lab approved by the executive director under the Texas Commission on Environmental Quality [~~TCEQ~~] Regulatory Guidance 384 "How to Develop a Monitoring Plan for a Public Water System." Analyses under this section for lead and copper shall only be conducted by laboratories that have been accredited by the executive director under [~~30 TAC~~] Chapter 25, Subchapter B of this title (relating to Environmental Testing Laboratory Accreditation and Certification).

(C) The executive director may allow the use of previously collected monitoring data for purposes of monitoring, if the data were collected and analyzed in accordance with the requirements of this section and 40 CFR Part 141, Subpart I.

(i) Reporting. Systems shall report any information required by this section and 40 CFR Part 141, Subpart I to the executive director.

(1) Reporting lead and copper tap sample results. Tap sample results shall be reported within ten days following the end of each monitoring period as specified by the executive director. For systems on annual or less frequent schedules, the end of the monitoring period is September 30 of the calendar year in which the sampling occurs, or if the executive director has established an alternate monitoring period, the last day of that period.

(A) A system shall provide documentation for each tap water lead or copper sample for which the water system requests invalidation.

(B) The system shall provide the following information to the executive director:

(i) the [~~The~~] results of all tap samples for lead and copper including the location of each site and the criteria under which the site was selected for the system's sampling pool; and [.]

(ii) an [~~An~~] identification of sampling sites utilized during the current monitoring period that were not sampled during previous monitoring periods, and an explanation why sampling sites have changed.

(2) Reporting entry point lead and copper sample results. A water system shall report the sampling results for all source water samples collected in accordance with subsection (e) of this section within the first 10 days following the end of each source water monitoring period.

(3) Reporting WQP results. Systems must report all results of WQP analyses including the location/address of each distribution system sampling point. This report must include each WQP specified in subsection (e) of this section, as well as all sample results from entry points to the distribution system. WQP reports should be submitted to the executive director within the first ten days following the end of each applicable monitoring period. For monitoring periods with a duration less than six months, the end of the monitoring period is the last date samples can be collected during that period.

(A) Systems shall report the results of all distribution samples for pH, and where applicable, alkalinity, calcium, conductivity, temperature, and orthophosphate or silica.

(B) Systems shall report the results of all samples collected at the entry point(s) to the distribution system for applicable water quality parameters.

(C) A system using only groundwater that is allowed to limit WQP monitoring to a subset of entry points shall report, by the commencement of such monitoring, written correspondence to the executive director that identifies the sources flowing to each of the system's entry points and report information sufficient to demonstrate that the sites are representative of water quality and treatment conditions throughout the system.

(4) Reporting distribution material and sample site data. New systems shall submit the first material survey by December 31 of the year in which they are assigned a Public Water System Identification Number. The executive director may allow a system to submit the first material survey by December 31 of the year in which the system's status becomes active.

(A) All systems shall submit Materials Survey and Site Selection Forms (TCEQ Form Number 20467) describing the entire system before performing tap sampling.

(B) Any system seeking reduced nine-year tap sampling under subsection (c)(2)(D) of this section shall submit current documentation showing that there are no lead- or copper-containing materials within the distribution system.

(i) Prior to starting reduced nine-year tap sampling, a system shall submit documentation showing that there are no lead- or copper- containing materials within the distribution system and that the system complies with all drinking water standards of this subchapter.

(ii) No later than nine years after the first nine-year tap samples are collected, any system desiring to remain on reduced nine-year tap sampling shall provide updated documentation showing that there are no lead- or copper- containing materials within the distribution system and that the system complies with all drinking water standards of this subchapter.

(iii) No later than 60 days after detecting lead-containing and/or copper-containing material, as appropriate, each system with a reduced nine-year tap sampling schedule [~~waiver~~] shall provide written notification to the executive director, setting forth the circumstances resulting in the lead-containing or copper-containing materials being introduced into the system and what corrective action, if any, the system plans to remove these materials.

(C) Water systems requesting a change to previously approved sample sites shall report supporting information, including an explanation as to why a sampling site was changed from the previous round of sampling, if applicable. If a water system changes a sampling site for any reason allowed in this section, the water system must provide the executive director with a written explanation showing which sampling site will be abandoned and the sampling site that replaces the abandoned sampling site.

(5) Reporting public education. A system that is required to perform public education must provide copies of public education materials and certification that distribution of said materials is being conducted in accordance with this subsection to the executive director within ten days after the delivery of the materials to the public.

(6) Reporting consumer notification. No later than three months following the end of the monitoring period, each system must mail a sample copy of the consumer notification of tap results to the executive director along with a certification that the notification has been distributed in a manner consistent with the requirements of subsection (j) of this section.

(7) Corrosion control reporting. Systems that are required to perform corrosion control studies and install corrosion control treatment shall report all information required under subsection (f) of this section. Corrosion control treatment data shall be reported as required by the executive director. Systems shall report the following information listed in this paragraph.

(A) Systems demonstrating that they have already optimized corrosion control, must provide all information required in subsection (f) of this section.

(B) Systems that are recommending optimal corrosion control treatment must provide all supporting documentation for their recommendation regarding optimal corrosion control treatment under 40 CFR §141.82(a).

(C) Systems that are required to evaluate the effectiveness of corrosion control treatments under subsection (f) of this section, must submit the information required by that section.

(D) Systems required to install optimal corrosion control designated by the executive director under 40 CFR §141.82(d), must submit a letter certifying that the system has completed installing that treatment.

(8) Reporting source treatment. A system that is required to install source water lead or copper removal treatment must certify in writing that the system has completed installing the approved treatment within 24 months after the executive director approved that treatment.

(9) Reporting system conditions and facility changes. Systems must report changes of system conditions and facilities that may impact corrosion to the executive director.

(A) The water system must inform the executive director of the identity of treated and non-treated entry points and their seasonal use, if any, and demonstrate that the WQPs represent water quality and treatment conditions throughout the system.

(B) At a time specified by the executive director, or if no specific time is designated by the executive director, then as early as possible prior to the addition of a new source or any long-term change in water treatment, a water system deemed to have optimized corrosion control or subject to reduced tap sampling shall submit written documentation to the executive director describing the change or addition. The water system may not implement the addition of a new source or long-term change in treatment until notified in writing that the change is approved by the executive director. Examples of long-term treatment changes include the addition of a new treatment process or modification of an existing treatment process. Examples of modifications include switching secondary disinfectants, switching coagulants (for example, alum to ferric chloride), and switching corrosion inhibitor products (for example, orthophosphate to blended phosphate). Long-term changes can include dose changes to existing chemicals if the system is planning long-term changes to its finished water pH or residual inhibitor concentration. Long-term treatment changes would not include chemical dose fluctuations associated with daily raw water quality changes.

(10) Other reporting. Any system which collects sampling data in addition to that required by this section shall report the results to the executive director within the first ten days following the end of the applicable monitoring period during which the samples are collected.

(11) Reporting lead service line replacement. A water system that is replacing lead service lines must certify that lead service lines have been replaced in accordance with directives of the executive director.

(j) Consumer notification. All water systems must provide a consumer notice of lead tap water monitoring results to persons served at the sites (taps) that are tested.

(1) Timing of consumer notification. A water system must provide the consumer notice as soon as practical, but no later than 30 days after the system receives the tap sampling results.

(2) Content of consumer notification. The consumer notice must include the results of lead tap sampling for the tap that was tested, an explanation of the health effects of lead, list steps consumers can take to reduce exposure to lead in drinking water, and contact information for the water utility. The notice must also provide the maximum contaminant level goal and the action level for lead and the definitions for these two terms from 40 CFR §141.153(c).

(3) Delivery of consumer notification. The consumer notice must be provided to persons served at the tap that was tested, either by mail or by another method approved by the executive director. Upon approval by the executive director, a nontransient, noncommunity water system may post the results on a bulletin board in the facility to allow users to review the information. The system must provide the notice to customers at sample taps tested, including consumers who do not receive water bills.

(k) Public education. A public water system that exceeds the lead action level based on tap water samples collected in accordance with subsection (c) of this section shall deliver the public education materials in accordance with the requirements of this subsection.

(1) Content of public education materials. Public water [~~Water~~] systems must include the elements in this paragraph in their printed materials in the same order as listed. Language in subparagraphs (A), (B), and (F) of this paragraph must be included in the materials, exactly as written, except for the text in brackets for which the public water system must include system-specific information. Any additional information presented by a public water system must be consistent with the information below and be in plain language that can be understood by the general public. Water systems must submit all written public education materials to the executive director prior to delivery. Public education materials must be approved by the executive director prior to delivery.

(A) "IMPORTANT INFORMATION ABOUT LEAD IN YOUR DRINKING WATER. {INSERT NAME OF WATER SYSTEM} found elevated levels of lead in drinking water in some homes/buildings. Lead can cause serious health problems, especially for pregnant women and young children. Please read this information closely to see what you can do to reduce lead in your drinking water."

(B) *"Health effects of lead."* Lead can cause serious health problems if too much enters your body from drinking water or other sources. It can cause damage to the brain and kidneys, and can interfere with the production of red blood cells that carry oxygen to all parts of your body. The greatest risk of lead exposure is to infants, young children, and pregnant women. Scientists have linked the effects of lead on the brain with lowered IQ in children. Adults with kidney problems and high blood pressure can be affected by low levels of lead more than healthy adults. Lead is stored in the bones, and it can be released later in life. During pregnancy, the child receives lead from the mother's bones, which may affect brain development."

(C) Sources of lead.

(i) Explain what lead is.

(ii) Explain possible sources of lead in drinking water and how lead enters drinking water. Include information on home and building plumbing materials and service lines that may contain lead.

(iii) Discuss other important sources of lead exposure in addition to drinking water such as lead-based paint or lead-contaminated soils.

(D) Discuss the steps the consumer can take to reduce their exposure to lead in drinking water.

(i) Encourage running the water to flush out the lead.

(ii) Explain concerns with using hot water from the tap and specifically caution against the use of hot water for preparing baby formula.

(iii) Explain that boiling water does not reduce lead levels.

(iv) Discuss other options consumers can take to reduce exposure to lead in drinking water, such as alternative sources or treatment of water.

(v) Suggest that parents have their child's blood tested for lead.

(E) Explain why there are elevated levels of lead in the system's drinking water (if known) and what the water system is doing to reduce the lead levels in homes and buildings in this area.

(F) "For more information, call us at {INSERT YOUR SYSTEM's PHONE NUMBER} if applicable) or visit our website [~~Web site~~] at {INSERT YOUR WEBSITE [~~WEB SITE~~] HERE}. For more information on reducing lead exposure around your home or building and the health effects of lead, visit EPA's website [~~Web site~~] *at www.epa.gov/lead* or contact your health care provider."

(G) In addition to including the elements specified in subparagraphs (A) - (F) of this paragraph, community water systems must:

(i) tell [~~Tell~~] consumers how to get their water tested, and

(ii) discuss [~~Discuss~~] lead in plumbing components and the difference between low lead and lead free.

(H) For public water systems serving a large proportion of non-English speaking consumers, as determined by the executive director, the public education materials must contain information in the appropriate language(s) regarding the importance of the notice or contain a telephone number or address where persons served may contact the water system to obtain a translated copy of the public education materials or to request assistance in the appropriate language.

(2) Delivery of public education materials by community systems. Systems must provide public education materials meeting the criteria of paragraph (1) of this subsection to the public in accordance with this paragraph.

(A) A community system must directly deliver printed public education materials to all bill paying customers.

(i) The community system must deliver public education materials to local public health agencies even if they are not located within the water system's service area, along with an informational notice that encourages distribution to all the organization's potentially affected customers or community water system's users. The system must contact the local public health agencies directly by phone or in person. The local public health agencies may provide a specific list of additional community based organizations serving target populations, which may include organizations outside the service area of the water system. If such lists are provided, systems must deliver public education materials to all organizations on the provided lists.

(ii) The community system must contact customers who are most at risk by delivering public education materials to the organizations listed in this clause that are located within the water system's service area, along with an informational notice that encourages distribution to all the organization's potentially affected customers or community water system's users.

(I) Public and private schools or school boards;

(II) Women, Infants and Children (WIC) and Head Start programs;

(III) Public and private hospitals and medical clinics;

(IV) Pediatricians;

(V) Family planning clinics; and

(VI) Local welfare agencies.

(iii) The community system must make a good faith effort to locate organizations of the types listed in this clause within the service area and deliver public education materials to them, along with an informational notice that encourages distribution to all potentially affected customers or users. The good faith effort to contact at-risk customers may include requesting a specific contact list of these organizations from the local public health agencies, even if the agencies are not located within the water system's service area.

(I) Licensed childcare centers;

(II) Public and private preschools; and

(III) Obstetricians-Gynecologists and Midwives.

(iv) The community system must implement at least three activities from one or more categories listed in this clause. The educational content and selection of these activities must be determined in consultation with the executive director.

(I) Public service announcements;

(II) Paid advertisements;

(III) Public area information displays;

(IV) E-mails to customers;

(V) Public meetings;

(VI) Household deliveries;

(VII) Targeted Individual Customer Contact;

(VIII) Direct material distribution to all multi-family homes and institutions; or

(IX) Other methods approved by the executive director.

(v) At least quarterly, the community system must provide information on or in each water bill as long as the system exceeds the action level for lead. The message on the water bill must include the following statement exactly as written except for the text in brackets for which the water system must include system-specific information: "{INSERT NAME OF WATER SYSTEM} found high levels of lead in drinking water in some homes. Lead can cause serious health problems. For more information please call {INSERT NAME OF WATER SYSTEM}" Upon written request, the executive director may allow a separate mailing of public education materials to customers if the water system cannot place the information on water bills.

(vi) A community system serving more than 100,000 people must post public education materials on the water system's website [~~Web site~~].

(vii) The community system must submit a press release to newspaper, television and radio stations.

(B) With executive director approval, a community public water system serving 3,300 or fewer people may limit certain aspects of their public education programs by distributing the public education materials required by subparagraph (A)(ii) of this paragraph to facilities and organizations served by the public water system that are most likely to be visited regularly by pregnant women and children. In addition:

(i) The executive director may waive the requirement of subparagraph (A)(vii) of this paragraph, to submit press releases to the media, as long as the public water system distributes notices to every household served by the system [~~The system may be allowed to deliver public education materials to only those potentially affected customers listed in subparagraph (A)(ii) of this paragraph served by the system that are most likely to be visited regularly by pregnant women and children~~].

(ii) The public water system shall implement at least one of the requirements found in subparagraph (A)(iv) of this paragraph [~~executive director may waive the requirement of subparagraph (A)(vi) of this paragraph to submit press releases to the media as long as system distributes notices to every household served by the system~~].

~~*[(iii)* The system may be allowed to perform only one of the additional activities in subparagraph (A)(vii) of this paragraph instead of three activities.]~~

(C) A community water system may apply to the executive director, in writing, to use only the text specified in paragraph (1)(A) - (F) of this subsection, omitting the text specified in paragraph (1)(G) of this subsection, and to post public education materials as described in paragraph (3) of this subsection, omitting the tasks in subparagraph (A) of this paragraph if:

(i) The system is a facility, such as a prison or a hospital, where the population served is not capable of or is prevented from making improvements to plumbing or installing point of use treatment devices; and

(ii) The system provides water as part of the cost of services provided and does not separately charge for water consumption.

(3) Delivery of public education materials by nontransient, noncommunity systems. Systems must provide public education materials meeting the criteria of paragraph (1) of this subsection to the public in accordance with this paragraph.

(A) The system must post informational posters on lead in drinking water in a public place or common area in each of the buildings served by the system.

(B) The system must distribute informational brochures on lead in drinking water to each person served by the nontransient, noncommunity water system. The executive director may allow the system to utilize electronic transmission in lieu of or combined with printed materials as long as it achieves at least the same coverage.

(4) Frequency and timing of public education. A system that exceeds the lead action level must provide educational materials meeting the content requirements of paragraph (1) of this subsection to the public within 60 days after the end of the monitoring period in which the exceedance occurred. For systems that are required to conduct monitoring annually or less frequently, the end of the monitoring period is September 30 of the calendar year in which the sampling occurs, or, if the executive director has established an alternate monitoring period, the last day of that period.

(A) Frequency and timing of public education activities for community systems. As long as a community water system exceeds the action level, it must repeat the activities of this paragraph at the frequency contained in this paragraph.

(i) A community system shall repeat tasks contained in paragraph (2)(A)(v) of this subsection every billing cycle.

(ii) A community system serving a population greater than 100,000 shall post and retain material on a publicly accessible website [~~Web site~~].

(iii) The community system shall repeat the press release task in paragraph (2)(A)(vii) of this subsection twice every 12 months on a schedule agreed upon with the executive director.

(B) Frequency and timing of public education activities for nontransient, noncommunity systems. A nontransient, noncommunity water system shall maintain the posting required by repeat the tasks contained in paragraph (3) of this subsection at least once during each calendar year in which the system exceeds the lead action level. Posted materials must remain posted until the system no longer exceeds the lead action level, and the executive director informs the system that the posting may be discontinued.

(C) Extension to public education start date. A nontransient, noncommunity system may request, and the executive director can approve, an extension for starting public education beyond the 60-day requirement on a case-by-case basis. The request and approval must be made in writing prior to the 60-day deadline.

(D) Discontinuing public education. A system may discontinue delivery of public education materials if the system has met the lead action level during the most recent six-month monitoring period conducted pursuant to subsection (c) of this section. Such a system shall recommence public education in accordance with this section if it subsequently exceeds the lead action level during any monitoring period.

(5) Notifying the executive director of public education activities. Any water system that is subject to the public education requirements of this subsection shall, within ten days after the end of each period in which the system is required to perform public education, send written documentation to the executive director containing all the elements in this paragraph.

(A) The system must provide documentation that the system has delivered the public education materials that meet the content requirements in paragraph (1) of this subsection and the delivery requirements in paragraph (2) or (3) of this subsection.

(B) The system must provide a list of all the newspapers, radio stations, television stations, and facilities and organizations to which the system delivered public education materials during the period in which the system was required to perform public education tasks.

(C) The system must resubmit certification of delivery of public education materials every time it distributes materials. Unless required by the executive director, a system that previously has submitted the information required by subparagraphs (A) and (B) of this paragraph need not resubmit the information as long as there have been no changes in the distribution list.

(l) Compliance determination. All applicable water systems shall determine compliance based on monitoring and reporting requirements established in this section or contained in 40 CFR Part 141, Subpart I.

(1) Compliance determination with action levels of subsection (b) of this section for lead and copper shall be based on the 90th percentile as described in this paragraph.

(A) The 90th percentile lead and copper levels shall be computed as provided in this subparagraph:

(i) Determination of 90th percentile levels shall be obtained by ranking the results of lead and copper samples collected during a monitoring period in ascending order (lowest concentration is sample Number 1; highest concentration are samples Numbers 10, 20, 30, 40, 50, and so on), up to the total number of samples collected.

(ii) The number of samples collected during the monitoring period shall be multiplied by 0.9. The concentration of lead and copper in sample with the number yielded by this calculation is the 90th percentile level, for systems serving 100 or more people.

(iii) For water systems serving fewer than 100 people, the 90th percentile level is computed by taking the average of the highest two sample results.

(iv) For a public water system that has been allowed by the executive director to collect fewer than five samples in accordance with subsection (c)(1)(F) of this section, the sample result with the highest concentration is considered the 90th percentile value.

(B) A sample invalidated under this section does not count toward determining lead or copper 90th percentile levels or toward meeting the minimum number of tap sample requirements.

(C) Monitoring approved by the executive director and conducted by systems in addition to the minimum requirements of this section shall be considered by the executive director in making any determination of compliance.

(D) The system is in compliance with the lead or copper action levels if the 90th percentile level of lead or copper, respectively, is equal to or less than the action levels specified in subsection (b)(1) of this section.

(2) Compliance determination for water quality parameters. If a water system fails to meet the OWQP values or ranges approved by the executive director, it is out of compliance with this section. WQP confirmation sample results will be included in compliance determination.

(A) A OWQP-range excursion occurs whenever the daily value for one or more WQPs measured at a sampling location is below a minimum value or outside a range approved by the executive director. The executive director has the discretion to delete results of obvious sampling errors from this calculation. Daily values are calculated as follows.

(i) Water systems that collect more than one WQP measurement in one day must record the daily value as an average of all WQP values collected during the day regardless of whether the measurements are collected through continuous monitoring, grab sampling, or a combination of both.

(ii) On days when only one measurement for the WQP is collected at the sampling location, the daily value shall be the result of that measurement.

(iii) On days when no measurement is collected for the WQP at the sampling location, the daily value last calculated on the most recent day shall serve as the daily value.

(B) Compliance periods for this paragraph are two six-month periods, January 1 to June 30, and July 1 to December 31. A water system is out of compliance with this subsection for a six-month period if the water system has OWQP excursions for any approved range for more than nine days during that period.

(C) The results of any monitoring conducted in addition to the minimum requirements of this section shall be considered by the system and the executive director in making any determinations under this section.

(D) The executive director may delete results of obvious sampling errors from this calculation.

(3) Compliance determination for source water treatment. A system required to install and operate source water treatment for lead or copper under subsection (g) of this section is out of compliance if the level of lead or copper in any sample collected under subsection (d)(2)(D)(v) of this section is greater than the MPL designated by the executive director. The initial and confirmation sample shall be averaged in determining compliance. Any sample value below the method detection limit shall be considered to be zero. Any value above the method detection limit but below the PQL shall either be considered as the measured value or be considered one-half the PQL.

(4) Compliance determination for public education. Failure to deliver public education materials required under subsection (k) of this section to customers is a public notification violation. Failure to certify delivery of public education materials to the executive director is a reporting violation.

(5) Failure to conduct or report any requirements of this section shall constitute a monitoring, reporting or treatment technique violation and shall be a violation of these standards.

(m) Lead service line replacement. The provisions of 40 CFR §141.84 and §141.90(e) relating to lead service line replacement are adopted by reference. Any system exceeding the lead action level after implementation of applicable corrosion control and source water treatment requirements shall complete the lead service line replacement requirements contained in 40 CFR §141.84. Any such water system shall submit reports required under 40 CFR §141.90(e).

(n) Additional sampling. The executive director may require systems to sample at additional times or locations in order to ensure that systems maintain minimal levels of corrosion in the distribution system.

§290.118. Secondary Constituent Levels.

(a) Applicability for secondary constituents. The requirements for secondary constituents apply to all public water systems. Water that does not meet the secondary constituent levels may not be used for public drinking water without written approval from the executive director. When drinking water that does not meet the secondary constituent levels is accepted for use by the executive director, such acceptance is valid only until such time as water of acceptable chemical quality can be made available at reasonable cost to the area(s) in question.

(b) Secondary constituent levels. The maximum secondary constituent levels are as follows.
Figure: 30 TAC §290.118(b) (No change.)

(c) Monitoring frequency for secondary constituents. All public water systems shall monitor for secondary constituents at the following frequency.

(1) Each groundwater source shall be sampled once every three years at the entry point to the distribution system.

(2) Each surface water source shall be sampled annually at the entry point to the distribution system.

(3) Each of the sampling frequencies listed in paragraph (3) of this subsection constitute one round of sampling for groundwater and surface water systems, respectively.

(d) Analytical requirements for secondary constituents. All analyses for determining compliance with the provisions of this subsection shall be conducted in accordance with §290.119 of this title (relating to Analytical Procedures) at a facility certified by the executive director.

(e) Reporting requirements for secondary constituents. Any owner or operator of a public water system subject to the provisions of this section is required to report to the executive director the results of any test, measurement, or analysis required to be made by this section within ten days following receipt of results of such test, measurement, or analysis.

(f) Compliance determination for secondary constituents. Compliance with the requirements of this subsection shall be based on the following criteria:

(1) A public water system that fails to conduct the monitoring tests required by this subsection commits a monitoring violation;

(2) A public water system that fails to report the results of the monitoring tests required by this subsection commits a reporting violation; and

(3) A public water system that exceeds the secondary constituent levels in subsection (b) of this section commits a secondary constituents level violation.

(g) Public notification for secondary constituents. Public notification must be consistent with the requirements of §290.122 of this title (relating to Public Notification).

(1) Community and nontransient, noncommunity water systems that exceed the secondary [~~maximum~~] constituent level for fluoride but are below the maximum contaminant level listed in §290.106 of this title (relating to Inorganic Contaminants) must notify the public. The notice must be made annually by including it with the water bill or by separate mailing to all customers. The form and content of the notice shall be as prescribed by the executive director.

(2) If a system exceeds the secondary constituent levels, notice must be given to new customers and in the annual Consumer Confidence Report [~~consumer confidence report~~].

§290.119. Analytical Procedures.

(a) Acceptable laboratories. Samples collected to determine compliance with the requirements of this chapter shall be analyzed at accredited or approved laboratories.

(1) Samples used to determine compliance with the maximum contaminant levels, samples used to determine compliance with action level, and raw groundwater source monitoring requirements of this subchapter, and samples for microbial contaminants must be analyzed by a laboratory accredited by the executive director in accordance with Chapter 25 of this title (relating to Environmental Testing Laboratory Accreditation and Certification). These samples include:

(A) compliance samples for synthetic organic chemicals;

(B) compliance samples for volatile organic chemicals;

(C) compliance samples for inorganic contaminants;

(D) compliance samples for radiological contaminants;

(E) compliance samples for microbial contaminants;

(F) compliance samples for total trihalomethanes (TTHM);

(G) compliance samples for haloacetic acid-group of five (HAA5);

(H) compliance samples for chlorite;

(I) compliance samples for bromate; and

(J) compliance samples for lead and copper.

(2) Samples used to determine compliance with the treatment technique requirements and maximum residual disinfectant levels (MRDLs) of this subchapter must be analyzed by a laboratory approved by the executive director. These samples include:

(A) compliance samples for turbidity treatment technique requirements;

(B) compliance samples for the chlorine MRDL;

(C) compliance samples for the chlorine dioxide MRDL;

(D) compliance samples for the combined chlorine (chloramine) MRDL;

(E) compliance samples for the disinfection byproduct precursor treatment technique requirements, including alkalinity, total organic carbon, dissolved organic carbon analyses, and specific ultraviolet absorbance;

(F) samples used to monitor chlorite levels at the point of entry to the distribution system; and

(G) samples used to determine pH.

(3) Non-compliance tests, such as control tests taken to operate the system, may be run in the plant or at a laboratory of the system's choice.

(b) Acceptable analytical methods. Methods of analysis shall be as specified in 40 Code of Federal Regulations (CFR) or by any alternative analytical technique as specified by the executive director and approved by the Administrator under 40 CFR §141.27. Copies are available for review in the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087. The following National Primary Drinking Water Regulations set forth in Title 40 CFR are adopted by reference:

(1) 40 CFR §141.852(a) [~~section 141.21(f)~~] for microbiological analyses;

(2) 40 CFR §141.74(a)(1) [~~section 141.74(a)(1)~~] for turbidity analyses;

(3) 40 CFR §141.23(k) [~~section 141.23(k)~~] for inorganic analyses;

(4) 40 CFR §141.24(e) - (g) [~~section 141.24(e), (f), and (g)~~] for organic analyses;

(5) 40 CFR §141.25 [~~section 141.25~~] for radionuclide analyses;

(6) 40 CFR §141.131(a) and (b) [~~section 141.131(a) and (b)~~] for disinfection byproduct methods and analyses;

(7) 40 CFR §141.131(c) [~~section 141.131(c)~~] for disinfectant analyses other than ozone, and 40 CFR §141.74(b) [~~141.74(b)~~] for ozone disinfectant;

(8) 40 CFR §141.131(d) [~~section 141.131(d)~~] for alkalinity analyses, bromide and magnesium, total organic carbon analyses, dissolved organic carbon analyses, specific ultraviolet absorbance analyses, and pH analyses;

(9) 40 CFR §141.89 [~~section 141.89~~] for lead and copper analyses and for water quality parameter analyses that are performed as part of the requirements for lead and copper;

(10) 40 CFR §141.402(c) [~~section 141.402(c)~~] for groundwater source microbiological analyses; and

(11) if a method is not contained in this section, a drinking water quality method can be approved for analysis if it is listed in 40 CFR Part 141, Subpart C, Appendix A.

(c) The definition of detection contained in 40 CFR §141.151(d) is adopted by reference.

§290.121. Monitoring Plans.

(a) Applicability. All public water systems shall maintain an up-to-date chemical and microbiological monitoring plan. Monitoring plans are subject to the review and approval of the executive director. A copy of the monitoring plan must be maintained at each water treatment plant and at a central location.

(b) Monitoring plan requirements. The monitoring plan shall identify all sampling locations, describe the sampling frequency, and

specify the analytical procedures and laboratories that the public water system will use to comply with the monitoring requirements of this subchapter.

(1) The monitoring plan shall include information on the location of all required sampling points in the system. Required sampling locations for regulated chemicals are provided in §290.106 of this title (relating to Inorganic Contaminants), §290.107 of this title (relating to Organic Contaminants), §290.108 of this title (relating to Radionuclides Other than Radon), §290.109 of this title (relating to Microbial Contaminants), §290.110 of this title (relating to Disinfectant Residuals), §290.111 of this title (relating to Surface Water Treatment), §290.112 of this title (relating to Total Organic Carbon (TOC)), §290.113 of this title (relating to Stage 1 Disinfection Byproducts (TTHM and HAA5)), §290.114 of this title (relating to Other Disinfection Byproducts (Chlorite and Bromate)), §290.115 of this title (relating to Stage 2 Disinfection Byproducts (TTHM and HAA5)), §290.116 of this title (Relating to Groundwater Corrective Actions and Treatment Techniques), §290.117 of this title (relating to Regulation of Lead and Copper), and §290.118 of this title (relating to Secondary Constituent Levels).

(A) The location of each sampling site at a treatment plant or pump station must be designated on a plant schematic. The plant schematic must show all water pumps, flow meters, unit processes, chemical feed points, and chemical monitoring points. The plant schematic must also show the origin of any flow stream that is recycled at the treatment plant, any pretreatment that occurs before the recycle stream is returned to the primary treatment process, and the location where the recycle stream is reintroduced to the primary treatment process.

(B) Each entry point to the distribution system shall be identified in the monitoring plan as follows:

(i) a written description of the physical location of each entry point to the distribution system shall be provided; or

(ii) the location of each entry point shall be indicated clearly on a distribution system or treatment plant schematic.

(C) The address of each sampling site in the distribution system shall be included in the monitoring plan or the location of each distribution system sampling site shall be designated on a distribution system schematic. The distribution system schematic shall clearly indicate the following:

(i) the location of all pump stations in the distribution system;

(ii) the location of all ground and elevated storage tanks in the distribution system; and

(iii) the location of all chemical feed points in the distribution system.

(D) The system must revise its monitoring plan if changes to a plant or distribution system require changes to the sampling locations.

(2) The monitoring plan must include a written description of sampling frequency and schedule.

(A) The monitoring plan must include a list of all routine samples required on a daily, weekly, monthly, quarterly, annual, or less frequent basis and identify the sampling location where the samples will be collected.

(B) The system must maintain a current record of the sampling schedule.

(3) The monitoring plan shall include the public water system's Sample Siting Plan as required by §290.109(d)(6) of this title. The public water system's Sample Siting Plans shall include a list of all routine and repeat microbial sample sites as required by §290.109(d) of this title. The repeat sample sites, as required by §290.109(d)(3) of this title, shall be associated to their originating routine microbial sample sites. The Sample Siting Plan shall include all groundwater sources and any associated sampling points necessary to meet the requirements of §290.109(d) of this title.

(4) [~~(3)~~] The monitoring plan must identify the analytical procedures that will be used to perform each of the required analyses.

(5) [~~(4)~~] The monitoring plan must identify all laboratory facilities that may be used to analyze samples required by this chapter.

(6) [~~(5)~~] The monitoring plan shall include a written description of the methods used to calculate compliance with all maximum contaminant levels, maximum residual disinfectant levels, and treatment techniques that apply to the system.

(7) [~~(6)~~] The monitoring plan shall include any groundwater source water monitoring plan developed under §290.109(d)(4) [~~§290.109(c)(4)~~] of this title to specify well sampling for triggered coliform monitoring.

(8) [~~(7)~~] The monitoring plan shall include any initial distribution system evaluation compliance documentation required by §290.115(c)(5) of this title. The monitoring plan must be revised to show Stage 2 sample sites by the date shown in Figure: 30 TAC §290.115(a)(2) titled "Date to Start Stage 2 Compliance."

(9) [~~(8)~~] The monitoring plan shall include any raw surface water monitoring plan required under §290.111 of this title.

(c) Reporting requirements. All public water systems shall maintain a copy of the current monitoring plan at each treatment plant and at a central location. The water system must update the monitoring plan when the water system's sampling requirements or protocols change.

(1) Public water systems that treat surface water or groundwater under the direct influence of surface water must submit a copy of the monitoring plan to the executive director upon development and revision.

(2) Public water systems that treat groundwater that is not under the direct influence of surface water or purchase treated water from a wholesaler must develop a monitoring plan and submit a copy of the monitoring plan to the executive director upon request.

(3) All water systems must provide the executive director with any revisions to the plan upon request.

(d) Compliance determination. Compliance with the requirements of this section shall be determined using the following criteria.

(1) A public water system that fails to submit an administratively complete monitoring plan by the required date documented in a request from the executive director or fails to submit updates to a plan when changes are made to a system's surface water treatment commits a reporting violation.

(2) A public water system that fails to maintain an up-to-date monitoring plan commits a monitoring violation.

(e) Public notification. A community system that commits a violation described in subsection (d) of this section shall notify its customers of the violation in the next Consumer Confidence Report [~~consumer confidence report~~] that is issued by the system.

§290.122. Public Notification.

(a) Tier 1 public [~~Public~~] notification requirements for acute violations or situations with significant potential to have serious adverse effects on human health as a result of short-term exposure which require a Tier 1 public notice as described in this subsection. The owner or operator of a public water system must notify persons served by their system of any maximum contaminant level [~~limit~~] (MCL), maximum residual disinfectant level (MRDL), treatment technique violation, or other situation that poses an acute threat to public health. Each notice required by this section must meet the requirements of subsection (d) of this section.

(1) Situations that pose an acute threat to public health include:

(A) a violation of the *Escherichia coli (E. coli)* MCL as described in §290.109(g)(1)(A) - (D) of this title [~~acute MCL for microbial contaminants as defined in §290.109(f)(1) of this title~~] (relating to Microbial Contaminants);

(B) an acute turbidity issue at a treatment plant that is treating surface water or groundwater under the direct influence of surface water, specifically:

(i) a combined filter effluent turbidity level above 5.0 nephelometric turbidity units (NTU);

(ii) a combined filter effluent turbidity level above 1.0 NTU at a treatment plant using membrane filters; [~~or~~]

(iii) a combined filter effluent turbidity level above 1.0 NTU at a plant using other than membrane filters at the discretion of the executive director after consultation with the system; [~~or~~]

(iv) failure of a system with treatment other than membrane filters to consult with the executive director within 24 hours after a combined filter effluent reading of 1.0 NTU;

(v) failure of a system to meet turbidity level, monitoring, and/or reporting requirements as described in §290.111(i)(3) of this title (relating to Surface Water Treatment); or

(vi) failure of a system to meet treatment, turbidity level, monitoring, and/or reporting requirements as described in §290.111(i)(4) of this title;

(C) a violation of the MCL for nitrate or nitrite as defined in §290.106(f)(2) of this title (relating to Inorganic Contaminants);

(D) a violation of the acute MRDL for chlorine dioxide as defined in §290.110(f)(5)(A) or (B) of this title (relating to Disinfectant Residuals);

(E) occurrence of a waterborne disease outbreak;

(F) Detection of *E. coli* or other fecal indicators in source water samples as specified in §290.109(b)(3) [~~§290.109(b)(2)~~] of this title, which requires a public notice to be issued within 24 hours of notification of the positive sample; and

(G) other situations deemed by the executive director to pose an acute risk to human health.

(2) The initial Tier 1 acute public notice and/or boil water notice required by this subsection shall be issued as soon as possible, but in no case later than 24 hours after the violation or situation is identified. The initial public notice for an acute violation or situation shall be issued in one or more of the following manners that are reasonably calculated to reach persons served by the public water system within the required time period [~~manner~~].

(A) The owner or operator of a public water system with an acute microbiological or turbidity violation as described in paragraph (1)(A) or (B) of this subsection shall include a boil water notice issued in accordance with the requirements of §290.46(q) of this title (relating to Minimum Acceptable Operating Practices for Public Drinking Water Systems). Public water systems are not required to issue a boil water notice under the conditions as referenced in paragraph (1)(B)(vi) of this subsection, unless required at the discretion of the executive director in accordance with §290.46(q)(5) of this title.

(B) The owner or operator of a community water system shall furnish a copy of the notice to the radio and television stations serving the area served by the public water system.

(C) The owner or operator of a community water system shall publish the notice in a daily newspaper of general circulation in the area served by the system. If the area is not served by a daily newspaper of general circulation, notice shall instead be issued by direct delivery or by continuous posting in conspicuous places within the area served by the system. Other methods of delivery may include electronic delivery or alert systems (e.g., reverse 911).

(D) The owner or operator of a noncommunity water system shall issue the notice by direct delivery or by continuously posting the notice in conspicuous places within the area served by the water system. Other methods of delivery may include electronic delivery or alert systems (e.g., reverse 911).

(E) If notice is provided by posting, the posting must remain in place for as long as the violation or situation exists or seven days, whichever is longer.

(3) The owner or operator of a water system required to issue an initial notice for an acute MCL or treatment technique violation shall issue additional notices. The additional public notices for acute violations shall be issued in the following manner.

(A) Not later than 45 days after the violation, the owner or operator of a community water system shall notify persons served by the system using mail (by direct mail or with the water bill) or hand delivery. The executive director may waive mail or hand delivery if it is determined that the violation was corrected within the 45-day period. The executive director must make the waiver in writing and within the 45-day period.

(B) The owner or operator of a community water system must issue a notice at least once every three months by mail delivery (by direct mail or with the water bill) or by hand delivery, for as long as the violation exists.

(C) If the owner or operator of a noncommunity water system issued the initial notice by continuous posting, posting must continue for as long as the violation exists and in no case less than seven days. If the owner or operator of a noncommunity water system issued the initial notice by direct delivery, notice by direct delivery must be repeated at least every three months for as long as the violation exists.

[~~(4) The owner or operator of the public water system must issue a notice when the public water system has corrected the acute violation or situation. This notice must be issued in the same manner as the original notice was issued.~~]

(4) [~~(5)~~] Copies of all notifications required under this subsection must be submitted to the executive director within ten days of its distribution.

(b) Tier 2 public [~~Public~~] notification requirements for other MCL, MRDL, or treatment technique violations and for variance and exemption violations which are violations and situations with potential to have serious adverse effects on human health, as defined in this sub-

section. The owner or operator of a public water system must notify persons served by their system of any MCL, MRDL, or treatment technique violation other than those described in subsection (a)(1) of this section and of any violation involving a variance or exemption requirement. Each notice required by this section must meet the requirements of subsection (d) of this section.

(1) Violations that require notification under this subsection include:

(A) any violation of an MCL, MRDL, or treatment technique not listed under subsection (a) of this section;

(B) failure to comply with the requirements of any variance or exemption granted under §290.102(d) of this title (relating to General Applicability);

(C) failure for a groundwater system to take corrective action, including uncorrected significant deficiencies, or failure to maintain at least 4-log treatment of viruses (using inactivation, removal, or a combination of 4-log virus inactivation and removal approved by the executive director) before or at the first customer under §290.116 of this title (relating to Groundwater Corrective Actions and Treatment Techniques); or

(D) failure to perform any three [~~3~~] months of raw surface water monitoring as required by §290.111(b) of this title [~~(relating to Surface Water Treatment)~~] or request bin classification from the executive director under §290.111(c)(3)(A) of this title; or

(E) other violations or situations deemed appropriate by the executive director that pose a non-acute risk to human health.

(2) The initial Tier 2 public notice for any violation, situation, or significant deficiency identified in this subsection must be issued as soon as possible, but in no case later than 30 days after the violation is identified. The initial public notice shall be issued in the following manner.

(A) The owner or operator of a community water system shall issue the notice by:

(i) mail or other direct delivery to each customer receiving a bill and to other service connections to which water is delivered by the public water system; and

(ii) any other method reasonably calculated to reach other persons regularly served by the system, if they would not normally be reached by the notice required in clause (i) of this subparagraph. Such persons may include those who do not pay water bills or do not have service connection addresses (e.g., house renters, apartment dwellers, university students, nursing home patients, prison inmates, etc.) Other methods may include: publication in a local newspaper; delivery of multiple copies for distribution by customers that provide drinking water to others (e.g., apartment building owners or large private employers); continuous posting in conspicuous public places within the area served by the system or on the Internet; electronic delivery or alert systems (e.g., reverse 911); or delivery to community organizations.

(B) The owner or operator of a noncommunity water system shall issue the notice by:

(i) posting the notice in conspicuous locations throughout the distribution system frequented by persons served by the system, or by mail or direct delivery to each customer and service connection (where known); and

(ii) any other method reasonably calculated to reach other persons served by the system if they would not normally be reached by the notice. Such persons may include those served who may not see a posted notice because the posted notice is not in a location they routinely pass by. Other methods may include: publication in a local newspaper or newsletter distributed to customers; use of e-mail to notify employees or students; electronic delivery or alert systems (e.g., reverse 911); or, delivery of multiple copies in central locations (e.g., community centers).

(C) If notice is provided by posting, the posting must remain in place for as long as the violation exists or seven days, whichever is longer.

(3) The owner or operator of a system required to issue an initial violation notice shall issue additional notices. The additional notices shall be issued in the following manner.

(A) The owner or operator of a community water system must issue a notice at least once every three months by mail delivery (by direct mail or with the water bill) or by direct delivery, for as long as the violation exists.

(B) If the owner or operator of a noncommunity water system issued the initial notice by continuously posting the notice, the posting must continue for as long as the violation exists, and in no case less than seven days. If the owner or operator of a noncommunity water system issued the initial notice by direct delivery, notice by direct delivery must be repeated at least every three months for as long as the violation exists.

[~~(4) The owner or operator of the public water system must issue a notice when the public water system has corrected the violation. This notice must be issued in the same manner as the original notice was issued.~~]

(c) Tier 3 public [~~Public~~] notification requirements for other violations, situations, variances, exemptions as defined in this subsection. The owner or operator of a public water system who fails to perform monitoring required by this chapter, fails to comply with a testing procedure established by this chapter, or is subject to a variance or exemption granted under §290.102(b) of this title shall notify persons served by the system. Each notice required by this section must meet the requirements of subsection (d) of this section.

(1) Violations or other situations that require notification as described in this subsection [~~section~~] include:

(A) exceedance of the secondary constituent levels (SCL) for fluoride;

(B) failure to perform monitoring or reporting required by this subchapter;

(C) failure to comply with the analytical requirements or testing procedures required by this subchapter;

(D) operating under a variance or exemption granted under §290.102(b) of this title; [~~and~~]

(E) failure to maintain records on recycle practices as required by §290.46(f)(3)(C)(iii) of this title;[~~.~~]

(F) a community and nontransient, noncommunity public water system shall notify its customers of the availability of unregulated contaminant monitoring results, as required under 40 Code of Federal Regulations (CFR) §141.207;

(G) failure of a community and nontransient, noncommunity water public water system to notify of the availability of unregulated contaminant monitoring results, as required under 40 CFR §141.207;

(H) failure of a public water system to maintain any assessment form, regardless of who conducts the assessment, and docu-

mentation of corrective actions completed as a result of those assessments, or other available summary documentation of the sanitary defects and corrective actions taken under §290.109 of this title;

(I) failure of a public water system to maintain a record of any repeat sample taken that meets the criteria for an extension of the 24-hour period for collecting repeat samples under §290.109 of this title;

(J) other violations or situations deemed by the executive director to pose an acute risk to human health or with significant potential to have serious adverse effects on human health as a result of short-term exposure may require a Tier 1 public notice as described in subsection (a)(2) of this section; and

(K) other violations or situations at the, discretion of the executive director, may require a Tier 2 public notice as described in subsection (b)(2) of this section.

(2) The initial Tier 3 public notice issued pursuant to this section shall be issued no later than one year after the public water system learns of the violation or situation or begins operating under a variance or exemption. Following the initial notice, the public water system shall repeat the notice annually for as long as the violation, variance, exemption, or other situation persists. If the public notice is posted, the notice shall remain in place for as long as the violation, variance, exemption, or other situation persists, but in no case less than seven days even if the violation or situation is resolved [~~within three months of the violation or the granting of a variance or exemption~~]. The initial public notice shall be issued in the following manner.

(A) The owner or operator of a community water system shall issue the notice by mail or other direct delivery to each customer receiving a bill and to other service connections. The owner or operator of a noncommunity water system shall issue the notice by either posting the notice in conspicuous locations throughout the distribution system frequented by persons served by the system, or by mail or direct delivery to each customer and service connection. Other methods of delivery may include electronic delivery or alert systems (e.g., reverse 911).

(B) The owner or operator of any public water system shall also notify the public using another method reasonably calculated to reach other persons regularly served by the system, if they would not normally be reached by the notice required in subparagraph (A) of this paragraph. Such persons may include people who do not pay water bills or do not have service connection addresses (e.g., house renters, apartment dwellers, university students, nursing home patients, prison inmates, etc.). These other methods may include publication in a local newspaper; delivery of multiple copies for distribution by customers that provide their drinking water to others (e.g., apartment building owners or large private employers); posting in public places or on the Internet; or delivery to community organizations. Other methods of delivery may include electronic delivery or alert systems (e.g., reverse 911).

(C) For community public water systems, the Consumer Confidence Report (CCR) as required under Subchapter H of this chapter (relating to Consumer Confidence Reports) may be used for delivering the initial Tier 3 public notice and all required repeat notices, under the following conditions.

(i) The CCR is provided to persons served no later than 12 months after the public water system learns of the violation or situation as described under paragraph (1) of this subsection.

(ii) The Tier 3 notice contained in the CCR follows the content requirements under §290.272 of this title (relating to Content of the Report).

(iii) The CCR is distributed following the delivery requirements under §290.274 of this title (relating to Report Delivery and Recordkeeping.

(D) [~~(C)~~] If notice is provided by posting, the posting must remain in place for as long as the violation exists or seven days, whichever is longer.

(3) The owner or operator of a system required to issue an initial violation notice shall issue additional notices. The additional notices shall be issued in the following manner.

(A) The owner or operator of a community water system shall issue repeat notices at least once every 12 months by mail delivery (by direct mail or with the water bill) or by hand delivery, for as long as the violation exists or variance or exemption remains in effect. Repeat public notice may be included as part of the CCR as described in paragraph (2) of this subsection [~~Consumer Confidence Report~~].

(B) If the owner or operator of a noncommunity water system issued the initial notice by continuously posting the notice, the posting must continue for as long as the violation exists, and in no case less than seven days. If the owner or operator of a noncommunity water system issued the initial notice by direct delivery, notice by direct delivery must be repeated at least every 12 months for as long as the violation exists.

[~~(4) The owner or operator of the public water system must issue a notice when the public water system has corrected the violation. This notice must be issued in the same manner as the original notice was issued.~~]

(d) Each public notice must conform to the following general requirements.

(1) The notice must contain a clear and readily understandable explanation of the violation, significant deficiency, or situation that led to the notification. The notice must not contain very small print, unduly technical language, formatting, or other items that frustrate or defeat the purpose of the notice.

(2) If the notice is required for a specific event or significant deficiency, it must state when the event occurred or the date the significant deficiency was identified by the executive director.

(3) For notices required under subsections (a), (b), or (c)(1)(A) of this section, the notice must describe potential adverse health effects.

(A) For MCL, MRDL, or treatment technique violations or situations (including uncorrected significant deficiencies), the notice must contain the mandatory federal contaminant-specific language contained in 40 CFR Part 141, [~~Code of Federal Regulations (CFR)~~] Subpart Q, Appendix B, in addition to any language required by the executive director.

(B) For fluoride SCL violations, the notice must contain the mandatory federal contaminant-specific language contained in 40 CFR §141.208, in addition to any language required by the executive director.

(C) For failure to perform any three [~~3~~] months of raw surface water monitoring or request bin classification from the executive director, the notice must contain the mandatory federal contaminant specific language contained in 40 CFR §141.211(d)(1) and (2), respectively, in addition to any language required by the executive director.

(D) The notice must describe the population at risk, especially subpopulations particularly vulnerable if exposed to the given contaminant.

(4) The notice must state what actions the water system is taking to correct the violation or situation, and when the water system expects to return to compliance. For groundwater systems with significant deficiencies, the notice must contain the executive director-approved plan and schedule for correction of the significant deficiency, including interim measures, progress to date, and any interim measures completed.

(5) The notice must state whether alternative drinking water sources should be used, and what other actions consumers should take, including when they should seek medical help, if known.

(6) Each notice must contain the name, business address and telephone number at which consumers may contact the owner, operator, or designee of the public water system for additional information concerning the notice.

(7) Where appropriate, the notice must be multilingual. The multilingual notice must explain the importance of the notice or provide a telephone number or address where consumers may contact the system to obtain a translated copy of the notice or assistance in the appropriate language.

(8) The notice shall include a statement to encourage the notice recipient to distribute the public notice to the other persons served.

(9) Systems with variances or exemptions must notify in accordance with 40 CFR §141.205(b).

(10) Systems must notify customers at sampled taps of the results of any required lead or copper analyses and certify completion of the notification to the executive director.

(e) Notice to new billing units. The owner or operator of a community water system must give a copy of the most recent public notice for any outstanding violation of any MCL, or any treatment technique requirement, or any variance or exemption schedule to all new billing units or new hookups prior to or at the time service begins. The owner or operator of a noncommunity water system must continuously post the public notice in conspicuous locations in order to inform new consumers of any continuing violation, variance or exemption, or other situation requiring a public notice for as long as the violation, variance, exemption, or other situation persists.

(f) Proof of public notification. A copy of any public notice required under this section must be submitted to the executive director within ten days of its distribution as proof of public notification. The copies must be mailed to the Water Supply Division, MC 155, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or other method of submission as specified by the executive director. Each proof of public notification must be accompanied with a signed Certificate of Delivery.

(g) Notice to consecutive systems. All public water systems shall provide public notice to persons served by the public water system in accordance with this section. All public water systems that are required to issue public notice to persons in accordance with this section, and that sell or otherwise provide drinking water to other public water systems (i.e., consecutive systems), shall provide public notice to the owner or operator of the consecutive system. The consecutive system is responsible for and shall provide public notice to the persons it serves in accordance with this section. [~~A public water system that is required to notify its customers must also provide a copy of the notification to the owner or operator of any public water systems that purchase or otherwise receive water from it in the same manner in which they inform their customers. Each public water system that is affected by the subject of the notification is responsible for notification to its own customers.~~]

(h) Notices given by the executive director. The executive director may give the notice required by this section on behalf of the owner and operator of the public water system following the requirements of this section. The owner or operator of the public water system remains responsible for ensuring that the requirements of this section are met.

(i) If a public water system has a violation in a portion of the distribution system that is physically or hydraulically isolated from other parts of the distribution system, the executive director may allow the system to limit distribution of the public notice to only persons served by that portion of the system which is out of compliance. Permission by the executive director for limiting distribution of the notice must be granted in writing.

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

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SUBCHAPTER H. CONSUMER CONFIDENCE REPORTS

30 TAC §290.272, §290.275

Statutory Authority

The amendments are proposed under Texas Water Code (TWC), §5.102, which establishes the commission's general authority necessary to carry out its jurisdiction; TWC, §5.103, which establishes the commission's general authority to adopt rules; TWC, §5.105, which establishes the commission's authority to set policy by rule; Texas Health and Safety Code (THSC), §341.031, which allows the commission to adopt rules to implement the federal Safe Drinking Water Act, 42 United States Code, §§300f - 300j-26; and THSC, §341.0315, which requires public water systems to comply with commission rules adopted to ensure the supply of safe drinking water.

§290.272. Content of the Report.

(a) Information on the source of the water delivered must be included in the report.

(1) Each report must identify the source(s) of the water delivered by the community water system by providing information on the type of the water (such as surface water or groundwater) and any commonly used name and location of the body(ies) of water.

(2) If a source water assessment has been completed, the report must notify consumers of the availability of this information and the means to obtain it. In the reports, systems should highlight significant sources of contamination in the source water area if they have readily available information.

(3) If a system has received a source water assessment from the executive director, the report must include a brief summary of the system's susceptibility to potential sources of contamination using language provided by the executive director or written by a water system official and approved by the executive director.

(b) The following explanations must be included in the annual report.

(1) Each report must contain the following definitions.

(A) Level 1 assessment--A Level 1 assessment is a study of the water system to identify potential problems and determine (if possible) why total coliform bacteria were found.

(B) Level 2 assessment--A Level 2 assessment is a very detailed study of the water system to identify potential problems and determine (if possible) why an *Escherichia coli (E. coli)* maximum contaminant level (MCL) violation has occurred and/or why total coliform bacteria were found on multiple occasions.

(C) [~~(A)~~] Maximum contaminant level goal (MCLG)--The level of a contaminant in drinking water below which there is no known or expected risk to health. MCLGs allow for a margin of safety.

(D) [~~(B)~~] Maximum contaminant level (MCL)--The highest level of a contaminant that is allowed in drinking water. MCLs are set as close to maximum contaminant level goals as feasible using the best available treatment technology.

(E) [~~(C)~~] Maximum residual disinfectant level goal (MRDLG)--The level of a drinking water disinfectant below which there is no known or expected risk to health. MRDLGs do not reflect the benefits of the use of disinfectants to control microbial contaminants.

(F) [~~(D)~~] Maximum residual disinfectant level (MRDL)--The highest level of a disinfectant allowed in drinking water. There is convincing evidence that addition of a disinfectant is necessary for control of microbial contaminants.

(2) The following terms and their descriptions must be included when they appear in the report:

(A) MFL--million fibers per liter (a measure of asbestos);

(B) mrem/year--millirems per year (a measure of radiation absorbed by the body);

(C) NTU--nephelometric turbidity units (a measure of turbidity);

(D) pCi/L--picocuries per liter (a measure of radioactivity);

(E) ppb--parts per billion, or micrograms per liter (µg/L);

(F) ppm--parts per million, or milligrams per liter (mg/L);

(G) ppt--parts per trillion, or nanograms per liter (ng/L); and

(H) ppq--parts per quadrillion, or picograms per liter (pg/L).

(3) A report for a community water system operating under a variance or an exemption of the Safe Drinking Water Act must include a description of the variance or the exemption granted under §290.102(b) of this title (relating to General Applicability).

(4) A report that contains data on a contaminant for which the United States Environmental Protection Agency (EPA) has set a treatment technique (TT) or an action level (AL) must include, depending on the contents of the report, the following definitions.

(A) TT--A required process intended to reduce the level of a contaminant in drinking water.

(B) AL--The concentration of a contaminant which, if exceeded, triggers treatment or other requirements that a water system must follow.

(c) Information on detected contaminants.

(1) This subsection specifies the requirements for information to be included in each report for detected contaminants subject to mandatory monitoring, excluding *Cryptosporidium.* Mandatory monitoring is required for:

(A) regulated contaminants subject to an MCL, MRDL, AL, or TT; and

(B) unregulated contaminants for which monitoring is required by 40 Code of Federal Regulations (CFR) §141.40, and found in §290.275(4) of this title (relating to Appendices A - D).

(2) The data relating to these detected contaminants must be displayed in one table or in several adjacent tables. Any additional monitoring results that a community water system chooses to include in its reports must be displayed separately.

(3) The data must be derived from data collected to comply with EPA and the commission monitoring and analytical requirements during the previous calendar year, except when a system is allowed to monitor for regulated contaminants less often than once per year. In that case, the table(s) must include the date and results of the most recent sampling, and the report must include a brief statement indicating that the data presented in the report is from the most recent testing done in accordance with the regulations. The report does not need to include data that is older than five years.

(4) For detected regulated contaminants listed under §290.275 of this title, the table(s) must contain:

(A) the MCLs for those contaminants expressed as a number equal to or greater than 1.0 (as provided under §290.275 of this title);

(B) the MCLGs for those contaminants expressed in the same units as the MCLs (as provided for under §290.275 of this title);

(C) if there is no MCL for a detected contaminant, the TT or specific AL applicable to that contaminant; and

(D) for contaminants subject to an MCL, except turbidity, [~~and~~] total coliform, fecal coliform, and *E. coli* [~~coliforms,~~] the highest contaminant level used to determine compliance with *National Primary Drinking Water Regulations* (NPDWR) and the range of detected levels.

(i) For contaminants subject to MCLs, except turbidity, total coliform, fecal coliform, and *E. coli,* [~~and total coliforms,~~] when sampling takes place once per year or less often, the table(s) must contain the highest detected level at any sampling point and the range of detected levels expressed in the same units as the MCL.

(ii) When sampling takes place more than once per year at each sampling point, the table(s) must contain the highest average of any of the sampling points and the range of all sampling points expressed in the same units as the MCL.

(iii) In accordance with date requirements included in the table under §290.115(a) of this title (relating to Stage 2 Disinfection Byproducts (TTHM and HAA5)), entitled "Date to Start Stage 2 Compliance," for the MCLs for total trihalomethanes (TTHM) and haloacetic acids (HAA5), systems must include the highest locational running annual average for TTHM and HAA5 and the range of individual sample results for all monitoring locations expressed in the same units as the MCL. If more than one location exceeds the TTHM or HAA5 MCL, the system must include the locational running annual averages for all sampling points that exceed the MCL.

(iv) When compliance with any MCL is determined on a system-wide basis by calculating a running annual average of all samples at all sampling points, the table(s) must include the average and range of detections expressed in the same units as the MCL.

(v) When the executive director allows the rounding of results to determine compliance with the MCL, rounding should be done after multiplying the results by the factor listed under §290.275 of this title.

(E) When turbidity is reported under §290.111 of this title (relating to Surface Water Treatment), the table(s) must contain the highest single measurement and the lowest monthly percentage of samples meeting the turbidity limits specified in that section for the filtration technology being used. The report should include an explanation of the reasons for measuring turbidity.

(F) When lead and copper are reported, the table(s) must contain the 90th percentile value of the most recent round of sampling and the number of sampling sites exceeding the AL.

(G) When *E. coli* is reported, the table(s) shall contain the total number of *E. coli* positive samples. [~~When total coliform is reported, the table(s) must contain either the highest monthly number of positive samples for systems collecting fewer than 40 samples per month or the highest monthly percentage of positive samples for systems collecting at least 40 samples per month.~~]

[~~(H) When fecal coliform is reported, the table(s) must contain the total number of positive samples.~~]

(H) [~~(I)~~] The table(s) must contain information on the likely source(s) of detected contaminants based on the operator's knowledge. Specific information regarding contaminants may be available in sanitary surveys or source water assessments and should be used when available. If the operator lacks specific information on the likely source, the report must include one or more typical sources most applicable to the system for any particular contaminant listed under §290.275 of this title.

(i) If a community water system distributes water to its customers from multiple hydraulically independent distribution systems that are fed by different raw water sources, the table(s) must contain a separate column for each service area, and the report must identify each separate distribution system. Systems may produce separate reports tailored to include data for each service area.

(ii) The table(s) must clearly identify any data indicating violations of MCLs, MRDLs, or TTs. The report must contain a clear and readily understandable explanation of the violation. The explanation must include the length of the violation, the potential adverse health effects, and the actions taken by the system to address the violation. To describe the potential health effects, the system must use the relevant language contained under §290.275 of this title.

(5) For detected unregulated contaminants found under §290.275 of this title, for which monitoring is required (except *Cryptosporidium),* the table(s) must contain the average and range of concentrations at which the contaminant was detected. The report must include the following explanation: "Unregulated contaminants are those for which EPA has not established drinking water standards. The purpose of unregulated contaminant monitoring is to assist EPA in determining the occurrence of unregulated contaminants in drinking water and whether future regulation is warranted."

(d) Information on *Cryptosporidium,* radon, and other contaminants.

(1) If the system has performed any monitoring for *Cryptosporidium,* the report must include a summary of the results of any detections and an explanation of the significance of the results.

(2) If the system has performed any monitoring for radon, which indicates that radon may be present in the finished water, the report must include the results of the monitoring and an explanation of the significance of the results.

(3) If the system has performed additional monitoring, which indicates the presence of other contaminants in the finished water, the executive director strongly encourages systems to report any results which may indicate a health concern. To determine if the results may indicate a health concern, the executive director recommends that systems find out if the EPA has proposed a standard in the NPDWR or issued a health advisory for any particular contaminant. This information may be obtained by calling the Safe Drinking Water Hotline at (800) 426-4791. The executive director considers detections that are above a proposed MCL or health advisory level to indicate possible health concerns. For such contaminants, the executive director recommends that the report include the results of the monitoring and an explanation of the significance of the results. The explanation should note the existence of a health advisory or a proposed regulation.

(4) Community and nontransient, noncommunity water systems that exceed the secondary constituent level for fluoride as described in §290.118 of this title (relating to Secondary Constituent Levels) but are below the maximum contaminant level listed in §290.106 of this title (relating to Inorganic Contaminants) shall notify the public using the mandatory language as described in 40 CFR §141.208(c).

(e) Compliance with NPDWR. In addition to the requirements in subsection (c)(4)(H)(ii) [~~(c)(4)(I)(ii)~~] of this section, the report must note any violation that occurred during the year covered by the report of a requirement listed in paragraphs (1) - (8) of this subsection.

(1) The report must include a clear and readily understandable explanation of each violation of monitoring and reporting of compliance data and explain any adverse health effects and steps the system has taken to correct the violation.

(2) The report must include a clear and readily understandable explanation of each violation of filtration and disinfection prescribed by Subchapter F of this chapter (relating to Drinking Water Standards Governing Drinking Water Quality and Reporting Requirements for Public Water Systems) and explain any adverse health effects and steps the system has taken to correct the violation. This applies both to systems that have failed to install adequate filtration, disinfection equipment, or processes, and to systems that have had a failure of such equipment or processes, each of which constitutes a violation. In either case, the report must include the following language as part of the explanation of potential adverse health effects: "Inadequately treated water may contain disease-causing organisms. These organisms include bacteria, viruses, and parasites that can cause symptoms such as nausea, cramps, diarrhea, and associated headaches."

(3) The report must include a clear and readily understandable explanation of each violation of the lead and copper control re-

quirements prescribed by §290.117 of this title (relating to Regulation of Lead and Copper). For systems that fail to take one or more actions prescribed by §290.117(g), (h), and (i) of this title, the report must include the applicable health effects language of §290.275(3) of this title for lead, copper, or both and the steps the system has taken to correct the violation.

(4) The report must include a clear and readily understandable explanation of each violation of TTs for Acrylamide and Epichlorohydrin prescribed by §290.107 of this title (relating to Organic Contaminants). If a system violates these requirements, the report must include the relevant health effects language from §290.275 of this title and the steps the system has taken to correct the violation.

(5) The report must include a clear and readily understandable explanation of each violation of recordkeeping of compliance data and explain any adverse health effects and steps the system has taken to correct the violation.

(6) The report must include a clear and readily understandable explanation of each violation of special monitoring requirements for unregulated contaminants and special monitoring for sodium as prescribed by 40 CFR §141.40 and §141.41 and explain any adverse health effects and steps the system has taken to correct the violation.

(7) For systems required to conduct initial distribution sampling evaluation (IDSE) sampling in accordance with §290.115(c)(5) of this title, the system is required to include individual sample results for the IDSE when determining the range of TTHM and HAA5 results to be reported in the annual Consumer Confidence Report [~~consumer confidence report~~] for the calendar year that the IDSE samples were taken.

(8) The report must include a clear and readily understandable explanation of each violation of the terms of a variance, exemption, administrative order, or judicial order and explain any adverse health effects and steps the system has taken to correct the violation.

(f) Variances and exemptions. If a system is operating under the terms of a variance or exemption issued under §290.102(b) of this title, the report must contain:

(1) an explanation of the variance or exemption;

(2) the date on which the variance or exemption was issued and on which it expires;

(3) a brief status report on the steps the system is taking, such as installing treatment processes or finding alternative sources of water, to comply with the terms and schedules of the variance or exemption; and

(4) a notice of any opportunity for public input as the review or renewal of the variance or exemption.

(g) Additional information.

(1) The report must contain a brief explanation regarding contaminants that may reasonably be expected to be found in drinking water (including bottled water). This explanation may include the language contained within subparagraphs (A) - (C) of this paragraph, or systems may include their own comparable language. The report must include the language of subparagraphs (D) and (E) of this paragraph.

(A) The sources of drinking water (both tap water and bottled water) include rivers, lakes, streams, ponds, reservoirs, springs, and wells. As water travels over the surface of the land or through the ground, it dissolves naturally occurring minerals and, in some cases, radioactive material, and can pick up substances resulting from the presence of animals or from human activity.

(B) Contaminants that may be present in source water include:

(i) microbial contaminants, such as viruses and bacteria, which may come from sewage treatment plants, septic systems, agricultural livestock operations, and wildlife;

(ii) inorganic contaminants, such as salts and metals, which can be naturally occurring or result from urban storm water runoff, industrial or domestic wastewater discharges, oil and gas production, mining, or farming;

(iii) pesticides and herbicides, which might have a variety of sources such as agriculture, urban storm water runoff, and residential uses;

(iv) organic chemical contaminants, including synthetic and volatile organic chemicals, which are byproducts of industrial processes and petroleum production, and can also come from gas stations, urban storm water runoff, and septic systems; and

(v) radioactive contaminants, which can be naturally occurring or the result of oil and gas production and mining activities.

(C) In order to ensure that tap water is safe to drink, the EPA prescribes regulations that limit the amount of certain contaminants in water provided by public water systems. Food and Drug Administration regulations establish limits for contaminants in bottled water that must provide the same protection for public health.

(D) Contaminants may be found in drinking water that may cause taste, color, or odor problems. These types of problems are not necessarily causes for health concerns. For more information on taste, odor, or color of drinking water, please contact the system's business office.

(E) Drinking water, including bottled water, may reasonably be expected to contain at least small amounts of some contaminants. The presence of contaminants does not necessarily indicate that water poses a health risk. More information about contaminants and potential health effects can be obtained by calling the EPA's Safe Drinking Water Hotline at (800) 426-4791.

(2) The report must include the telephone number of the owner, operator, or designee of the community water system as an additional source of information concerning the report.

(3) Each English language report must include the following statement in a prominent place on the first page: "Este reporte incluye informacion importante sobre el agua para tomar. Para asistencia en español, favor de llamar al telefono (XXX) XXX-XXXX." In addition to this statement in Spanish, for communities with a large proportion of limited English proficiency residents, as determined by the executive director, the report must contain information in the appropriate language(s) regarding the importance of the report or contain a telephone number or address where such residents may contact the system to obtain a translated copy of the report or assistance in the appropriate language.

(4) The report must include information about opportunities for public participation in decisions that may affect the quality of the water (e.g., time and place of regularly scheduled board meetings). Investor-owned utilities are encouraged to conduct public meetings, but must include a phone number for public input.

(5) The systems may include such additional information for public education consistent with, and not detracting from, the purposes of the report.

(6) Systems that use an interconnect or emergency source to augment the drinking water supply during the calendar year of the

report must provide the source of the water, the length of time used, an explanation of why it was used, and whom to call for the water quality information.

(7) Beginning December 1, 2009, any groundwater system that receives notice from a laboratory of a fecal indicator positive [~~indicator-positive~~] groundwater source sample that is not invalidated by the executive director under §290.109(e) [~~§290.109(d)~~] of this title (relating to Microbial Contaminants) must inform its customers of any fecal indicator positive [~~indicator-positive~~] groundwater source sample in the next report. The system must continue to inform the public annually until the executive director determines that the fecal contamination in the groundwater source is addressed under §290.116(a) of this title (relating to Groundwater Corrective Actions and Treatment Techniques). Each report must include the following elements:

(A) the source of the fecal contamination (if the source is known) and the dates of the fecal indicator positive [~~indicator-positive~~] groundwater source samples;

(B) actions taken to address the fecal contamination in the groundwater source as directed by §290.116 of this title and the date of such action;

(C) for each fecal contamination in the groundwater source that has not been addressed under §290.116 of this title, the plan approved by the executive director and schedule for correction, including interim measures, progress to date, and any interim measures completed; and

(D) for a fecal indicator positive [~~indicator-positive~~] groundwater source sample that is not invalidated by the executive director under §290.109(e) [~~§290.109(d)~~] of this title, the potential health effects using the health effects language of §290.275(3) of this title.

(8) Beginning December 1, 2009, any groundwater system that receives notice from the executive director of a significant deficiency must inform its customers of any significant deficiency that is uncorrected at the time of the next report. The system must continue to inform the public annually until the executive director determines that particular significant deficiency is corrected under §290.116 of this title. Each report must include the following elements:

(A) the nature of the particular significant deficiency and the date the significant deficiency was identified by the executive director;

(B) for each significant deficiency, the plan approved by the executive director and schedule for correction, including interim measures, progress to date, and any interim measures completed; and

(C) if corrected before the next report, the nature of the significant deficiency, how the deficiency was corrected, and the date of the corrections.

(9) Any public water system required to comply with the Level 1 or Level 2 assessment requirements under §290.109 and §290.116 of this title that is not due to an *E. coli* MCL violation shall include in the following elements in the report as appropriate:

(A) Coliforms are bacteria that are naturally present in the environment and are used as an indicator that other, potentially harmful, waterborne pathogens may be present or that a potential pathway exists through which contamination may enter the drinking water distribution system. We found coliforms indicating the need to look for potential problems in water treatment or distribution. When this occurs, we are required to conduct assessment(s) to identify problems and to correct any problems that were found during these assessments.

(B) During the past year we were required to conduct {INSERT NUMBER OF LEVEL 1 ASSESSMENTS} Level 1 assessment(s). {INSERT NUMBER OF LEVEL 1 ASSESSMENTS} Level 1 assessment(s) were completed. In addition, we were required to take {INSERT NUMBER OF CORRECTIVE ACTIONS} corrective actions and we completed {INSERT NUMBER OF CORRECTIVE ACTIONS} of these actions.

(C) During the past year {INSERT NUMBER OF LEVEL 2 ASSESSMENTS} Level 2 assessments were required to be completed for our water system. {INSERT NUMBER OF LEVEL 2 ASSESSMENTS} Level 2 assessments were completed. In addition, we were required to take {INSERT NUMBER OF CORRECTIVE ACTIONS} corrective actions and we completed {INSERT NUMBER OF CORRECTIVE ACTIONS} of these actions.

(D) Any public water system that failed to complete all the required assessments or correct all identified sanitary defects, is in violation of the treatment technique requirement and shall also include one or both of the following statements as appropriate:

(i) During the past year we failed to conduct all of the required assessment(s).

(ii) During the past year we failed to correct all identified defects that were found during the assessment.

(10) Any public water system required to comply with the Level 2 assessment requirements under §290.109 and §290.116 of this title that is due to an *E. coli* MCL violation shall include in the following elements in the report as appropriate:

(A) *E. coli* are bacteria whose presence indicates that the water may be contaminated with human or animal wastes. Human pathogens in these wastes can cause short-term effects, such as diarrhea, cramps, nausea, headaches, or other symptoms. They may pose a greater health risk for infants, young children, the elderly, and people with severely compromised immune systems. We found *E. coli* bacteria, indicating the need to look for potential problems in water treatment or distribution. When this occurs, we are required to conduct assessment(s) to identify problems and to correct any problems that were found during these assessments.

(B) We were required to complete a Level 2 assessment because we found *E. coli* in our water system. In addition, we were required to take {INSERT NUMBER OF CORRECTIVE ACTIONS} corrective actions and we completed {INSERT NUMBER OF CORRECTIVE ACTIONS} of these actions.

(C) Any public water system that has failed to complete the required assessment or correct all identified sanitary defects, is in violation of the treatment technique requirement and shall also include one or both of the following statements, as appropriate:

(i) We failed to conduct the required assessment.

(ii) We failed to correct all sanitary defects that were identified during the assessment that we conducted.

(11) If a public water system detects *E. coli* and has violated the *E. coli* MCL, in addition to completing the table as required in subsection (c)(4) of this section, the system shall include one or more of the following statements to describe any noncompliance, as applicable:

(A) We had an *E. coli*-positive repeat sample following a total coliform-positive routine sample.

(B) We had a total coliform-positive repeat sample following an *E. coli*-positive routine sample.

(C) We failed to take all required repeat samples following an *E. coli*-positive routine sample.

(D) We failed to test for *E. coli* when any repeat sample tests positive for total coliform.

(12) [~~(9)~~] Every report must include the following lead-specific information - a short informational statement about lead in drinking water and its effect on children.

(A) The statement must include the information set forth in this example statement. "If present, elevated levels of lead can cause serious health problems, especially for pregnant women and young children. Lead in drinking water is primarily from materials and components associated with service lines and home plumbing. NAME OF UTILITY is responsible for providing high quality drinking water, but cannot control the variety of materials used in plumbing components. When your water has been sitting for several hours, you can minimize the potential for lead exposure by flushing your tap for 30 seconds to two minutes before using water for drinking or cooking. If you are concerned about lead in your water, you may wish to have your water tested. Information on lead in drinking water, testing methods, and steps you can take to minimize exposure is available from the Safe Drinking Water Hotline or at *http://www.epa.gov/safewater/lead."*

(B) A public water system may write its own educational statement, but only in consultation with the executive director.

(h) If a public water system detects *E. coli* and has not violated the *E. coli* MCL, in addition to completing the table as required in subsection (c)(4) of this section, the system may include a statement that explains that although they have detected *E. coli,* they are not in violation of the *E. coli* MCL.

(i) [~~(h)~~] Customer notification of water loss by a retail public utility. A retail public utility required to file a water loss audit with the Texas Water Development Board under the provisions of Texas Water Code, §16.0121, shall notify its customers of its water loss reported in the water loss audit by including the water loss information on or with the next report following the filing of the water loss audit, unless the retail public utility elects to notify its customers of its water loss reported in the water loss audit by including the water loss information on or with the next bill sent to its customers following the filing of the water loss audit in accordance with §291.87 of this title (relating to Billing).

§290.275. Appendices A - D.

The following appendices are integral components of the subchapter.

(1) Appendix A--Converting Maximum Contaminant Level [~~MCL~~] Compliance Values for Consumer Confidence Reports (CCR).
Figure: 30 TAC §290.275(1)
[~~Figure: 30 TAC §290.275(1)~~]

(2) Appendix B--Sources of Regulated Contaminants.
Figure: 30 TAC §290.275(2)
[~~Figure: 30 TAC §290.275(2)~~]

(3) Appendix C--Health Effects Language.
Figure: 30 TAC §290.275(3)
[~~Figure: 30 TAC §290.275(3)~~]

(4) Appendix D--Unregulated Contaminants.
Figure: 30 TAC §290.275(4) (No change.)

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201604980
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 239-2141

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 353. INTRODUCTORY PROVISIONS

SUBCHAPTER B. EMPLOYEE TRAINING AND EDUCATION

31 TAC §353.31

The Texas Water Development Board (TWDB) proposes amendments to 31 Texas Administrative Code (TAC) §353.31, concerning agency-funded employee training and education. Existing 31 TAC §353.32 and §353.33 are being consolidated into the amended §353.31 and are proposed for repeal elsewhere in this issue of the *Texas Register.*

BACKGROUND AND SUMMARY OF THE FACTUAL ISSUES FOR THE PROPOSED AMENDMENTS.

The proposed amendments update the TWDB rule regarding agency-funded employee training and education in compliance with Texas Government Code Chapter 656, Subchapters C and D, and consolidate three rules into a single rule. Texas Government Code Chapter 656 requires state agencies to adopt rules requiring that the executive head of an agency authorize tuition reimbursement payments for courses offered by an accredited institution of higher education.

SECTION BY SECTION DISCUSSION OF PROPOSED AMENDMENTS

Subchapter B. Employee Training and Education

Section 353.31 Purpose of Employee Training and Education.

The section name is revised to Agency-Funded Employee Training and Education to reflect the consolidation of §353.32 and §353.33 into the amended §353.31.

The term "training" is defined using the statutory definition in Texas Government Code §656.101.

Employee eligibility for training and the types of job-related training are described.

The requirements for obtaining reimbursement for a course offered by an accredited institution of higher education are outlined, including the requirement that tuition reimbursement be approved by the executive administrator.

Obligations assumed by administrators and employees after completing an education or training program are outlined.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENTS

Ms. Rebecca Treviño, Chief Financial Officer has determined that there will be no fiscal implications for state or local governments as a result of the proposed amendments. For the first five years these rule amendments are in effect, there is no expected additional cost to state or local governments resulting from their administration.

The amendments are not expected to result in reductions in costs to either state or local governments. The intent of the rulemaking is to update TWDB policies regarding agency-funded training and education. There is no change in costs because there are no direct costs associated with the proposed amendments. These rule amendments are not expected to have any impact on state or local revenues. The rule amendments do not require any increase in expenditures for state or local governments as a result of administering the amended rule. Additionally, there are no foreseeable implications relating to state or local governments' costs or revenue resulting from the amended rule.

PUBLIC BENEFITS AND COSTS

Ms. Treviño has also determined that for each year of the first five years the proposed rulemaking is in effect, the anticipated public benefit will be enhanced capability of participating employees to perform job duties and an effective review and approval process for expenditure of state funds to reimburse eligible employee tuition expenses.

LOCAL EMPLOYMENT IMPACT STATEMENT

The board has determined that a local employment impact statement is not required. The proposed amendments do not adversely affect a local economy in a material way for the first five years that they are in effect because they will impose no new requirements on local economies. The board also has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing this rulemaking. The board also has determined that there is no anticipated economic cost to persons who are required to comply with the rulemaking as proposed. Therefore, no regulatory flexibility analysis is necessary.

DRAFT REGULATORY IMPACT ANALYSIS DETERMINATION

The board reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code §2001.0225 and determined that the rulemaking is not subject to Texas Government Code §2001.0225 because the proposed rulemaking does not meet the definition of a "major environmental rule" as defined in the Administrative Procedure Act. A "major environmental rule" is defined as a rule with the specific intent to protect the environment or reduce risks to human health from environmental exposure, a rule that may adversely affect in a material way the economy or a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The intent of the rulemaking is to update the board's policies regarding agency-funded employee training and education.

Even if the rulemaking being proposed was a major environmental rule, Texas Government Code §2001.0225 still would not apply to this rulemaking because Texas Government Code §2001.0225 only applies to a major environmental rule the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking does not meet any of these four applicability criteria because it: 1) does not exceed any standard set by a federal law; 2) does not exceed an express requirement of state law; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; and 4) is not proposed solely under the general powers of the agency, but rather is also proposed under authority of Texas Water Code §§6.104 and 6.109. Therefore, these proposed amendments do not fall under any of the applicability criteria in Texas Government Code §2001.0225.

The board invites public comment regarding this draft regulatory impact analysis determination. Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submission of Comments section of this preamble.

TAKINGS IMPACT ASSESSMENT

The board evaluated this proposed rulemaking and performed an analysis of whether it constitutes a taking under Texas Government Code Chapter 2007. The specific purpose of this rule is to update board policies regarding agency-funded employee training and education.

The board's analysis indicates that Texas Government Code Chapter 2007 does not apply to the proposed amendments because this rulemaking is an action that is reasonably taken to fulfill an obligation mandated by state law, which is exempt under Texas Government Code §2007.003(b)(4). Nevertheless, the board further evaluated the proposed amendments and performed an assessment of whether they constitute a taking under Texas Government Code Chapter 2007. Promulgation and enforcement of these proposed amendments would be neither a statutory nor a constitutional taking of private real property. Specifically, the subject proposed amendments do not affect a landowner's rights in private real property because this rulemaking does not burden or restrict or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulation. Therefore, the proposed amendments do not constitute a taking under Texas Government Code Chapter 2007.

SUBMISSION OF COMMENTS

Comments on the proposed rulemaking will be accepted until 30 days following publication in the *Texas Register* and may be submitted to Mr. Les Trobman, Office of General Counsel, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231 or *rulescomments@twdb.texas.gov* or by fax to (512) 475-2053.

STATUTORY AUTHORITY

This amendment is proposed under Texas Water Code §6.101, which gives the TWDB authority to adopt rules, and Texas Government Code §656.048, which requires the TWDB to adopt rules relating to employee eligibility for training and education funded by the agency, the obligations of employees upon receiving the training and education, and a requirement that the executive administrator authorize tuition reimbursement payments.

Cross reference to statute: Texas Water Code §6.101, Texas Government Code §656.048

§353.31. Agency-Funded [~~Purpose of~~] Employee Training and Education.

(a) The agency may use state funds, when available, to provide training or education for its administrators and full- or part-time employees, including salary, tuition and other fees, travel and living expenses, training stipend, expense of training materials and other necessary expenses of an instructor, student or other participant in a training or education program. The training must be related to the duties or prospective duties of the administrator or employee.

(b) "Training" as used in this rule means instruction, teaching, or other education received by a state employee that is not normally received by other state employees and that is designed to enhance the ability of the employee to perform the employee's job. The term includes a course of study at an institution of higher education or a private or independent institution of higher education as defined by §61.003, Education Code, if the agency spends money to assist the state employee to meet the expense of the course of study or pays salary to the employee to undertake the course of study as an assigned duty. The term does not include training required either by state or federal law or that is determined necessary by the agency and offered to all employees of the agency performing similar jobs.

(c) All administrators and active employees are eligible to participate in job-related training or education programs supported by the agency, including training inside or outside the agency, seminars and conferences, college and university coursework and online training.

(d) When an administrator or employee seeks reimbursement for a training or education program offered by an institution of higher education, the agency may only reimburse the tuition expenses for a program course successfully completed by an employee at an accredited institution of higher education. Reimbursement for such program courses requires the approval of the executive administrator.

(e) After completing an education or training program sponsored by the agency, an administrator or employee will be required, if applicable, to:

(1) Discuss information obtained and share materials with other agency employees, to the extent that sharing does not violate copyright laws;

(2) Assume additional job duties for which the training or education program prepared the employee; and/or

(3) Conduct training for other department employees based on the information or skills taught at the training or education program.

(f) The executive administrator will adopt policies and procedures to obtain training and/or education for administrators and employees that include eligibility requirements and procedures for reimbursement that are in conformity [~~conformance~~] with these rules and Texas Government Code Chapter 656, Subchapters C and D. [~~Chapter 656 of the Texas Government Code.~~]

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201604982

Les Trobman
General Counsel
Texas Water Development Board
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 463-7686

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31 TAC §353.32, §353.33

The Texas Water Development Board (TWDB) proposes to repeal 31 Texas Administrative Code (TAC) §353.32 and §353.33.

BACKGROUND AND SUMMARY OF THE FACTUAL ISSUES FOR THE PROPOSED REPEAL.

The TWDB proposes to repeal §353.32 and §353.33 because both sections are incorporated into amendments to 31 TAC §353.31 being proposed elsewhere in this issue of the *Texas Register.*

DISCUSSION OF THE PROPOSED REPEAL

31 TAC §353.32, relating to eligibility for training and education, and §353.33, relating to eligible expenses of a training or education program, are being incorporated in proposed amendments to 31 TAC §353.31.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENTS

Ms. Rebecca Treviño, Chief Financial Officer has determined that there will be no fiscal implications for state or local governments as a result of the proposed repeals. For the first five years the repeals are in effect, there is no expected additional cost to state or local governments.

The repeal of these rules is not expected to result in reductions in costs to either state or local governments. There is no change in costs because there are no direct costs associated with the proposed repeals. These repeals are not expected to have any impact on state or local revenues. These repeals do not require any increase in expenditures for state or local governments. Additionally, there are no foreseeable implications relating to state or local governments' costs or revenue resulting from these repeals.

PUBLIC BENEFITS AND COSTS

Ms. Treviño has also determined that for each year of the first five years the proposed repeals are in effect, there will be no impact to the public.

LOCAL EMPLOYMENT IMPACT STATEMENT

The board has determined that a local employment impact statement is not required. The proposed repeals do not adversely affect a local economy in a material way for the first five years that they are in effect because they will impose no new requirements on local economies. The board also has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing these repeals. The board also has determined that there is no anticipated economic cost to persons who are required to comply with the repeals as proposed. Therefore, no regulatory flexibility analysis is necessary.

DRAFT REGULATORY IMPACT ANALYSIS DETERMINATION

The board reviewed the proposed repeals in light of the regulatory analysis requirements of Texas Government Code §2001.0225 and determined that the repeals are not subject to Texas Government Code §2001.0225 because they do not

meet the definition of a "major environmental rule" as defined in the Administrative Procedure Act. A "major environmental rule" is defined as a rule with the specific intent to protect the environment or reduce risks to human health from environmental exposure, a rule that may adversely affect in a material way the economy or a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The intent of the proposed repeals is to update the board's policies regarding agency-funded employee training and education.

Even if the proposed repeals affected a major environmental rule, Texas Government Code §2001.0225 still would not apply to this rulemaking because Texas Government Code §2001.0225 only applies to a major environmental rule the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking does not meet any of these four applicability criteria because it: 1) does not exceed any standard set by a federal law; 2) does not exceed an express requirement of state law; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; and 4) is not proposed solely under the general powers of the agency, but rather is also proposed under authority of Texas Water Code §6.104 and §6.109. Therefore, these proposed repeals do not fall under any of the applicability criteria in Texas Government Code §2001.0225.

The board invites public comment regarding this draft regulatory impact analysis determination. Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submission of Comments section of this preamble.

TAKINGS IMPACT ASSESSMENT

The board evaluated these proposed repeals and performed an analysis of whether they constitute a taking under Texas Government Code Chapter 2007. The specific purpose of these repeals is to update and consolidate board policies regarding agency-funded employee training and education.

The board's analysis indicates that Texas Government Code Chapter 2007 does not apply to the proposed repeals because this rulemaking is an action that is reasonably taken to fulfill an obligation mandated by state law, which is exempt under Texas Government Code §2007.003(b)(4). Nevertheless, the board further evaluated the proposed repeals and performed an assessment of whether they constitute a taking under Texas Government Code Chapter 2007. Promulgation and enforcement of these proposed repeals would be neither a statutory nor a constitutional taking of private real property. Specifically, the subject proposed repeals do not affect a landowner's rights in private real property because this rulemaking does not burden or restrict or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulation. Therefore, the proposed repeals do not constitute a taking under Texas Government Code Chapter 2007.

SUBMISSION OF COMMENTS

Comments on the proposed rulemaking will be accepted until 30 days following publication in the *Texas Register* and may be submitted to Mr. Les Trobman, Office of General Counsel, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231 or *rulescomments@twdb.texas.gov* or by fax to (512) 475-2053.

STATUTORY AUTHORITY

This repeal is proposed under Texas Water Code §6.101.

Cross reference to statute: Texas Water Code §6.101.

§353.32. Eligibility for Training and Education.

§353.33. Eligible Expenses.

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

Filed with the Office of the Secretary of State on September 23, 2016.

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Les Trobman
General Counsel
Texas Water Development Board
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 463-7686

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SUBCHAPTER J. ENHANCED CONTRACT MONITORING

31 TAC §353.140

The Texas Water Development Board (TWDB) proposes new Subchapter J, Enhanced Contract Monitoring, §353.140, relating to an enhanced contract and performance monitoring procedure. The proposed new rule would outline the procedure for identifying contracts that require enhanced monitoring and the process for enhanced monitoring and board notification.

BACKGROUND AND SUMMARY OF THE FACTUAL ISSUES FOR THE PROPOSED RULE

Texas Government Code §2261.253, amended by Senate Bill 20, 84th Legislature, requires agencies by rule to establish a procedure for identifying each contract that requires enhanced contract or performance monitoring and submitting information on the contract to the agency's governing body. The proposed rule details the factors used in the risk analysis performed to determine whether enhanced monitoring is necessary. The rule also describes the type of enhanced monitoring that will be applied to a contract identified as high risk and outlines the documentation and reporting activities for this type of contract.

SECTION BY SECTION DISCUSSION OF THE PROPOSED RULE

Subchapter J. Enhanced Contract Monitoring

Section 353.140. Enhanced Contract Monitoring Procedure

The proposed rule outlines the risk analysis performed to determine whether enhanced contract or performance monitoring is necessary, and lists the factors used in the risk analysis.

The type of enhanced monitoring that will be applied to any contract identified as having a high risk is described.

Documentation and reporting of contract and performance monitoring activities are identified.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENTS

Ms. Rebecca Treviño, Chief Financial Officer, has determined that there will be no fiscal implications for state or local governments as a result of the proposed rule. For the first five years this rule is in effect, there is no expected additional cost to state or local governments resulting from enforcement or administration.

The rule is not expected to result in reductions in costs to either state or local governments. The intent of the rulemaking is to establish a procedure for identifying contract risk factors and providing increased monitoring for contracts identified as high risk. There is no change in costs because there are no direct costs associated with the proposed rule. This rule is not expected to have any impact on state or local revenues. The rule does not require any increase in expenditures for state or local governments as a result of administering the rule. Additionally, there are no foreseeable implications relating to state or local governments' costs or revenue resulting from the rule.

PUBLIC BENEFITS AND COSTS

Ms. Treviño has also determined that for each year of the first five years the proposed rulemaking is in effect, the anticipated public benefit will be a higher level of performance monitoring associated with board contracts that have a risk level identified as high.

LOCAL EMPLOYMENT IMPACT STATEMENT

The board has determined that a local employment impact statement is not required. The proposed rule does not adversely affect a local economy in a material way for the first five years that it is in effect because it will impose no new requirements on local economies. The board also has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing this rulemaking. The board also has determined that there is no anticipated economic cost to persons who are required to comply with the rulemaking as proposed. Therefore, no regulatory flexibility analysis is necessary.

DRAFT REGULATORY IMPACT ANALYSIS DETERMINATION

The board reviewed the proposed rulemaking in light of the regulatory analysis requirements of Texas Government Code §2001.0225 and determined that the rulemaking is not subject to Texas Government Code §2001.0225 because the proposed rulemaking does not meet the definition of a "major environmental rule" as defined in the Administrative Procedure Act. A "major environmental rule" is defined as a rule with the specific intent to protect the environment or reduce risks to human health from environmental exposure, a rule that may adversely affect in a material way the economy or a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The intent of this rulemaking is to outline the procedure for identifying high risk contracts and monitoring performance under those contracts.

Even if the rulemaking being proposed was a major environmental rule, Texas Government Code §2001.0225 still would not apply to this rulemaking because Texas Government Code §2001.0225 only applies to a major environmental rule the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking does not meet any of these four applicability criteria because it: 1) does not exceed any standard set by a federal law; 2) does not exceed an express requirement of state law; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; and 4) is not proposed solely under the general powers of the agency, but rather is also proposed under authority of Texas Water Code §§6.104 and 6.109. Therefore, these proposed rule does not fall under any of the applicability criteria in Texas Government Code §2001.0225.

The board invites public comment regarding this draft regulatory impact analysis determination. Written comments on the draft regulatory impact analysis determination may be submitted to the contact person at the address listed under the Submission of Comments section of this preamble.

TAKINGS IMPACT ASSESSMENT

The board evaluated this proposed rulemaking and performed an analysis of whether it constitutes a taking under Texas Government Code Chapter 2007. The specific purpose of this rule is to outline the procedure for identifying high risk contracts and monitoring performance under those contracts.

The board's analysis indicates that Texas Government Code Chapter 2007 does not apply to the proposed rule because this rulemaking is an action that is reasonably taken to fulfill an obligation mandated by state law, which is exempt under Texas Government Code §2007.003(b)(4). Nevertheless, the board further evaluated the proposed rule and performed an assessment of whether it constitutes a taking under Texas Government Code Chapter 2007. Promulgation and enforcement of this proposed rule would be neither a statutory nor a constitutional taking of private real property. Specifically, the subject proposed rule does not affect a landowner's rights in private real property because this rulemaking does not burden or restrict or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulation. Therefore, the proposed rule does not constitute a taking under Texas Government Code Chapter 2007.

SUBMISSION OF COMMENTS

Comments on the proposed rulemaking will be accepted until 30 days following publication in the *Texas Register* and may be submitted to Mr. Les Trobman, Office of General Counsel, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231 or *rulescomments@twdb.texas.gov* or by fax to (512) 475-2053.

STATUTORY AUTHORITY

This new rule is proposed under Texas Water Code §6.101, which gives the TWDB authority to adopt rules, and Texas Government Code §2261.253, which requires the TWDB to establish by rule a procedure to identify contracts that require enhanced monitoring.

Cross reference to statute: Texas Water Code §6.101, Texas Government Code §2261.253.

§353.140. Enhanced Contract Monitoring Procedure.

(a) All contract managers, with the support of contract administration, will perform a risk analysis prior to the execution of a contract to determine whether enhanced contract or performance monitoring is necessary. The impact and probability of the following attributes will be considered, as applicable:

(1) contract cost revisions;

(2) contract duration limitations;

(3) transaction and data volume;

(4) monitoring and quality assurance;

(5) vendor control activities and data quality;

(6) communication and customer service;

(7) complexity of vendor operations and processes;

(8) complexity of contract scope or deliverables;

(9) close out, including untimely delivery, outstanding invoices or unresolved matters creating delays;

(10) extent of government regulations;

(11) vendor cooperation with audits;

(12) potential for public disclosure;

(13) vendor experience and past performance;

(14) physical and system security;

(15) data security;

(16) business continuity/disaster recovery;

(17) training;

(18) financial assurance and credit worthiness;

(19) fraud, waste and abuse; and/or

(20) any other factors that may impact the contract.

(b) Any contract rated high risk will receive enhanced contract monitoring to be performed by the contract manager. Enhanced contract monitoring may include the following actions, as applicable:

(1) weekly or monthly progress reports;

(2) documented controlled correspondence;

(3) regular site visits;

(4) project team meetings; and/or

(5) documentation of corrective actions.

(c) Contract and performance monitoring activities will be documented and reported to the board on a quarterly basis. Contract administration will immediately notify the board of any serious issue or risk that is identified with respect to a contract subject to enhanced monitoring.

(d) This process does not apply to an interagency agreement or contract, interlocal agreement, memorandum of understanding, or a contract for which there is not a cost.

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

Filed with the Office of the Secretary of State on September 23, 2016.

TRD-201604974
Les Trobman
General Counsel
Texas Water Development Board
Earliest possible date of adoption: November 6, 2016
For further information, please call: (512) 463-7686

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 1. CENTRAL ADMINISTRATION

SUBCHAPTER A. PRACTICE AND PROCEDURES

DIVISION 3. SUPPORT SERVICES

34 TAC §1.73

The Comptroller of Public Accounts proposes new §1.73, concerning exemption from vehicle inscription requirement. The new section will be under Chapter 1, Central Administration, Subchapter A, Practice and Procedures, Division 3, Support Services.

New §1.73 exempts certain motor vehicles that are under the control and custody of the comptroller's office from the inscription requirements of Transportation Code, §721.002. The purpose of this rule is to facilitate secure transportation and civil and criminal investigations or enforcement.

Tom Currah, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Currah also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule would assist the comptroller to effectively and efficiently perform agency functions. The proposed amendment would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Stephen McDonald, Manager, Support Services, P.O. Box 12050, Austin, Texas 78711. Comments must be received no later than 30 days from the date of publication of the proposal in the *Texas Register.*

The new section is proposed under Transportation Code, §721.003, which authorizes the comptroller to adopt a rule to exempt a motor vehicle that is under the comptroller's custody and control.

The new section implements Transportation Code, §721.003.

§1.73. Exemption From Vehicle Inscription Requirement.

(a) State-owned motor vehicles under the control and custody of the comptroller shall be exempt from the inscription requirement in Transportation Code, §721.002 if used primarily for:

(1) civil or criminal investigations or enforcement; or

(2) transportation of the comptroller or deputy comptroller.

(b) The purposes of this new section are to provide secure transportation necessary for statewide oversight, management and supervision of the comptroller's office, and to increase the effectiveness of civil and criminal investigations and enforcement by enabling investigators and enforcement personnel to accomplish their tasks undetected.

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

Filed with the Office of the Secretary of State on September 20, 2016.

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Lita Gonzalez
General Counsel
Comptroller of Public Accounts
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