

# ADOPTED RULES

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

## TITLE 4. AGRICULTURE

### PART 1. TEXAS DEPARTMENT OF AGRICULTURE

#### CHAPTER 19. QUARANTINES AND NOXIOUS AND INVASIVE PLANTS

##### SUBCHAPTER R. FORMOSAN TERMITE QUARANTINE

###### 4 TAC §19.181

The Texas Department of Agriculture (the department) adopts an amendment to §19.181, concerning a quarantine for the Formosan subterranean termite, *Coptotermes formosanus* Shiraki, without changes to the proposed text as published in the July 31, 2009, issue of the *Texas Register* (34 TexReg 4986).

The amendment is adopted to add Brazos, Chambers, Comal, Fort Bend and Nacogdoches counties to the list of subterranean termite-infested counties in Texas. The Texas A&M University recently informed the department that the subterranean termite infestations were detected in these five counties since publication of the list of the 25 termite-infested counties in the August 11, 2006, issue of the *Texas Register* (31 TexReg 6297).

The amended section was adopted on an emergency basis on June 16, 2009, as published in the July 3, 2009, issue of the *Texas Register* (34 TexReg 4389). The department believes that restriction on the movement of quarantined articles from these five counties would delay the spread of this termite into free areas of Texas. The department further believes that it is necessary to take this action to reduce spread of the Formosan subterranean termite into free areas of Texas.

The amendment to §19.181 adds Brazos, Chambers, Comal, Fort Bend and Nacogdoches counties to the list of the Formosan subterranean termite-infested counties in Texas.

No comments were received on the proposal.

The amendment to §19.181 is adopted under the Texas Agriculture Code (the Code) §71.002, which provides the department with the authority to quarantine an area if it determines that a dangerous insect pest or plant disease not widely distributed in this state exists within an area of the state; the Code, §71.003, which provides the department with the authority to declare an area pest-free and quarantine surrounding areas if it determines that an insect pest or plant disease of general distribution in this state does not exist in an area; and the Code, §71.007, which authorizes the department to adopt rules as necessary to protect agricultural and horticultural interests, including rules to provide for a specific treatment of quarantined articles.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 10, 2009.

TRD-200903982

Dolores Alvarado Hibbs

General Counsel

Texas Department of Agriculture

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For further information, please call: (512) 463-4075

## TITLE 16. ECONOMIC REGULATION

### PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

#### CHAPTER 45. MARKETING PRACTICES

##### SUBCHAPTER E. MISCELLANEOUS

###### DIVISION 1. DELINQUENT LIST

The Texas Alcoholic Beverage Commission (Commission) adopts the repeal of §45.121, relating to delinquent list, without changes and adopts the new §45.121, relating to credit restrictions and delinquent list for liquor, with changes to the proposed text as published in the June 5, 2009, issue of the *Texas Register* (34 TexReg 3489).

Section 102.32 of the Texas Alcoholic Beverage Code (Code) provides that no seller may sell and no retailer may purchase liquor except for cash or on terms requiring payment on or before the 25th of the month for purchases made between the 1st and the 15th of the month and on or before the 10th day of the following month for purchases made between the 16th and the last day of the month. The section requires records of deliveries and purchases. The section also requires a seller to immediately report when a retailer becomes delinquent on an account and prohibits sales of any liquor to a retailer who is delinquent until the account is paid in full. An account becomes delinquent under subsection (d) of the statute if it is not paid as required by subsection (c). A seller who violates the section commits an offense under the Code. The section was amended by HB 2560, 81st Legislative Session (2009), which added §102.32(d-1). The amendment prohibits the Commission from accepting a voluntary cancellation or suspension from a retailer who is delinquent. It also disqualifies a retailer from holding another permit if the re-

tailer's permit was cancelled or expired while the retailer was delinquent on an account, until all delinquencies are satisfied.

Existing §45.121 is repealed and replaced with adopted new §45.121.

The new section reorganizes the content of the existing rule, updates the text of the rule to a plain language standard, and equalizes the duties of sellers and retailers for avoiding credit law violations. It additionally implements the amendment to §102.32(b-1).

Comments were received from individuals and representatives of the following industry members; the Texas Package Store Association, the Texas Restaurant Association, the Texas Petroleum and Convenience Store Association, the Greater Austin Merchants Association, the Northern Texas Trade Association, the South Texas Merchants Association and the Greater Houston Retailers Association. Comments were also received from agency staff.

Comment: Regarding §45.121(b) agency staff requested that definitions be added for delinquent payment, event, and incident.

Response: The Commission agrees with the comment. The terms were added to the definition subsection to provide clarity to the rule.

Comment: Regarding §45.121(d)(2) agency staff suggested that since HB 2560 made the disqualification mandatory the subsection was no longer needed in the rule.

Response: The Commission agrees in part and disagrees in part. The Commission agrees that making the disqualification for a permit mandatory in the Code for a credit law violation requires that the rule be changed from the proposed discretionary language. Most reasons for mandatory or discretionary refusals are located in the general provisions Chapters 11 and 61, or in the chapters providing authority for each permit. Because this is a significant change, and because it is not located in the usual places, the Commission has determined that the subsection, as changed should be retained in the rule text.

Comment: Regarding §45.121(e)(1) staff commented that the proposed language was too limiting and should be more general to allow the Commission to change forms and the web based reporting system.

Response: The Commission agrees and the rule was changed.

Comment: Regarding §45.121(e)(3) one commenter suggested that the two day reporting imposes a specific time requirement that is not necessary to accomplish the purpose of ensuring that delinquent reports and payments are timely and accurately filed before the publication of the delinquent list.

Response: The Commission agrees with the comment and the rule was changed.

Comment: Regarding §45.121(h), Commission staff commented that because paper documents are no longer routinely required as a part of the reporting requirements, a person requesting an exception should be required to submit documents and records tending to support the exception.

Response: The Commission agrees with the comment and greater detail was added to provide examples of the kind of documents or records that the Commission would consider to evaluate the exception.

Comment: Regarding §45.121(i), Commission staff suggested that "repeat" be changed to read "one or more" to allow the Commission to consider not just how many delinquencies occurred but also the dollar amounts.

Response: The Commission agrees with the comment and the rule has been changed.

Comment: Regarding §45.121(j), many comments were received requesting that the dates the delinquent list is published remain the same as they were in the previous rule, or in the alternative that the implementation of a shorter time frame be phased in over time.

Response: The Commission agrees in part and disagrees in part. The publication dates in the proposed rule accurately reflect the dates in §102.32(c) of the Code. The reason the time was extended for 10 days in the repealed rule was to allow the Commission the time needed to compile the information, to data-enter all of the paper reports and supporting documents, and to ensure accuracy before publication of the delinquent list. The direct submission of information by industry has eliminated the paper process and the delay no longer justifies a conflict between the statute and the rule. However, because systems have been structured around the time delays the Commission has agreed to a step down period. The rule will be amended to subtract 2 days from the publication date each year until the publication date of the delinquent list will be the same as the Code requires.

Comment: Regarding §45.121(j)(4) staff commented that the web-based system could be continuously updated, regardless of whether the Commission was open. Additionally, the continuous updates are for payments received; violations are only reported on the date the delinquent list is published.

Response: The Commission agrees and the rule text was changed.

#### **16 TAC §45.121**

The repeal is adopted under the authority of §5.31 and §102.32 of the Alcoholic Beverage Code. Section 5.31 gives the commission authority to prescribe and publish rules necessary to carry out the provisions of Code. Section 102.32 provides the specific authority to adopt these rules to give effect to the section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 8, 2009.

TRD-200903954

Alan Steen

Administrator

Texas Alcoholic Beverage Commission

Effective date: September 28, 2009

Proposal publication date: June 5, 2009

For further information, please call: (512) 206-3204



#### **16 TAC §45.121**

The new rule is adopted under the authority of §5.31 and §102.32 of the Alcoholic Beverage Code. Section 5.31 gives the commission authority to prescribe and publish rules necessary to carry

out the provisions of Code. Section 102.32 provides the specific authority to adopt these rules to give effect to the section.

*§45.121. Credit Restrictions and Delinquent List for Liquor.*

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

(b) Definitions.

(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 day it is required to be paid by §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.

(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, and their agents, servants and employees.

(7) Seller--A wholesaler, class B wholesaler, winery, wine bottler, or local distributor 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.

(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 is cancelled for cause, voluntarily cancelled, expires, suspended or placed in suspension while on the 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.state.tx.us](http://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 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 on or before the date the 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 Delinquent List, or 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 to 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 bank error or circumstances beyond the control of Retailer caused the check to be returned to Seller unpaid, or

(D) bank statement or records showing 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 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 the violation(s) is/are 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 <http://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) The Delinquent List will be published the 5th day of the month for purchases made from the 1st to the 15th day of the preceding month, for which payment was not made on or before the 25th day of the preceding month. The Delinquent List will be published the 20th day of the month for purchases made between the 16th and the last day of the preceding month for which payment was not made on or before the 10th day of the 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, Sunday or a state or federal holiday, will be the next regular business day. A payment sent by U.S. postal service or other mail delivery service is deemed made on the date postmarked or proof of date delivered to the mail delivery service. A payment hand delivered to an individual authorized to accept payment on behalf of the Seller is deemed made when the authorized individual takes possession of the payment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 8, 2009.

TRD-200903956

Alan Steen

Administrator

Texas Alcoholic Beverage Commission

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For further information, please call: (512) 206-3204



## TITLE 25. HEALTH SERVICES

### PART 1. DEPARTMENT OF STATE HEALTH SERVICES

#### CHAPTER 409. MENTAL HEALTH SERVICES--MEDICAID PROGRAMS

##### SUBCHAPTER B. ADVERSE ACTIONS

###### 25 TAC §§409.31 - 409.35

The Executive Commissioner of the Health and Human Services Commission (HHSC) on behalf of the Department of State Health Services (department) adopts the repeal of §§409.31 - 409.35, concerning adverse actions for the Mental Health Services Medicaid Programs, without changes to the proposal as published in the June 5, 2009, issue of the *Texas Register* (34 TexReg 3494) and, therefore, the sections will not be republished.

#### BACKGROUND AND PURPOSE

These rules adopted by the former Texas Department of Mental Health and Mental Retardation (TDMHMR) were part of a broader set of rules that addressed fraud, abuse, and recovery of Medicaid payments, adverse actions and sanctions, and processes for requesting an administrative hearing. At the time they were adopted, these rules were necessary to fulfill the obligations of the former TDMHMR in administering the Mental Health Services Medicaid Programs. House Bill 2292, 78th Legislature, Regular Session (2003), effective September 1, 2004, resulted in the consolidation of organizational structure and functions of the health and human services agencies. As part of that consolidation, responsibility for matters relating to Medicaid program integrity, including administrative enforcement, sanctions, damages, and penalties, was made the exclusive jurisdiction of the Office of Inspector General (OIG) at HHSC. Also, at the time of the consolidation, these former TDMHMR rules were transferred to the department.

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). The department has determined that there is no need to retain the rules in Chapter 409, Subchapter B, because they have been superseded by the OIG rules in 1 TAC Chapter 371, Subchapter G, relating to Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity.

#### SECTION-BY-SECTION SUMMARY

The rules concern the application of the rules, definitions, notice of adverse actions, request for an administrative hearing, and withholding provider agreement payments.

#### COMMENTS

The department, on behalf of HHSC, did not receive any comments regarding the proposed repeal during the comment period.

#### LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the repeal, as adopted, has been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

#### STATUTORY AUTHORITY

The repeals are authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 10, 2009.

TRD-200903975

Lisa Hernandez  
General Counsel

Department of State Health Services

Effective date: September 30, 2009

Proposal publication date: June 5, 2009

For further information, please call: (512) 458-7111



## TITLE 28. INSURANCE

### PART 1. TEXAS DEPARTMENT OF INSURANCE

#### CHAPTER 21. TRADE PRACTICES

The Commissioner of Insurance adopts amendments to §§21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, and 21.3543, concerning exclusion of certain state-mandated health benefits in consumer choice health benefit plans, and new §§21.4401 - 21.4404, concerning mandated health benefit plan coverage for autism spectrum disorder coverage. Section 21.4402 and §21.4403 are adopted with changes to the proposed text published in the April 3, 2009, issue of the *Texas Register* (34 TexReg 2217). Sections 21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, 21.3543, 21.4401, and 21.4404 are adopted without changes.

**REASONED JUSTIFICATION.** The adopted amendments and new sections implement (i) House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008, relating to required autism spectrum disorder coverage for certain children; (ii) HB 1485, 79th Legislature, Regular Session, effective September 1, 2005, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans; and (iii) HB 1030, 79th Legislature, Regular Session, effective September 1, 2005, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. The adopted amendments are necessary to: (i) update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice health benefit plans; (ii) update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code; and (iii) correct citation style errors. New Subchapter JJ, consisting of §§21.4401 - 21.4404, is necessary to implement §1355.015 of the Insurance Code, which requires that health benefit plans provide autism spectrum disorder coverage for certain children.

A public hearing on the rule proposal was held on June 17, 2009. No public comments were received at the hearing. In response to written comments on the published proposal, the Department has changed some of the proposed language in the text of the rule as adopted. None of the changes made to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text as a result of comments.

The Department has revised the definition of "primary care physician" in §21.4402(7) as adopted to provide that if an enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a primary care physician is "a physician selected or otherwise designated by the enrollee or the enrollee's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder." The Department has added the words "by the enrollee or the enrollee's parent or guardian" in response to comments requesting that the rules ensure that health benefit plans cannot select or designate an enrollee's primary care physician. The purpose of this change is to ensure that the adopted rules do not inadvertently give a health benefit plan the ability to designate an enrollee's primary care physician in instances where selection or designation of the enrollee's primary care physician is not addressed within the health benefit plan policy or evidence of coverage.

The Department has revised §21.4403(a)(1) as adopted to provide that "[a]t a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). The Department has also revised §21.4403(a)(2) as adopted to provide that "[p]ursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a)." These changes are made in response to a comment requesting that the Department withdraw the rule as a result of the enactment of HB 451, passed by the 81st Legislature, Regular Session, effective September 1, 2009. The Department does not agree that it is necessary to withdraw the rule proposal because of the enactment of HB 451. Existing §1355.015(a) provides that at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder, and that if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Existing §1355.015(a) is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2008. HB 451 amends §1355.015(a) to provide that, at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. HB 451 also amends §1355.015(a) to provide that if an enrollee who is being treated for autism spectrum disorder becomes 10 years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Section 1355.015(a) as amended by HB 451 is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. These changes in §1355.015(a) by HB 451 to raise the age requirements for children eligible for coverage for autism spectrum disorder treatment under §1355.015 are the only changes enacted by HB 451 that impact the rules as proposed. The revision of §21.4403(a)(1) and (2) as adopted to reference the applicable statutory provision is consistent both with existing §1355.015(a) and §1355.015(a) as amended by HB 451.

HB 1919, relating to required autism spectrum disorder coverage for certain children. HB 1919 amends Insurance Code Chapter 1355, which regulates benefits for certain mental disorders. HB 1919 enacts §1355.015 to include, as a state-mandated benefit, coverage for certain children for all generally recognized services prescribed in relation to autism spectrum disorder by an insured's primary care physician in the treatment plan recommended by that physician. As a result of the enactment of HB 1919, the Department adopts new Subchapter JJ, consisting of §§21.4401 - 21.4404, to implement the Insurance Code §1355.015. The new adopted sections do not impose any new or additional requirements to those in the statute. Pursuant to §1355.015(e), Chapter 1507 consumer choice health benefit plans are not required to provide the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. It is, therefore, necessary to amend existing rules regulating consumer choice health benefit plans to provide that the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A, is not required to be offered or provided by these consumer choice health benefit plans.

The following paragraphs provide a brief summary as well as an analysis of the reasons for the adopted amendments and new sections necessitated by the enactment of HB 1919.

New Subchapter JJ consisting of §§21.4401 - 21.4404 is necessary to implement §1355.015 of the Insurance Code. Section 1355.015 requires that health benefit plans provide autism spectrum disorder coverage for certain children. The new sections simply set forth statutory provisions and provide necessary interpretations of those provisions. The new sections do not impose any new or additional requirements to those in the statute. New §21.4401 addresses the purpose and applicability of Subchapter JJ. New §21.4401(a) states that the subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of the new subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services for certain child enrollees diagnosed with autism spectrum disorder in accordance with the Insurance Code Chapter 1355, Subchapter A. New §21.4401(b)(1) and (2) is necessary to address the applicability of the subchapter, specifying the types of health benefit plans to which Subchapter JJ does and does not apply.

New §21.4402 provides definitions of terms used in Subchapter JJ. The terms defined in the section include: "applied behavior analysis," "autism spectrum disorder," "enrollee," "generally recognized services," "health care practitioner," "neurobiological disorder," and "primary care physician."

New §21.4403 addresses required coverage for autism spectrum disorder in accordance with the Insurance Code §1355.015. New §21.4403(a)(1) is necessary to specify that, at a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). New §21.4403(a)(2) is necessary to provide that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

In accordance with the Insurance Code §1355.015, new §21.4403(b) is necessary to clarify that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees

of other ages. New §21.4403(c) specifies that in accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. New §21.4403(d) specifies that pursuant to the Insurance Code §1355.015(d), coverage under the section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

New §21.4404 addresses health care practitioners. Pursuant to the Insurance Code §1355.015(b), new §21.4404(a) specifies that, a health care practitioner providing treatment for autism spectrum disorder under Chapter 1355, Subchapter A, of the Insurance Code and proposed new Subchapter JJ must meet one of the following requirements: (i) be licensed, certified, or registered by an appropriate agency of this state; (ii) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) be certified as a provider under the TRICARE military health system. In accordance with the Insurance Code §1355.015(b), new §21.4404(b) specifies that a health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

Existing §§21.3510 - 21.3513 and §§21.3515 - 21.3518 specify state-mandated health benefits that are not required to be included in specific types of consumer choice benefit plans that may be provided under Insurance Code Chapter 1507. The amendments to these sections are necessary to update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice health benefit plans. The amendments simply reflect statutory provisions and do not impose any new or additional requirements to those in the statute. The Insurance Code in Chapter 1507, which regulates consumer choice health benefit plans, specifies those health benefit plans that are not required to offer or provide state-mandated health benefits, including individual indemnity policies, group association indemnity policies, small employer indemnity policies, large employer indemnity policies, individual HMO plans, group HMO plans, small employer HMO plans, and large employer HMO plans. Pursuant to §1507.001 and §1507.051, Chapter 1507 was enacted in recognition of the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans and health maintenance organization plans that are more affordable and flexible than policies offering accident and sickness insurance coverage and health care plans offered by health maintenance organizations available in the existing market. The purpose of Chapter 1507, therefore, is to increase the availability of health insurance coverage by allowing authorized insurers and health maintenance organizations to issue health plans that, in whole or in part, do not offer or provide state-mandated health benefits. Because of the §1355.015(e) provision that the statutorily mandated coverage of autism spectrum disorder does not apply to a standard health benefit plan provided under Chapter 1507, it is necessary to amend certain existing rules for consistency with §1355.015(e). The Insurance Code Chapter 1355, Subchapter A, applies to group health benefit plans. There are six types of

consumer choice group health benefit plans. However, pursuant to §1355.015(e), no consumer choice health benefit plans are required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. As a result, the following amendments are adopted to reflect this statutory exemption: (i) §21.3511(23) reflects the exemption for group association indemnity consumer choice health benefit plans; (ii) §21.3512(16) reflects the exemption for small employer group indemnity consumer choice health benefit plans; (iii) §21.3513(23) reflects the exemption for large employer group indemnity consumer choice health benefit plans; (iv) §21.3516(27) reflects the exemption for non-employer group HMO consumer choice health benefit plans; (v) §21.3517(20) reflects the exemption for small employer group HMO consumer choice health benefit plans; and (vi) §21.3518(27) reflects the exemption for large employer group HMO consumer choice health benefit plans.

HB 1485, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans. It is also necessary to adopt amendments to existing rules to implement HB 1485, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans. Enacted by the 79th Legislature, HB 1485 amended former Insurance Code Articles 3.80 §3 and 20A.09N(d), now §1507.003 and §1507.053, respectively. The 79th Legislature also enacted HB 2018 which, as part of the non-substantive revision of the Insurance Code, adopted without substantive change both Article 3.80 §3 as the Insurance Code §1507.003 and Article 20A.09N(d) as the Insurance Code §1507.053, effective September 1, 2005. The HB 1485 amendment to Article 3.80 §3 (now §1507.003) revised the definition of "state mandated benefits," to not include "coverage for serious mental illness under Subchapter A, Chapter 1355." Prior to the amendment, the term did not include coverage for serious mental illness "under Article 3.51-14, Insurance Code, if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The amendment updated the statutory reference and deleted the qualifying phrase "if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The result of this amendment is: (i) a small employer group indemnity consumer choice health benefit plan is required to include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a standard health benefit plan issued as part of a group association indemnity policy is required to include serious mental illness under Subchapter A, Chapter 1355. The HB 1485 amendment to Article 20A.09N(d) (now §1507.053) revised the definition of "state mandated benefits," to not include coverage for "serious mental illness under Subchapter A, Chapter 1355 of the Insurance Code." Prior to the amendment, the term did not include coverage for serious mental illness "under Article 3.51-14, Insurance Code, if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The amendment deleted the qualifying phrase "if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The result of this amendment is: (i) a small employer group Health Maintenance Organization (HMO) consumer choice health benefit plan is required to include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a non-employer group HMO consumer choice health benefit plan is required include serious mental illness under Subchapter A, Chapter 1355.

Prior to the HB 1485 amendments to Articles 3.80 §3 and 20A.09N(d), four types of consumer choice health benefit plans were not required to include either the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness as required by the Insurance Code Article 3.51-14 (now Chapter 1355, Subchapter A, of the Insurance Code). As a result, the exemptions were reflected in §§21.3511(9), 21.3512(9), 21.3516(13), and 21.3517(13). Section 21.3511(9) provided that the state-mandated health coverage for serious mental illness was not required to be included in a group association indemnity consumer choice health benefit plan. Section 21.3512(9) provided that the state-mandated offer of health coverage for serious mental illness was not required to be included in a small employer group indemnity consumer choice health benefit plan. Therefore, when these state-mandated exemptions in §21.3511(9) and §21.3512(9) were originally adopted in 2004, the exclusions were consistent with the Insurance Code Article 3.80 §3 (now §1507.003 of the Insurance Code). Section 21.3516(13) provided that the state-mandated health coverage of serious mental illness was not required to be included in a non-employer group HMO consumer choice health benefit plan. Section 21.3517(13) provided that the state-mandated offer of health coverage for serious mental illness was not required to be included in a small employer group HMO consumer choice health benefit plan. Therefore, when these state-mandated exemptions in §21.3516(13) and §21.3517(13) were originally adopted in 2004, the exclusions were consistent with the Insurance Code Article 20A.09N(d) (now §1507.053 of the Insurance Code). All four of these exemptions are deleted in this adoption because the exemptions are no longer statutorily authorized pursuant to the Insurance Code §§1507.003 and 1507.053. The adopted deletions are necessary for consistency with statutory provisions revised by the enactment of HB 1485.

HB 1030, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. Deletion of some existing rules is necessary to implement HB 1030, enacted by the 79th Legislature, which added §1301.0046 to the Insurance Code. Section 1301.0046 provides that an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. The §1301.0046 coinsurance limitation supersedes the Department's rule in §3.3704(a)(6), relating to Freedom of Choice, Availability of Preferred Providers.

Prior to the enactment of HB 1030, the Insurance Code did not specify a specific percentage limit by which an insured's coinsurance amount applicable to payment to a non-preferred provider could exceed the total covered amount applicable to the medical or health care services. Therefore, pursuant to the Insurance Code Article 3.42(i)(2) (now §1701.055(a)(2)), the Department adopted a limit by rule in §3.3704(a)(6).

Section 3.3704(a)(6) specifies the basic level of coverage required for a preferred provider benefit plan to not be considered unjust or unfair discrimination under the Insurance Code. Section 3.3704(a)(6) provides that: "A preferred provider benefit plan shall not be considered unjust under the Insurance Code Article 3.42, or unfair discrimination under the Insurance Code Articles 21.21-6 or 21.21-8, or to violate Articles 3.70-2(B) or 21.52 of the Insurance Code provided that. . . (6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30% less than the higher level of coverage. A reasonable difference in deductibles shall be determined considering the benefits of each individual policy; . . ." However, prior to this

adoption, §§21.3510 - 21.3513 specified exemptions for certain consumer choice health benefit plan to the limitations or restrictions on coinsurance imposed by §3.3704(a)(6) based on Chapter 1507 of the Insurance Code. As previously noted, Chapter 1507 of the Insurance Code regulates consumer choice health benefit plans. Section 1507.001 states the purpose of the chapter: "The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits." To meet the stated purpose of Chapter 1507 to provide for more affordable and flexible health insurance plans, the Department adopted the exemptions to §3.3704(a)(6) in §§21.3510 - 21.3513. These exemptions, which are deleted in this adoption, were specified in the following consumer choice health benefit plan rules: (i) §21.3510(5), individual indemnity consumer choice health benefit plans; (ii) §21.3511(5), group association indemnity consumer choice health benefit plans; (iii) §21.3512(5), small employer group indemnity consumer choice health benefit plans; and (iv) §21.3513(5), large employer group indemnity consumer choice health benefit plans. However, as a result of the enactment of HB 1030, it is no longer necessary to include exemptions to §3.3704(a)(6) in §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5). With the enactment of HB 1030, an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. As previously noted, the §1301.0046 coinsurance limitation is applicable to all health benefit plans, including consumer choice health benefit plans. Also, as previously noted, the §1301.0046 coinsurance limitation supersedes the §3.3704(a)(6) requirement. According to the Senate Research Center bill analysis for HB 1030, the purpose of the legislation is to provide more options for employers and individuals looking for affordable health insurance. (SENATE RESEARCH CENTER, BILL ANALYSIS (ENGROSSED)), HB 1030, 79TH Legislature, Regular Session effective September 1, 2005.) This purpose is consistent with the purpose of the Insurance Code Chapter 1507 as stated in §1507.001. Therefore, because the exemptions are no longer statutorily authorized and because HB 1030 addresses the purpose for adopting them, it is necessary to delete the exemptions in §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5) from the §3.3704(a)(6) requirement.

Update of obsolete statutory citations and conformation with current Department citation style. Amendments are also necessary to update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code. This will result in easier use and readability of the rules. Additionally, amendments are necessary throughout the amended sections to change references to "Insurance Code" to "the Insurance Code" to conform to current Department citation style. Amendments are adopted in the following sections to update statutory citations to conform with the non-substantive revised Insurance Code: §21.3502(3), (7), (10)(A)(ii) and (B); §21.3510(1) - (4); renumbered §21.3510(5) - (8), (11), and (13); §21.3511(1) - (4); renumbered §21.3511(5) - (7), (8) - (20), and (22); §21.3512(1) - (4); renumbered §21.3512(5) - (7), (8) - (13), and (15); §21.3513(1) - (4); renumbered §21.3513(5) - (20) and (22); §21.3515(1) - (7), (10) - (14), and (16); §21.3516(1)

- (7) and (10) - (12); renumbered §21.3516(13) - (24) and (26); §21.3517(1) - (7) and (10) - (12); renumbered §21.3517(13) - (17) and (19); §21.3518(1) - (7), (10) - (24), and (26); §21.3540; and §21.3543(1)(A) and (B).

HOW THE SECTIONS WILL FUNCTION. Adopted §21.3511(23) provides that a group association indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. Under adopted §21.3512(16), a small employer group indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. Adopted §21.3513(23) provides that a large employer group indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. A non-employer group HMO consumer choice health benefit plan is not required under adopted §21.3516(27) to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. Under adopted §21.3517(20), a small employer group HMO consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. A large employer group HMO consumer choice health benefit plan is not required under adopted §21.3518(27) to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

Adopted new Subchapter JJ implements the coverage for autism spectrum disorder mandated by HB 1919, 80th Legislature, Regular Session, effective January 1, 2008. Adopted new §21.4401 addresses the purpose and applicability of Subchapter JJ. Adopted §21.4401(a) states that the subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of the proposed new subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services for certain child enrollees diagnosed with autism spectrum disorder in accordance with the Insurance Code Chapter 1355, Subchapter A. Adopted §21.4401(b)(1) and (2) addresses the applicability of the subchapter, specifying the types of health benefit plans to which Subchapter JJ does and does not apply.

New §21.4402 defines terms used in Subchapter JJ. The terms defined in the section include: "applied behavior analysis," "autism spectrum disorder," "enrollee," "generally recognized services," "health care practitioner," "neurobiological disorder," and "primary care physician."

New §21.4403 addresses required coverage for autism spectrum disorder. New §21.4403(a)(1) specifies that, at a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). New §21.4403(a)(2) provides that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

New §21.4403(b) clarifies that a health benefit plan is not precluded from providing coverage of treatment and services described by the Insurance Code §1355.015(b) for enrollees of other ages. New §21.4403(c) specifies that in accordance with

the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. New §21.4403(d) specifies that pursuant to the Insurance Code §1355.015(d), coverage under the section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

New §21.4404 addresses health care practitioners. New §21.4404(a) specifies that, pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under Chapter 1355, Subchapter A, of the Insurance Code and proposed new Subchapter JJ must meet one of the following requirements: (i) be licensed, certified, or registered by an appropriate agency of this state; (ii) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) be certified as a provider under the TRICARE military health system. New §21.4404(b) specifies that a health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long as the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

Several provisions are adopted with updated statutory citations to conform to the non-substantive revised Insurance Code. These provisions include: §21.3502(3), (7), (10)(A)(ii) and (B); §21.3510(1) - (8), (11), and (13); §21.3511(1) - (20) and (22); §21.3512(1) - (13) and (15); §21.3513(1) - (20) and (22); §21.3515(1) - (7), (10) - (14), and (16); §21.3516(1) - (7) and (10) - (24) and (26); §21.3517(1) - (7) and (10) - (17) and (19); §21.3518(1) - (7), (10) - (24), and (26); §21.3540; and §21.3543(1)(A) and (B).

## SUMMARY OF COMMENTS AND AGENCY RESPONSE.

### General Comments

#### Withdrawal of the rule proposal

Comment: A commenter requests that the rule proposal be withdrawn because HB 451 was filed in the 2009 Texas Legislature, and the bill amends the existing law created by HB 1919 in order to change the age range of coverage for children with autism spectrum disorder. The commenter says that this change makes the proposed rule's interpretation of the covered ages null and void.

Agency Response: The Department disagrees with the commenter's suggestion to withdraw the rule proposal and declines to take this action. HB 451 was passed by the Texas Legislature and amends the existing law enacted by HB 1919 to change the age of coverage for children with autism spectrum disorder. As a result, the Department has modified the text of §21.4403(a)(1) as adopted to provide: "At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a). Additionally, the Department has modified the text of §21.4403(a)(2) as adopted to provide: "Pursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because

an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a)." Existing §1355.015(a) provides that at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder, and that if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Existing §1355.015(a) is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2008. HB 451 amends §1355.015(a) to provide that, at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. HB 451 also amends §1355.015(a) to provide that if an enrollee who is being treated for autism spectrum disorder becomes 10 years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Section 1355.015(a) as amended by HB 451 is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. The revision of §21.4403(a)(1) and (2) as adopted is consistent with the Insurance Code §1355.015(a) as enacted by HB 1919 and by HB 451.

#### Creation of a Resource Guide

Comment: Two hundred and two commenters ask that the Department work with stakeholders to create a Frequently Asked Questions list regarding autism coverage in Texas. Another commenter requests that the Department work in cooperation with health benefit plans, providers, and consumers to create and post a web-based resource guide or list of Frequently Asked Questions to provide specific guidance on implementation of HB 1919.

Agency Response: While the Department already has a web-based resource page addressing coverage for autism spectrum disorder, it does not currently contain a list of Frequently Asked Questions (FAQs). This is because the Department has not yet received enough inquiries regarding coverage for autism spectrum disorder with which to compile such a list. In accordance with the Department's current procedure, when enough such questions are received, a list of FAQs will be compiled and posted on the Department's web-based resource page addressing coverage for autism spectrum disorder.

#### §21.4401. Purpose and applicability

Comment: A commenter suggests striking the following statement from proposed §21.4401: "The general purpose of this subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services of certain children enrollees diagnosed with autism spectrum disorder, as provided in the Insurance Code Chapter 1355, Subchapter A." According to the commenter, the purpose of HB 1919 is determined by the language of the bill, and absent any legislative finding or direction, the rule should reflect the language of the statute.

Agency Response: The Department disagrees with the commenter and declines to make a change. Section 21.4401 does not state the purpose of HB 1919; it states the purpose of the Department's rules.

Comment: Two hundred and three commenters request that the adopted rule clarify that the Texas Health Risk Pool is required to provide autism coverage under HB 1919.

Agency Response: The Department cannot make the requested change because it would exceed the Department's rulemaking authority. Neither the Insurance Code Chapter 1506 (relating to the Texas Health Risk Pool) nor the Insurance Code Chapter 1355, Subchapter A, (relating to Group Benefit Health Plan Coverage for Certain Serious Mental Illnesses and Other Disorders) provide that the Texas Health Risk Pool is to provide coverage for autism spectrum disorder. Neither Chapter 1506 nor Chapter 1355 authorizes the Department to require coverage that is not authorized by statute. Rather, the Insurance Code §1506.151(a) provides that the Texas Health Risk Pool is required to offer "coverage consistent with major medical expense coverage to each eligible individual." Section 1506.151(b) provides that the specific coverages to be provided by the Texas Health Risk Pool are to be established by the Board of Directors of the Texas Health Risk Pool with the approval of the Commissioner. Therefore, in order for the Texas Health Risk Pool to be required to provide coverage for autism spectrum disorder, the Board of Directors of the Risk Pool would have to authorize such coverage, and such coverage would have to be approved by the Commissioner.

#### §21.4402(1). Definition of "applied behavior analysis"

Comment: One commenter objects to the definition of "applied behavior analysis" in proposed §21.4402(1) because, while it is an improvement over earlier drafts, it is still "vague to the point of providing no direction." A second commenter suggests revising the definition to include reference to empirical validation by adding the following: ". . . meaningful degree. This would include the collection and analysis of individual data collected on treatment progress."

Agency Response: The Department disagrees with the commenters and declines to make any change. The proposed definition for "applied behavior analysis," which is adopted without change, is based on the definition developed and used by TRICARE. Because TRICARE certified providers are expressly permitted to provide ASD services and treatment under the Insurance Code §1355.015, the Department believes that it is appropriate that this definition apply for all other statutorily recognized providers of ASD treatment as required under §1355.015 of the Insurance Code. Therefore, the Department does not agree that the definition is "vague to the point of providing no direction" or that the requested change to the proposed definition is necessary or appropriate.

Comment: A commenter suggests referencing "board certified" behavior analysis in proposed §21.4402(1), so that individuals with some other credential that would meet the state requirement but who do not have training in applied behavior analysis cannot practice or bill for it.

Agency Response: The Department disagrees with the comment and declines to make a change. The Department does not have the authority to regulate the practice of medicine. Additionally, the Insurance Code §1355.015(b) specifies the types of health care practitioners who meet the statutory requirements to provide ASD treatment under §1355.015 of the Insurance Code. The Department does not have the authority to prevent a health care practitioner who meets those qualifications from billing for the treatment the health care practitioner provides as long as the treatment is in accordance with §1355.015 and these rules.

#### §21.4402(4). Definition of "generally recognized services"

Comment: One commenter requests that the definition of "generally recognized services" in proposed §21.4402(4) be revised to track the statutory language in §1355.015(c) of the Insurance Code. The statutory language provides that "generally recognized services" "may include services such as . . ." and then specifies those services listed in §21.4402(4). Section 1355.015(c), however, does not include the language in §21.4402(4) "The term includes, but is not limited. . . ." The commenter also observes that the proposed definition of "generally recognized services" does not include a requirement that services prescribed be "medically necessary." The commenter asserts that with the exception of preventive care services, the commenter is not aware of any precedent that provides for coverage of medical care that does not have to meet a standard of medical necessity. According to the commenter, removing the ability of an insurer to establish that proposed care is appropriate removes any restriction on the reasonableness of care and can result in increased expenses. Additionally, it can also result in danger to consumers, as review of proposed care by a third party protects the consumer by comparing the proposed care to well established standards of care.

Agency Response: The Department disagrees with the commenter and declines to make a change. Pursuant to the Government Code §311.005(13), the term "includes" when used in a statute is a term of enlargement, not limitation, and use of the term does not create a presumption that components not expressed are excluded. Therefore, the provision in proposed §21.4402(4), stating that the term "generally recognized service. . . includes, but is not limited to, the following services. . . ." is consistent with the Government Code §311.005(13) rule of construction and is adopted without change. It is the Department's position that this statement is a necessary and accurate clarification of §1355.015(c) of the Insurance Code. With regard to the comment concerning the addition of an express requirement that generally recognized services must be "medically necessary," the Department disagrees that such a requirement should be included. The inclusion of such a requirement is not consistent with the Insurance Code §1355.015, which does not address medical necessity. The Insurance Code §1355.015 neither mandates that utilization review be conducted nor restricts a health benefit plan's ability to conduct utilization review. These rules are consistent with §1355.015.

#### §21.4402(5). Definition of "health care practitioner"

##### §21.4404(b). Coverage for applied behavior analysis

Comment: A commenter objects to the definition for "health care practitioner" in proposed §21.4402(5) because it appears to allow for any type of provider, qualified or not, to deliver services. The commenter points out that the Insurance Code already contains a definition of "health care practitioner" in §1451.001 of the Insurance Code. The commenter also objects to proposed §21.4404(b), which provides that a health plan may not deny coverage on the basis that a health care practitioner does not hold a license issued by an agency of this state because the Insurance Code contains a definition of health care practitioner in the Insurance Code §1451.001. The commenter again points out that §1451.001 provides a list of practitioners, and the commenter states that all of the listed practitioners are required to be licensed by a state board or agency.

Agency Response: The Department disagrees with the commenter and declines to make a change. The definition in the Insurance Code §1451.001 is applicable to the Insurance Code Chapter 1451, which regulates access to certain practitioners

and facilities. These rules implement the Insurance Code Chapter §1355.015, which regulates autism spectrum disorder coverage for certain children. The definition in proposed §21.4402(5) and the provision proposed in §21.4404(b), which are adopted without change, are based on provisions in the Insurance Code §1355.015(b) that specify the qualifications of a health care practitioner whose autism spectrum disorder treatment is covered under §1355.015.

#### §22.4402(7). Definition of "primary care physician"

Comment: One commenter references the words "develop a treatment plan for the purpose of treating autism spectrum disorder" in proposed §21.4402(7) and states that clarification is needed regarding what is to be involved in such a treatment plan. The commenter asserts that the final rule should indicate that any treatment plan developed by a primary care physician should be a very general treatment plan. According to the commenter, the final rule should not leave open the possibility of a physician dictating to other specially and appropriately trained professionals details of what to do and how to do it. Otherwise, the rule could result in physicians recommending or prescribing inappropriate interventions or inappropriately sequenced interventions as well as inappropriate therapeutic methods or time and resource wasting delays in development of appropriate treatment plans.

Agency Response: The Department disagrees with the commenter and declines to make a change. The treatment plan is part of the medical care provided by a doctor, and the Department does not have the authority to regulate or direct the care that a doctor provides. In regard to the commenter's concern that a physician might recommend or prescribe inappropriate care that results in a waste of time or resources, neither the Insurance Code §1355.015 nor these adopted rules prevent a health benefit plan from conducting utilization review. Through use of a utilization review program, health benefit plans can prevent the use of inappropriate or wasteful treatments.

Comment: A commenter requests that proposed §22.4402(7) be revised to read: "A physician selected or otherwise designated by the enrollee as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated *by the enrollee* to develop a treatment plan for the purpose of treating autism spectrum disorder." The commenter notes that the proposed definition for "primary care physician" includes the words "selected or designated." According to the commenter, insurance companies, historically, have used "designated" primary care physicians combined with financial disincentive plans to ensure extremely low uptake of particular services which might otherwise be covered. The commenter also asserts that many primary care physicians have no more than a cursory knowledge of autism and that these physicians would prefer the enrollee switch to a primary care physician who has extensive experience with autism and autism treatment programs. The commenter states that if autism treatment program quality is to be kept high the person prescribing and managing it should be knowledgeable about the intricacies of quality treatment. According to the commenter, the proposed definition for "primary care physician" potentially allows health benefit plans the ability to select or designate an enrollee's primary care physician, even without specific plan authorization to do so.

Agency Response: The Department agrees in part with the commenter and has revised §22.4402(7) as adopted similarly to the change requested. The first instance in which the phrase "A physician selected or otherwise designated as the enrollee's primary care physician. . . ." is used references health benefit plans that contain provisions specifying how a primary care physician is to be selected or designated. Such health benefit plans might have instances in which the health benefit plan issuer is permitted to designate a primary care physician. It is not appropriate for the rule to exclude or negate such permitted instances. The second instance in which the phrase "a physician selected or otherwise designated as the enrollee's primary care physician. . . ." is used references health benefit plans that do not contain provisions specifying how a primary care physician is to be selected or designated. It is necessary to stipulate what a "primary care physician" is in regard to such health benefit plans; otherwise there would be no "primary care physician" to prescribe treatment. It is not the intent of these rules to authorize health benefit plans to designate an enrollee's primary care physician in the absence of a contract provision that gives the plan that authority. Therefore, it is appropriate and necessary to clarify that in those instances in which a health benefit plan does not contain provisions specifying how a primary care physician is to be selected or designated, it is the enrollee that has the ability to choose a primary care physician. However, because the enrollees subject to the Insurance Code §1355.015 are young children suffering from a condition that often limits one's ability to communicate, it is not feasible to make the change exactly as requested by the commenter. Therefore, the Department has revised the definition of "primary care physician" in §22.4402(7) as adopted to read: "A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated by the enrollee or the enrollee's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder."

#### §21.4403(a)(1). Age range of covered enrollees

Comment: A commenter suggests that the lower limit of the age range for covered children in proposed §21.4403(a)(1) be set at two rather than three. The commenter offers the following reasons for the suggestion: (i) this would be in line with the legislative intent of HB 1919; (ii) such a provision would also facilitate very early intervention for children with ASD, which is important because scientific research has shown that intensive intervention for children two years of age results in a need for less intensive and expensive services in the future; and (iii) ensuring availability of another year of services for children between their second and third birthdays would be beneficial and consistent with best practice in the field of autism intervention.

Agency Response: The change requested by the commenter is unnecessary as a result of the revision made to adopted §21.4403(a)(1) in response to another comment. Section 21.4403(a)(1) as adopted reads: "At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a)."

#### §21.4403(c). ASD coverage as a medical and surgical benefit

Comment: One commenter questions the authority of the Department to include in the rules proposed §21.4403(c), which provides that services provided for autism spectrum disorder

must be provided under the medical and surgical provisions of the benefit plan as a medical and surgical benefit. The commenter points out that HB 1919 amended Chapter 1355 of the Insurance Code which is entitled "Benefits For Certain Mental Disorders." According to the commenter, because coverage for mental disorders often have different terms of coverage than medical and surgical benefits, the proposed language appears to impose a higher standard than authorized by HB 1919.

Agency Response: The Department disagrees with the commenter and declines to make a change. The Department's reasons are the following. First, pursuant to Government Code §311.024, "The heading of a title, subtitle, chapter, subchapter, or section does not limit or expand the meaning of a statute." Therefore, the fact that the heading of the Insurance Code Chapter 1355 is "Benefits For Certain Mental Disorders" does not limit or prevent implementation of the autism spectrum disorder coverage mandate in a way that reflects the legislative intent of HB 1919. Second, documents in the legislative history of HB 1919, along with a reading of the changes made to the Insurance Code by HB 1919, indicates legislative intent to apply the autism spectrum disorder coverage mandate as a medical benefit. For example, SB 419, 80th Legislature, Regular Session, was a predecessor bill to HB 1919, and the author of SB 419 was also the author of the amendment that added the autism spectrum disorder coverage mandate to HB 1919. The bill analysis for the Introduced version of SB 419 states that "Insurers deny treatment coverage for children with ASD by classifying ASD as a mental illness, although autism is recognized as a neurobiological disorder in the [DSM-IV] of the American Psychiatric Association." This statement indicates intent by the author of SB 419 for autism spectrum disorder to be classified as something other than a mental illness. Third, the author's intent is also reflected in the changes made by HB 1919 to the Insurance Code. For example, the heading for the Insurance Code Chapter 1355, Subchapter A was changed from "Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses" to "Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders." (Emphasis added.) While the addition of the reference to "Other Disorders" in the Subchapter A heading cannot be argued to expand the meaning of the statute pursuant to the Government §311.024, it arguably provides insight into the author's intent in amending the subchapter. Fourth, a definition for "autism spectrum disorder" was added to the Insurance Code §1355.001 that defines the condition as a "neurobiological disorder." Also, a definition for "neurobiological disorder" was added to the Insurance Code §1355.001 which provides that a neurobiological disorder is an illness of the nervous system, and the term "pervasive developmental disorder," which is a form of autism spectrum disorder, was removed from the definition of "serious mental illness" and incorporated into the definition of "autism spectrum disorder."

§21.4402(5). Definition of "health care practitioner"

§21.4404(a). Requirements for health care practitioner who provides treatment

§21.4404(b). Coverage for applied behavior analysis

Comment: Numerous commenters suggest that the proposed rules directly recognize and address practitioners that have credentials issued by the Behavior Analyst Certification Board.

Two hundred and two commenters request that the definition of "health care practitioner" in §21.4402(5) ensure that health benefit plans clearly understand that Board Certified Behavior

Analysts are covered health care practitioners. Fourteen other commenters suggest explicitly listing Board Certified Behavior Analysts as a type of health care practitioner in proposed §21.4402(5). According to the commenters, Board Certified Behavior Analysts are eligible practitioners by virtue of the fact that they are eligible to provide these services under TRICARE, which makes them eligible as health care practitioners as provided by §21.4404(a)(3). Another commenter requests that the following sentence be added to proposed §21.4402(5): "Board Certified Behavior Analysts (BCBAs) are health care practitioners as it relates to §1355.015(b), and as such, treatment programs supervised by BCBA certified individuals will be covered when prescribed in accordance with 1355.015(b)." According to the commenter, this is needed to send a clear message to insurance companies that Board Certified Behavior Analysts are covered practitioners. The commenter asserts that the legislative intent of HB 1919 is to enable children with ASD to access high quality intensive intervention and that programs supervised by Board Certified Behavior Analysts are clearly part of that intent. According to the commenter, the Board Certified Behavior Analyst certifications are consistent with the associated requirements for becoming a provider under §1355.015(b) of the Insurance Code. The commenter asserts additional reasons for the requested language: (i) the Board Certified Behavior Analyst credential is certified through the national Behavior Analyst Certification Board and is recognized by the National Council for Certifying Agencies; (ii) the following professional organizations endorse the credential: the Association of Professional Behavior Analysts, the Association for Behavior Analysis International, and Division 25 (Behavior Analysis) of the American Psychological Association; (iii) the Defense Department has recognized the credential under its TRICARE health plan; (iv) the U.S. Centers for Disease Control refers patients to the Association for Behavior Analysis International; and (v) at the state level, the Texas Home Living Medicaid Waiver and the Home and Community Services Waiver have certified Board Certified Behavior Analysts as approved service providers for applied behavior analysis.

One commenter suggests that proposed §21.4404(a)(3) be revised to clearly spell out that Board Certified Behavior Analysts are eligible practitioners under the rule, rather than just providing that a practitioner certified as a provider under TRICARE is an eligible practitioner. The commenter asserts the following reasons for the suggested revision: (i) the third option in the Insurance Code §1355.015(b), requiring that a provider providing treatment under the Insurance Code §1355.015, be certified as a provider under TRICARE military health system was inserted in HB 1919 to enable reimbursement for Board Certified Behavior Analysts, who are certified by the Board Certified Behavior Analysts; (ii) Board Certified Behavior Analysts do not meet the second or third qualification in §1355.015(b) because there is not a state or federal licensure or certification, but the Board Certified Behavior Analyst credential is recognized under TRICARE, and thus the Board Certified Behavior Analyst credential must be recognized in this rule and its implementation; and (iii) Board Certified Behavior Analysts do not have to be individually credentialed by TRICARE, but are certified as eligible merely by their inclusion on the certificate registry maintained by the Behavior Analyst Certification Board.

One commenter requests that the rule be more direct in stating that §21.4404(b) applies to Board Certified Behavior Analysts. The commenter objects to proposed §21.4404(b), which relates to coverage for applied behavior analysis, because it raises con-

cerns that anyone can provide services under the rule. According to the commenter, these fears will be allayed if §21.4404(b) is more direct in stating that the rule applies to Board Certified Behavior Analysts. Another commenter opines that proposed §21.4404(b) regarding which health care practitioners are included in coverage for applied behavior analysis is circuitous, and that the clear intent of the statute is that insurance cover applied behavior analysis services provided by any person who is a Board Certified Behavior Analyst. Fourteen commenters assert that proposed §21.4404(b) should explicitly state that an insurer "shall provide coverage for services for autism spectrum disorder by a practitioner with the Board Certified Behavior Analyst credential issued by the Behavior Analyst Certification Board."

Agency Response: The Department disagrees with the commenters and declines to make the requested changes because the requested changes are not in compliance with the Insurance Code §1355.015(b). Therefore, §21.4402(5) and §21.4404(a) and (b) are adopted without changes to the proposed text. For the following reasons, the Department does not have the authority under the Insurance Code Chapter 1355 to explicitly list Board Certified Behaviors Analysts as a type of health care practitioner in the definitions section of the rules or to require that treatment provided by individuals certified by the Behavior Analyst Certification Board is to automatically be covered as a benefit under the ASD coverage mandate in the Insurance Code Chapter 1355, Subchapter A.

First, the Behavior Analyst Certification Board is a non-governmental professional association, and the Department is not authorized under the Insurance Code Chapter 1355 to recognize or specify that providers certified by non-governmental professional associations are qualified to provide treatment under the Insurance Code §1355.015.

Second, the Insurance Code §1355.015(b)(1) - (3) specifies that a health care practitioner must be "licensed, certified, or registered by an appropriate agency of this state," must have a professional credential "recognized and accepted by an appropriate agency of the United States," or must be "certified as a provider under the TRICARE military health system" to provide services under §1355.015(b), and the paragraphs in proposed §21.4404(a) simply reiterate §1355.015(b)(1) - (3), and proposed §21.4404(b) clearly references the health care practitioner requirements in the Insurance Code §1355.015(b)(1) - (3). The authority of a person holding a certification issued by the Behavior Analyst Certification Board to provide services under the Insurance Code §1355.015(b)(2) hinges on recognition and acceptance of the professional credential issued by the Behavior Analyst Certification Board by an appropriate agency of the United States. Currently TRICARE, a healthcare delivery system that is a part of the Department of Defense, does recognize and accept the certifications issued by the Behavior Analyst Certification Board. Therefore, practitioners holding certifications issued by the Behavior Analyst Certification Board are qualified to provide services under the Insurance Code §1355.015 pursuant to the Insurance Code §1355.015(b)(2). However, the fact that TRICARE currently recognizes and accepts the certifications issued by the Behavior Analyst Certification Board does not mean that TRICARE will accept such certifications in the future. According to Chapter 11, Section 3.2 of the TRICARE Policy Manual 6010.54-M, August 1, 2002, certified membership in a national or professional association that sets standards for the profession is accepted in place of state licensure or certification in instances when the state where a provider practices does not offer licensure or certification. Chapter 11, Section 3.2 of the

TRICARE Policy Manual also provides that when a new state law is enacted that requires or provides for licensing or certification of a provider, authorized providers must obtain the license as soon as the state begins issuance. This means that if Texas begins to license or certify applied behavior analysis providers, TRICARE will no longer recognize and accept the certifications issued by the Behavior Analyst Certification Board within this state. While other federal agencies may also recognize and accept the certifications issued by the Behavior Analyst Certification Board, the Department is not aware of any such federal agencies. One commenter references recognition by the "National Council for Certifying Agencies." There does not appear to be such an agency. A "National Commission for Certifying Agencies" exists, but it is not a federal agency. The commenter also states that the U.S. Centers for Disease Control refers patients to the Association for Behavior Analysis International. However, "referral" does not correlate to "recognition and acceptance." Additionally, the Association for Behavior Analysis International does not issue certifications on behalf of the Behavior Analyst Certification Board. Finally, the same commenter lists various professional organizations and state agencies that it asserts recognizes and accepts the Board Certified Behavior Analyst credential. Recognition and acceptance by a professional organization or a state agency, however, is not sufficient for compliance with the Insurance Code §1355.015(b)(2). The authority of a person holding a certification issued by the Behavior Analyst Certification Board to provide covered services under the Insurance Code §1355.015(b)(3) hinges on certification by TRICARE. While one of the requirements for certification as an applied behavior analysis provider under the TRICARE military health system is that the provider be certified by the Behavior Analyst Certification Board, the TRICARE military health system also requires that an applied behavior analysis provider meet "all best standards of the medical community" and be "verified as having met those standards by one of the TRICARE regional contractors."

During this rulemaking process, numerous stakeholders have asserted that TRICARE does not require certification of applied behavior analysis providers, and have expressed confusion over the reference to TRICARE certification in the statute and the rule drafts. Therefore, the following summarizes the TRICARE certification process that is currently required for a practitioner to be authorized to provide applied behavior analysis treatment services pursuant to the Insurance Code §1355.015(b)(3). Chapter 20, Section 10 of the TRICARE Operations Manual, 6010.51-M, August 1, 2002, identifies three types of applied behavior analysis providers that can become certified: Autism Demonstration Corporate Services Providers (ACSPs), EIA Supervisors, and EIA Tutors (EIA is an acronym for "Educational Interventions for Autism spectrum disorder"). Pursuant to the TRICARE Operations Manual, ACSPs must meet the following requirements: (i) submit evidence of professional liability insurance; (ii) submit all documentation necessary to support an application for designation as a TRICARE ACSP; (iii) enter into a TRICARE participation agreement; (iv) employee directly or contract with EIA Supervisors and EIA Tutors; (v) certify that all EIA Supervisors and EIA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision, and demonstration requirements specified by the TRICARE Operations Manual; (vi) comply with all applicable organizational and individual licensing or certification requirements in the state, county, municipality, or other political subdivision in which services are provided; and (vii) comply with all other requirements applicable to TRICARE-authorized providers. Additionally, an

ACSP who is an individual must undergo a criminal history review by the TRICARE regional contractor. Pursuant to the TRICARE Operations Manual, an EIA Supervisor must have: (i) a current, unrestricted state-issued license to provide applied behavior analysis services; (ii) a current, unrestricted state-issued certificate as a provider of applied behavior analysis services; or (iii) be certified by the Behavior Analyst Certification Board as either a Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst where state issued licenses or certificates are not available. Additionally, an EIA Supervisor must meet the following requirements: (i) enter into a TRICARE participation agreement; (ii) employee directly or contract with EIA Tutors; (iii) report sanctions by the Behavior Analyst Certification Board or loss of Behavior Analyst Certification Board certification to TRICARE's regional contractor within 30 days; (iv) ensure that the quality of services provided by EIA Tutors meets the current Behavior Analyst Certification Board evidence-based standards; (v) maintain all applicable business licenses and employment or contractual documentation in accordance with federal, state, and local requirements; (vi) meet all applicable requirements of the state in which services are provided; (vii) cooperate fully with TRICARE's designated utilization and clinical quality management organization; and (viii) comply with all other requirements applicable to TRICARE-authorized providers. Pursuant to the TRICARE Operations Manual, an EIA Tutor must have completed 40 hours of classroom training in applied behavior analysis techniques in accordance with BACB guidelines prior to providing services. Additionally, an EIA Tutor must have: (i) completed a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development, or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; (ii) completed a minimum of 48 semester hours of college courses in an accredited college or university; or (iii) have a High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP. Finally, an EIA Tutor must receive no less than two hours supervision per month from the EIA Supervisor, in accordance with BACB guidelines.

§21.4404(a). Requirements for health care practitioner who provides treatment

Comment: One commenter questions whether the term "appropriate" in proposed §21.4404(a)(1) and (2) means that there is some type of standard a provider must meet in order to provide services. Proposed §21.4404(a)(1) and (2) read: "a health care practitioner. . . must. . . be licensed, certified, or registered by an appropriate agency of this state. . . [or] have professional credentials that are recognized by and accepted by an appropriate agency of the United States." According to the commenter, inclusion of the term "appropriate" in both of these paragraphs suggests that some level of expertise should be required under each paragraph. As an example, the commenter asserts that there are no inappropriate agencies of the United States.

Agency Response: The standards a health care practitioner must meet under the Insurance Code §1355.015 and §21.4404(a)(1) - (3) are those standards (i) that are required to become licensed, certified or registered by an appropriate agency of this state; (ii) that are necessary to obtain professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) that are required to become certified as a provider under the TRICARE military health system. The specific standards a health care practitioner must meet depend on the services that the health care

practitioner provides. For example, in order for an individual to be qualified to provide speech therapy services pursuant to §21.4404(a)(1), the individual must be licensed as a speech-language pathologist by the Texas State Board of Examiners for Speech-Language Pathology and Audiology, the appropriate state agency to license a provider of speech therapy services. If the individual providing the speech therapy services only has a license for accounting issued by the Texas State Board of Public Accountancy, the provider of the speech therapy services would be licensed by an inappropriate state agency and would not be qualified to provide speech therapy services pursuant to §21.4404(a).

Comment: A commenter suggests that §21.4404(a)(1) and (2) be revised to provide that only those with a minimum of a Master level license in the Human Developmental Field (Social Worker, Marriage and Family Therapists, Licensed Professional Counselors, Psychologists) be permitted to treat autism. The commenter expresses concern that under proposed §21.4404(a)(1) and (2) "just about anyone with minimum education and credentials approved by an appropriate agency" may treat a disorder as complex as autism. The commenter asserts that there is no reference to type of education, such as GED or credentials that could be obtained through a weekend workshop, and asks which agencies are appropriate and who determines them. The commenter expresses concern that this is a way for insurance companies to cut costs, and enrollees will suffer inadequate care from lack of knowledge of the behavioral health care provider.

Agency Response: The Department disagrees with the commenter and declines to make a change. The Insurance Code §1355.015(d) specifies the requirements for a health care practitioner who may provide covered treatment under §1355.015. There is no statutory requirement for any of the minimum Master degree levels requested by the commenter. Additionally, the minimum Master degree levels cited by the commenter would not necessarily ensure appropriate providers to deliver all of the treatments authorized in the Insurance Code §1355.015(c). For example, such licensed providers could not necessarily provide generally recognized services such as speech therapy or medications or nutritional supplements.

Comment: A commenter objects to proposed §21.4404(a) because it permits unlicensed providers to provide care for autism. According to the commenter, only licensed mental health providers should treat autistic individuals. The commenter asserts the following reasons: (i) licensure exists to protect the public, and qualifications for licensure ensure that one has met stringent requirements for training at accredited universities and provides the public with the assurance that the state of Texas is vetting all providers of mental health services; (ii) children are an especially vulnerable population and children with autism even more so as many are not capable of communicating with parents or care givers should any abuse occur; and (iii) there is particular concern about pedophiles having access to children suffering from autism; and while licensure does not provide a 100 percent guarantee of protection, individuals convicted of a felony cannot hold a license to practice.

Agency Response: The Department disagrees with the commenter and declines to make a change because required licensure for all health care practitioners providing treatment under the Insurance Code §§1355.015 would not be in compliance with the statute. Under proposed §21.4404(a), which is derived directly from the Insurance Code §1355.015(b), practitioners do not have to be licensed to provide treatment for autism spectrum

disorder under the Insurance Code Chapter 1355, Subchapter A, if the practitioner either has a "professional credential [that] is recognized and accepted by an appropriate agency of the United States" or is "certified as a provider under the TRICARE military health system."

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: None.

For, with changes: Texana, Texas Association of Health Plans, Shorkey Center, Behavioral Innovations, Families for Effective Autism Treatment, Texas Autism Advocacy, and 218 individuals.

Against: One individual.

## SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS DIVISION 1. GENERAL PROVISIONS

### 28 TAC §21.3502

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Gene C. Jarmon

General Counsel and Chief Clerk

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For further information, please call: (512) 463-6327



## DIVISION 2. STATE-MANDATED HEALTH BENEFITS

### 28 TAC §§21.3510 - 21.3513, 21.3515 - 21.3518

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary

to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## DIVISION 4. ADDITIONAL REQUIREMENTS

### 28 TAC §21.3540, §21.3543

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## SUBCHAPTER JJ. AUTISM SPECTRUM DISORDER COVERAGE

## DIVISION 1. GENERAL PROVISIONS

### 28 TAC §§21.4401 - 21.4404

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

#### §21.4402. Definitions.

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

(1) Applied behavior analysis--The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

(2) Autism spectrum disorder--As defined in the Insurance Code §1355.001(3).

(3) Enrollee--A person covered by a health benefit plan described by the Insurance Code §1355.002.

(4) Generally recognized services--The term includes, but is not limited to, the following services, when such services are prescribed in accordance with the Insurance Code §1355.015(b) and §21.4403(b) of this subchapter (relating to Required Coverage):

- (A) evaluation and assessment services;
- (B) applied behavior analysis;
- (C) behavior training and behavior management;
- (D) speech therapy;
- (E) occupational therapy;
- (F) physical therapy; or
- (G) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(5) Health care practitioner--A physician, advance practice nurse, physician assistant, or other individual appropriately licensed, registered, or certified, or whose professional credential is recognized and accepted as described by the Insurance Code §1355.015(b).

(6) Neurobiological disorder--As defined in the Insurance Code §1355.001(4).

(7) Primary care physician--A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's

health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated by the enrollee or the enrollee's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder.

#### §21.4403. Required Coverage.

##### (a) Certain Children Enrollees.

(1) At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a).

(2) Pursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

(b) Enrollees of Other Ages. A health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages.

(c) Medical and Surgical Benefit. In accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

(d) Deductibles, Copayments, and Coinsurance. Pursuant to the Insurance Code §1355.015(d), coverage under this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## CHAPTER 26. SMALL EMPLOYER HEALTH INSURANCE REGULATIONS

### SUBCHAPTER D. HEALTH GROUP COOPERATIVES

#### 28 TAC §26.409

The Commissioner of Insurance adopts an amendment to §26.409, concerning the exclusion of state-mandated health benefits for autism spectrum disorder coverage in health benefit plans issued through health group cooperatives. The amendment is adopted without changes to the proposed text published in the April 3, 2009, issue of the *Texas Register* (34 TexReg 2229).

REASONED JUSTIFICATION. House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008, amends Chapter 1355 of the Insurance Code to include, as a state mandated benefit, all generally recognized services prescribed in relation to autism spectrum disorder by an insured's primary care physician in the treatment plan recommended by that physician. However, pursuant to the Insurance Code §1501.0581(i), a health benefit plan issued by a health benefit plan issuer to provide coverage with a health group cooperative is not subject to a state law, including a rule, that relates to a particular illness, disease, or treatment. Pursuant to the Insurance Code §1355.001(3), which defines "autism spectrum disorder" as a neurobiological disorder, and the Insurance Code §1355.001(4), which defines a "neurobiological disorder" as an illness of the nervous system, autism spectrum disorder is a particular illness. Therefore, the mandated autism spectrum disorder coverage requirements enacted by HB 1919 are not applicable to health benefit plans that provide coverage with a health group cooperative pursuant to §1501.0581 of the Insurance Code. Chapter 26, Subchapter D, of Title 28 of the Texas Administrative Code regulates health benefit plans issued by health carriers through health group cooperatives. Section 26.409 specifies the state mandates that are not required to be provided by such plans. The amendment is necessary to update existing §26.409(a) to specify that the state-mandated health benefit of coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A, is not required in a health benefit plan issued by a health carrier through a health group cooperative.

HOW THE SECTION WILL FUNCTION. The adopted amendment, which is consistent with the Insurance Code §1501.0581(i), provides that the state-mandated coverage for autism spectrum disorder, as required by the Insurance Code Chapter 1355, Subchapter A, is not required to be included in a health benefit plan issued by a health carrier through a health group cooperative.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department did not receive any comments on the published proposal.

STATUTORY AUTHORITY. The amendment is adopted pursuant to the Insurance Code §§1355.015, 1355.001(3) and (4), 1501.0581(i) and 36.001. Section 1355.015 requires that health benefit plans provide autism spectrum disorder coverage for certain children. Pursuant to the Insurance Code §1355.001(3), which defines "autism spectrum disorder" as a neurobiological disorder, and the Insurance Code §1355.001(4), which defines a "neurobiological disorder" as an illness of the nervous system, autism spectrum disorder is a particular illness. Section 1501.0581(i) provides that except as provided by §1501.0581(n), which concerns coverage for diabetes equipment, supplies, and services, a health benefit plan issued by a health benefit plan issuer to provide coverage with a health group cooperative is not subject to a state law, including a rule, that relates to a particular illness, disease, or treatment. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 14, 2009.

TRD-200904034

Gene C. Jarmon

General Counsel and Chief Clerk

Texas Department of Insurance

Effective date: October 4, 2009

Proposal publication date: April 3, 2009

For further information, please call: (512) 463-6327

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**TITLE 31. NATURAL RESOURCES AND CONSERVATION**

**PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT**

**CHAPTER 65. WILDLIFE**

**SUBCHAPTER A. STATEWIDE HUNTING AND FISHING PROCLAMATION**

**DIVISION 1. GENERAL PROVISIONS**

**31 TAC §65.11**

The Texas Parks and Wildlife Commission adopts an amendment to §65.11, concerning Lawful Means, with changes to the proposed text as published in the June 19, 2009, issue of the *Texas Register* (34 TexReg 4078).

The change reorganizes and adds clarifying language to paragraphs (2) and (3). In part, the intent of the rule as proposed was to allow the use of crossbows to take deer during the archery-only open season in all counties except Grayson County and to create an exception for Grayson County. The proposed rule was made necessary by the passage of House Bill (H.B.) 968 by the 81st Texas Legislature, Regular Session. An inadvertent consequence of the department's interpretation of H.B. 968, reflected in the rule as proposed, was that crossbows would have been lawful in Grayson County only when used by person with an upper-limb disability, irrespective of season. The department has since determined that the effect of H.B. 968 is to authorize the commission to allow the use of crossbows during archery-only open seasons, but not to require that crossbow use be restricted to persons with an upper-limb disability in counties where archery equipment is the only lawful method.

The change also alters paragraph (6)(B)(i)(I) for purposes of clarification. As proposed, paragraph (6)(B)(i)(I) stipulated that a person using a laser sighting device because of a disability that prevents the person from using traditional sighting devices must be assisted by another person, provided the person is not a disabled person or legally blind. The department did not intend for the provision to mean that disabled persons in general cannot assist, only that assistance cannot be provided by another person who has a disability that prevents the use of traditional sighting devices.

H.B. 968 states that "In a county that does not permit hunting with a firearm, a hunter may use a crossbow only if the hunter is a person with upper limb disabilities and has an archery hunting stamp." The department interpreted this statement to apply to counties where any hunting is restricted to archery only, but

has since concluded that the statement applies only to counties where all hunting is restricted to archery equipment. In Grayson County, deer hunting is restricted to archery equipment, but turkey, for instance, may be taken by firearm.

Therefore, the rule as adopted has been changed to maintain status quo in Grayson County with respect to crossbow use (i.e., crossbows can be used to take deer during the archery season only by persons with a documented upper-limb disability, but could be used by anyone, regardless of physical ability, during the general season).

The amendment allows the use of crossbows by all persons during the archery-only season, with an exception related to one county, and allows the use of laser sighting devices by any person with a physical disability that renders the person incapable of using a traditional firearm sighting device, provided the person possesses a physician's or optometrist's statement certifying the extent of the disability.

Under Government Code, §2001.006(b), an agency may adopt a rule in preparation for the implementation of legislation that has become law but has not taken effect. With the passage of H.B. 968 and H.B. 1805 by the 81st Texas Legislature, Regular Session, it is necessary for the department to promulgate rules to implement the provisions of the bills.

Under Parks and Wildlife Code, §43.201(a), no person may hunt deer, turkey, or javelina during an open archery season restricted to longbows, recurved bows, compound bows, or crossbows used by hunters with upper limb disabilities unless the person has acquired an archery hunting stamp. H.B. 968 removes the reference to upper-limb disabilities in connection with the use of crossbows, and makes this applicable in all counties except those in which firearms are not lawful means for hunting. The amendment allows any person, regardless of physical ability, to use a crossbow during the archery-only season, provided the person has acquired an archery stamp, except in counties where hunting by firearms is prohibited.

Under current §65.11, a person may hunt during an archery-only season only by means of "lawful archery equipment," which is defined by §65.3, concerning Definitions, as "longbow, compound bow or recurved bow." However, there is an exception for crossbow use by persons with an upper-limb disability. The proposed amendment would alter the definition of "lawful archery equipment" to include crossbows and eliminate the upper-limb disability requirement. This change, in concert with the provisions of H.B. 968, would provide for the use of crossbows by any person during the archery season in all counties except Grayson County, where the use of crossbows during the archery-only season will be restricted to persons with a documented upper-limb disability.

Current §65.11 also allows a person who is legally blind to use a laser sighting device to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person is assisted by a person who is not legally blind, has a hunting license; and is at least 13 years of age. H.B. 1805 provides for the use of laser sighting devices by persons with a physical disability (defined as "a documented permanent physical disability that renders the person incapable of using a traditional firearm sighting device") to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person possesses a physician's or optometrist's statement certifying the extent of the disability, and is assisted by a person who does not have a

physical disability, has a hunting license, and is at least 13 years of age.

The proposed amendment would alter the current rule to incorporate the provisions of H.B. 1805.

The proposed amendment will function by allowing the use of crossbows during the archery-only season in all counties except Grayson County, where only persons with an upper-limb disability may use crossbows during the archery-only season, and by allowing the use of laser sighting devices by disabled hunters who are incapable of using traditional sighting devices provided the person is assisted by a person who is not legally blind and is at least 13 years of age.

The department received 144 comments opposing adoption of the portion of the proposed rule that allows crossbows to be used by any person during the archery-only open season. Those comments, accompanied by the department's response to each, follow.

Seventy-one commenters opposing adoption stated that crossbows are not genuine archery equipment, that allowing crossbows to be used by anyone during archery-only seasons is an insult to archers and archery, and that archers pay for a stamp in order to have a season devoted exclusively to archery. The department disagrees with the comments and responds that the amendment does not eliminate the archery-only season, but merely adds crossbows as lawful archery equipment that may be used during an archery-only season. The department also responds that one person's choice to hunt with a crossbow during an archery-only season does not affect the hunting experience of another person who chooses to use some other type of archery equipment during the same season. No changes were made as a result of the comments.

Thirty commenters opposing adoption stated that only disabled hunters should be allowed to use crossbows during the archery-only season. The department disagrees with the comments and responds that the legislature has removed the upper-limb disability requirement. The department has determined that allowing the use of crossbows during the archery-only season does not infringe upon or reduce the opportunity of hunters who choose to use other forms of archery equipment during that time period. No changes were made as a result of the comments.

Seven commenters opposing adoption stated that allowing the use of crossbows during the archery-only season is inhumane and will result in increased wounding loss. The department disagrees with the comments and responds that like any other lawful means, archery equipment, including crossbows, are efficient and humane means for killing wildlife, but must be employed in a prudent manner to produce desired results. No changes were made as a result of the comments.

Six commenters opposing adoption stated that crossbows should not be lawful at any time. The department disagrees with the comments and responds that crossbows are an efficient and effective means for killing wildlife and are authorized by statute. No changes were made as a result of the comments.

Four commenters opposing adoption stated that crossbows should be lawful only during the general season. The department disagrees with the comments and responds that now that the statutory requirement restricting crossbow use during archery seasons to persons with an upper-limb disability has been removed, there is no reason not to provide additional opportunity for persons interested in using crossbow during the

archery-only season. No changes were made as a result of the comments.

Six commenters opposing adoption stated that crossbows should only be allowed to be used by disabled persons, and only during the archery-only season. The department disagrees with the comments and responds that now that the statutory requirement restricting crossbow use during archery seasons has been removed, there is no reason not to provide additional opportunity for persons interested in using crossbow during the archery-only season. No changes were made as a result of the comments.

Three commenters opposing adoption stated that the rule was an attempt by the department to raise additional revenue. The department disagrees with the comment and responds that the intent of the rule as adopted in to provide additional opportunity for persons to participate in archery-only seasons. No changes were made as a result of the comments.

Four commenters opposing adoption stated that allowing anyone to use crossbows during the archery-only season will result in increased poaching. The department disagrees with the comments and responds that it is not aware of any data showing a correlation between unlawful activities and the use of crossbows as opposed to other types of archery equipment. No changes were made as a result of the comments.

Eight commenters opposing adoption stated that there should be no exceptions to the statewide applicability of the rule. The department disagrees with the comments and responds that Grayson County is unique among the counties with an open deer season in that means and methods during the general season are restricted to archery equipment. The exception for Grayson County in the rule as adopted is to maintain the status quo. No changes were made as a result of the comments.

Nine commenters opposing adoption stated that allowing the use of crossbows by anyone during the archery-only season would present safety risks. The department disagrees with the comments and responds that crossbows are no more dangerous than other types of archery equipment. No changes were made as a result of the comments.

The department received four comments opposing adoption of the portion of the proposed rule that allows disabled persons to use laser sighting devices. Those comments, accompanied by the department's response to each, follow.

Two commenters opposing adoption stated that blind people should not be hunting. The department disagrees with the comments and responds that the purpose of the proposed amendment is to enable persons who are visually impaired to participate in hunting, as authorized by statute. No changes were made as a result of the comments.

Two commenters opposing adoption stated that laser sighting devices should not be lawful. The department disagrees with the comment and responds that under Parks and Wildlife Code, §62.0055, a legally blind person is entitled to use a laser sighting device, and that provision cannot be altered or eliminated by the commission. No changes were made as a result of the comments.

No groups or associations commented in favor of or opposition to adoption of the proposed rule.

The amendment is adopted under Parks and Wildlife Code, §61.054, which requires the commission to specify the means

or method that may be used to hunt, take, or possess game animals, game birds, or aquatic animal life.

*§65.11. Lawful Means.*

It is unlawful to hunt any of the wildlife resources of this state except by the means authorized by this section and as provided in §65.19 of this title (relating to Hunting Deer with Dogs).

(1) Firearms.

(A) It is lawful to hunt alligators, game animals, and game birds with any legal firearm, including muzzleloading weapons, except as specifically restricted in this section.

(B) Special muzzleloader-only deer seasons are restricted to muzzleloading firearms only.

(C) It is unlawful to use rimfire ammunition to hunt alligator, deer, antelope, or desert bighorn sheep.

(D) It is unlawful to hunt alligators, game animals or game birds with a fully automatic firearm or any firearm equipped with a silencer or sound-suppressing device.

(E) In Angelina, Brazoria, Calhoun, Chambers, Galveston, Hardin, Jackson, Jasper, Jefferson, Liberty, Matagorda, Nacogdoches, Newton, Orange, Polk, Refugio, Sabine, San Augustine, San Jacinto, Trinity, Tyler and Victoria counties, alligators may not be hunted by means of firearms. In all other counties, alligators may be hunted by means of firearms on private property, including private waters, but may not be hunted by means of firearms from, on, in, across, or over public water.

(F) Alligators lawfully caught on a taking device may be dispatched by means of firearms in all counties.

(2) Archery.

(A) Except as provided in paragraph (3) of this section, a person may hunt by means of lawful archery equipment or crossbow during any open season; however, no person shall hunt deer by lawful archery equipment or crossbow during a special muzzleloader-only deer season.

(B) Arrows that are treated with poisons or drugs, or that contain explosives are not lawful devices for hunting any species of wildlife resource in this state.

(C) While hunting turkey and all game animals other than squirrels by means of longbow, compound bow, or recurved bow the arrow must be equipped with a broadhead hunting point at least 7/8-inch in width upon impact, with a minimum of two cutting edges. A mechanical broadhead must begin to open upon impact and when open must be a minimum of 7/8-inch in width.

(D) It is unlawful to hunt deer or turkey with a broadhead hunting point while in possession of a firearm during an archery-only season.

(E) Lawful archery equipment and crossbows are the only lawful means that may be used during archery-only seasons, except as provided in paragraph (3) of this section.

(3) Crossbow--Special Provisions.

(A) In Grayson County:

(i) no person may use a crossbow to hunt deer during the archery-only season (October 3 - November 6) unless the person has an upper-limb disability and has in immediate possession a physician's statement that certifies the extent of the disability; and

(ii) any person may hunt deer by means of crossbow during the general open season (November 7 - January 3) and the requirements of clause (i) of this subparagraph do not apply.

(B) When hunting turkey and all game animals other than squirrels by means of crossbow:

(i) the crossbow must have a minimum of 125 pounds of pull;

(ii) the crossbow must have a mechanical safety;

(iii) the crossbow stock must be not less than 25 inches in length; and

(iv) the bolt must conform with paragraph (2)(B) and (C) of this section.

(4) Falconry. It is lawful to hunt any game bird or game animal by means of falconry under the provisions of Subchapter K of this chapter (relating to Raptor Proclamation).

(5) Alligator.

(A) Legal devices for taking alligators in the wild are as follows:

(i) hook and line (line set);

(ii) alligator gig;

(iii) lawful archery equipment and barbed arrow;

(iv) hand-held snare with integral locking mechanism; and

(v) lawful firearms, in counties where take by firearm is allowed.

(B) A line of at least 300-pound test shall be securely attached to all taking devices other than firearms used to hunt alligators. Except as provided in this subsection, hook-bearing lines must be attached to a stationary object capable of maintaining a portion of the line above water when an alligator is caught on the line. A line attached to an arrow, snare, or gig must have a float attached when used to take alligators. The float shall be no less than six inches by six inches by eight inches, or, if the float is spherical, no less than eight inches in diameter.

(C) Line-set provisions.

(i) Hook-bearing lines may not be set prior to the general open season and shall be removed no later than sunset of the last day of the open season.

(ii) From sunset to one-half hour before sunrise:

(I) no person shall use any taking device other than line sets to hunt alligators; and

(II) no person shall set any baited line capable of taking an alligator and no person shall remove alligators from line sets.

(iii) On a property for which the department has issued hide tags, no person shall set more than one line per unused hide tag in possession.

(iv) On a property that is not in a county listed in paragraph (1)(E) of this section and for which the department has not issued hide tags, no person shall set more than one line.

(v) Line sets shall be inspected daily, and alligators shall be killed, tagged or documented, and removed immediately upon discovery.

(vi) All line sets on properties for which hide tags have been issued shall be secured at one end on the tract of land specified for the hide tags. All other line sets shall be secured at one end on private property.

(vii) Each baited line shall be labeled with a plainly visible, permanent, and legibly marked gear tag that contains:

(I) the full name and current address of the person who set the line;

(II) the hunting license number of the person who set the line; and

(III) a valid hide tag number, if the line is set on a property for which hide tags have been issued.

(6) Use of laser sighting devices. All provisions concerning hunter education requirements apply to persons hunting with laser sighting devices under this paragraph.

(A) Use of laser sighting devices by persons who are legally blind.

(i) A person who is legally blind may use a laser sighting device to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person is assisted by a person who:

(I) is not legally blind;

(II) has a hunting license; and

(III) is at least 13 years of age.

(ii) A person who uses a laser sighting device under the provisions of this subparagraph must have in possession a signed statement from a physician or optometrist to the effect that the person is legally blind by the standard of Government Code, §62.104, and must present the statement to any peace officer or department employee acting within the scope of official duties.

(B) Use of laser sighting devices by persons who are physically disabled.

(i) A person with a physical disability may use a laser sighting device during lawful hunting hours in open seasons when assisted by a person who:

(I) is not legally blind or a person with a physical disability that renders the person incapable of using a traditional firearm sighting device;

(II) has a hunting license; and

(III) is at least 13 years of age.

(ii) A person who uses a laser sighting device under the provisions of this subparagraph must have in possession a signed statement from a physician or optometrist certifying that the person is incapable of using a traditional firearm sighting device.

(7) Special Provisions.

(A) Desert bighorn sheep. Except as provided in this paragraph, no motorized conveyance of any type shall be used to herd or harass desert bighorn sheep.

(B) Hunting by remote control. It is an offense for any person to hunt a wildlife resource by the means listed in this section if that person is not physically present and personally operating the means of take at the location where the hunting occurs during the time that the hunting occurs.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 11, 2009.

TRD-200904000

Ann Bright

General Counsel

Texas Parks and Wildlife Department

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For further information, please call: (512) 389-4775



## TITLE 37. PUBLIC SAFETY AND CORRECTIONS

### PART 7. TEXAS COMMISSION ON LAW ENFORCEMENT OFFICER STANDARDS AND EDUCATION

#### CHAPTER 211. ADMINISTRATION

##### 37 TAC §211.30

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts new §211.30, concerning Chief Administrator Responsibilities for Class B Waivers, without changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4280) and will not be republished.

New 37 TAC §211.30, Chief Administrator Responsibilities for Class B Waivers, explains the chief administrator's responsibilities for the waiver request process for individuals with a Class B conviction or deferred adjudication within 5 years.

No comments were received regarding adoption of this new rule.

The new rule is adopted under Texas Occupations Code §1701.307, Issuance of License.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 11, 2009.

TRD-200903991

Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7713



## CHAPTER 215. TRAINING AND EDUCATIONAL PROVIDERS AND RELATED MATTERS

### 37 TAC §215.15

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, §215.15, concerning Enrollment Standards, with changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4281) and will be republished.

The amendment adds language to 37 TAC §215.15, Enrollment Standards. Subsection (b) is added to identify factors considered for mitigating circumstances. Subsection (c) is amended to clarify enrollment requirements for basic peace officer licensing courses. Subsection (d) is amended to identify examinations required for enrollment to basic peace officer licensing courses. Subsection (e) is amended to clarify that academies may establish additional enrollment standards. Subsection (f) is added to reflect the effective date.

No comments were received regarding adoption of this amendment.

The amendment is adopted under Texas Occupations Code §1701.255, Enrollment Qualifications.

#### §215.15. Enrollment Standards.

(a) In order for an individual to enroll in any basic licensing course that provides instruction in defensive tactics, arrest procedures, firearms, or use of a motor vehicle for law enforcement purposes, the academy must have on file:

(1) written documentation that the person is currently licensed by the commission; or

(2) if the individual is not licensed by the commission, documentation that the individual has been subjected to a search of local, state and national records to disclose any criminal record;

(A) is not currently charged with any criminal offense for which conviction would be a bar to licensure;

(B) community supervision history:

(i) has never been on court-ordered community supervision or probation for any criminal offense above the grade of a Class B misdemeanor or a Class B misdemeanor within the last ten years from the date of the court order; but

(ii) the commission may approve the application of an individual who received probation or court-ordered community supervision for a Class B misdemeanor at least five (5) years prior to enrollment if an agency administrator sufficiently demonstrates in writing with supporting documentation that mitigating circumstances exist with the case and with the individual applying for licensure, and that the public interest would be served by reducing the waiting period;

(C) conviction history:

(i) has never been convicted of an offense above the grade of a Class B misdemeanor or a Class B misdemeanor within the last ten years; but

(ii) the commission may approve the application of an individual who was convicted of a Class B misdemeanor at least five (5) years prior to enrollment if an agency administrator sufficiently demonstrates in writing with supporting documentation that mitigating circumstances exist with the case and with the individual applying for

licensure, and that the public interest would be served by reducing the waiting period.

(D) For purposes of this section, the commission will construe any court ordered community supervision, probation, or conviction for a criminal offense to be its closest equivalent under the Texas Penal Code classification of offenses if the offense arose from:

- (i) another penal provision of Texas law; or
- (ii) a penal provision of any other state, federal, military or foreign jurisdiction.

(E) A classification of an offense as a felony at the time of conviction will never be changed because Texas law has changed or because the offense would not be a felony under current Texas law.

(F) has never been convicted of any family violence offense;

(G) is not prohibited by state or federal law from operating a motor vehicle;

(H) is not prohibited by state or federal law from possessing firearms or ammunition; and

(I) is a U.S. citizen.

(b) In evaluating whether mitigating circumstances exist, the commission will consider the following factors:

- (1) the applicant's history of compliance with the terms of community supervision;
- (2) the applicant's continuing rehabilitative efforts not required by the terms of community supervision;
- (3) the applicant's employment record;
- (4) whether the disposition offense contains an element of actual or threatened bodily injury or coercion against another person under the Texas Penal Code or the law of the jurisdiction where the offense occurred;
- (5) the required mental state of the disposition offense;
- (6) whether the conduct resulting in the arrest resulted in the loss of or damage to property or bodily injury;
- (7) the type and amount of restitution made by the applicant;
- (8) the applicant's prior community service;
- (9) the applicant's present value to the community;
- (10) the applicant's post-arrest accomplishments;
- (11) the applicant's age at the time of arrest; and
- (12) the applicant's prior military history.

(c) In order for an individual to enroll in any basic peace officer training program that provides instruction in defensive tactics, arrest procedures, firearms, or use of a motor vehicle for law enforcement purposes, the academy must have on file:

- (1) a high school diploma;
- (2) a high school equivalency certificate; or
- (3) an honorable discharge from the armed forces of the United States after at least 24 months of active duty service.

(d) In order for an individual to enroll in any basic peace officer training program that provides instruction in defensive tactics, ar-

rest procedures, firearms, or use of a motor vehicle for law enforcement purposes, the academy must have on file:

(1) written documentation that the individual has been examined by a physician, selected by the appointing, employing agency, or the academy, who is licensed by the Texas Medical Board. The physician must be familiar with the duties appropriate to the type of license sought. The individual must be declared in writing by that professional to be:

(A) physically sound and free from any defect which may adversely affect the performance of duty appropriate to the type of license sought; and

(B) show no trace of drug dependency or illegal drug use after a physical examination, blood test, or other medical test; and

(2) written documentation that the individual has been examined by a psychologist, selected by the appointing, employing agency, or the academy, who is licensed by the Texas State Board of Examiners of Psychologists. The psychologist must be familiar with the duties appropriate to the type of license sought. This examination may also be conducted by a psychiatrist. The individual must be declared in writing by that professional to be in satisfactory psychological and emotional health to serve as the type of officer for which the license is sought. The examination must be conducted pursuant to professionally recognized standards and methods:

(A) the commission may allow for exceptional circumstances where a licensed physician performs the evaluation of psychological and emotional health. This requires the appointing agency to request in writing and receive approval from the commission, prior to the evaluation being completed; or

(B) the examination may be conducted by qualified persons identified by §501.004, Occupations Code. This requires the appointing agency to request in writing and receive approval from the commission, prior to the evaluation being completed.

(e) The enrollment standards established in this section do not preclude the licensed academy from establishing additional requirements or standards for enrollment in law enforcement training programs.

(f) The effective date of this section is October 26, 2009.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 11, 2009.

TRD-200903987

Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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Proposal publication date: June 26, 2009

For further information, please call: (512) 936-7713



## CHAPTER 217. LICENSING REQUIREMENTS

### 37 TAC §217.9

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37,

§217.9, concerning Continuing Education Credit for Licensees, without changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4282) and will not be republished.

The amendment adds language to 37 TAC §217.9, Continuing Education Credit for Licensees. Subsection (b) is amended to provide for refusal of licensing or certification courses by unlicensed or non-contractual training providers. Subsection (d) is amended to reflect the effective date of these changes.

No comments were received regarding adoption of this amendment.

The amendment is adopted under Texas Occupations Code §1701.251, Training Programs; Instructors, §1701.353, Continuing Education Procedures, and §1701.402, Proficiency Certificates.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7713



## CHAPTER 219. PRELICENSING AND REACTIVATION COURSES, TESTS, AND ENDORSEMENTS

### 37 TAC §219.2

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, §219.2, concerning Reciprocity for Out-of-State Peace Officers, Federal Criminal Investigators, and Military Police, with changes to the proposed text as published in the June 26, 2009 issue of the *Texas Register* (34 TexReg 4283) and will be republished.

The amendment adds language to §219.2, Reciprocity for Out-of-State Peace Officers, Federal Criminal Investigators, and Military Police. The title will be amended to reflect the addition of military police personnel. Subsection (c) is amended to provide clarity for the eligibility requirements for out-of-state peace officers to qualify for an endorsement to attempt a state licensing examination. Subsection (f) is amended to add the military police occupational specialties. Subsection (g) is amended to add the military training and service time requirements. The following subsections were re-lettered due to these additions. Subsection (m) reflects the effective date of these changes.

No comments were received regarding adoption of this amendment.

The amendment is adopted under Texas Occupations Code §1701.304, Examination.

§219.2. *Reciprocity for Out-of-State Peace Officers, Federal Criminal Investigators, and Military Police.*

(a) To be eligible to take a state licensing examination, an out of state, federal criminal investigator, or military police must comply with all provisions of §219.1 of this title and this section.

(b) Prospective out-of-state peace officer, federal criminal investigator, and military police applicants for peace officer licensing in Texas must:

(1) meet all statutory licensing requirements of the state of Texas and the rules of the Commission;

(2) successfully complete a supplementary peace officer training course, the curriculum of which is developed by the Commission; and

(3) successfully pass the Texas Peace Officer Licensing Examination.

(c) Requirements (Peace Officers): applicants who are peace officers from other U.S. states must meet the following requirements:

(1) provide proof of successful completion of a state POST-approved (or state licensing authority) basic police officer training academy (with equivalent course topics and hours of training at the time of initial certification or licensure);

(2) have honorably served (employed, benefits eligible) as a sworn peace officer for twelve consecutive months, following initial basic training, with an agency in the state where the license or certificate was issued;

(3) be subject to continued employment or eligible for re-hire (excluding retirement); and

(4) the applicant's license or certificate must never have been, nor currently be in the process of being, surrendered, suspended, or revoked.

(d) Requirements (Federal): The Texas Code of Criminal Procedures Section 2.122 recognizes certain named criminal investigators of the United States as having the authority to enforce selected state laws by virtue of their authority. These individuals are deemed to have the equivalent training for licensure consideration.

(e) Qualifying Federal Officers must:

(1) have successfully completed an approved federal agency law enforcement training course (equivalent course topics and hours) at the time of initial certification or appointment;

(2) have honorably served (employed, benefits eligible) in one of the aforementioned federal capacities for twelve consecutive months, following initial basic training; and

(3) be subject to continued employment or eligible for re-hire (excluding retirement).

(f) Requirements (Military): must have a military police military occupation specialty (MOS) or air force specialty code (AFSC) classification in one of the following:

(1) United States Army 95B or 31B;

(2) United States Marine Corps 5811;

(3) United States Air Force 3PO51, 3PO71, or 3PO91; or

(4) United States Navy Master at Arms or NEC 9545 and successfully completed NAVEDTRA 14137.

(g) Qualifying military personnel must provide proof of:

(1) successfully completed basic military police course for branch of military served; and

(2) served at least 24 months active duty in the designated career field.

(h) Procedures for requesting an endorsement to take state licensing examination:

(1) complete the Commission application for endorsement and have it properly notarized;

(2) attach a certified check or money order for the currently required fee (non-refundable); and

(3) submit the application and fee with all required documents to the Commission by U.S. mail, by courier, or in person.

(i) Required documents to accompany the application for endorsement:

(1) a certified or notarized copy of the basic training certificate for a peace officer, a certified or notarized copy of a federal agent's license or credentials, or a certified or notarized copy of the peace officer license or certificate issued by the state POST or proof of military training;

(2) a notarized statement from the state POST, current employing agency or federal employing agency revealing any disciplinary action(s) that may have been taken against any license or certificate issued by that agency or any pending action;

(3) a notarized statement from each applicant's employing agency confirming time in service as a peace officer or federal officer or agent;

(4) a certified or notarized copy of the applicant's valid state-issued driver's license;

(5) a certified copy of the applicant's military discharge (DD-214), if applicable; and

(6) a passport-sized color photograph (frontal, shoulders and face), signed with the applicant's full signature on the back of the photograph.

(j) The Commission may request that applicants submit a copy of the basic and advanced training curricula for equivalency evaluation and final approval.

(k) All out-of-state, federal, and military applicants will be subject to a search of the National Decertification Database (NDD), NCIC/TCIC, and National Criminal History Databases to establish eligibility.

(l) All documents must bear original certification seals or stamps.

(m) The effective date of this section is October 26, 2009.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on September 11, 2009.

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Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7713



## CHAPTER 221. PROFICIENCY CERTIFICATES AND OTHER POST-BASIC LICENSES

### 37 TAC §221.15

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts the repeal of Title 37, §221.15, concerning Crime Prevention Inspector Proficiency, without changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4285) and will not be republished.

The repeal of §221.15 is being adopted because the authority for that certificate, §5.33A, was repealed from the Insurance Code. The effective date of this repeal will be October 26, 2009.

No comments were received regarding adoption of this repeal.

The repeal is adopted under Texas Occupations Code §1701.402, Proficiency Certificates.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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### 37 TAC §221.21

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, §221.21 concerning Firearms Proficiency for Community Supervision Officers, without changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4285) and will not be republished.

The amendment adds language to 37 TAC §221.21, Firearms Proficiency for Community Supervision Officers. Subsection (b) is amended to reflect weapons proficiency requirements for community supervision officers. Subsection (c) is amended to reflect the expiration date for certificates issued under this section and stipulates requirements for renewal of the certificate for community supervision officers. Subsection (d) is added to establish the effective date of the amendments.

No comments were received regarding adoption of this amendment.

The amendment is adopted under Texas Occupations Code §1701.257, Firearms Training Program for Supervision Officers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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## CHAPTER 223. ENFORCEMENT

### 37 TAC §223.7

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, §223.7, concerning Contested Cases and Hearings, without changes to the proposed text as published in the June 26, 2009, issue of the *Texas Register* (34 TexReg 4286) and will not be republished.

The amendment adds language to 37 TAC §223.7, Contested Cases and Hearings. Subsection (b) is amended to allow for the Commission to recover transcription fees as allowed under §2001.059 of the Texas Government Code. Subsection (c) is added to establish the effective date of the amendments.

No comments were received regarding adoption of this amendment.

The amendment is adopted under Texas Occupations Code §1701.505, Administrative Procedure and Texas Government Code, Chapter 2001, §2001.059.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Timothy A. Braaten

Executive Director

Texas Commission on Law Enforcement Officer Standards and Education

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