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INTRODUCTION. The commissioner of insurance adopts 28 TAC §§21.109, 21.120, 21.701, 21.705, 21.3003, 21.4003, 21.4502, 21.4703, 21.5501, and 21.5503 concerning trade practices. Amendments to §§21.109, 21.120, 21.701, 21.705, 21.4502, 21.4703, 21.5501, and 21.5503 are adopted without changes to the proposed text published in the July 31, 2026, issue of the *Texas Register* (51 TexReg 4991). Section 21.3003 is adopted with changes in response to public comment, and §21.4003 is adopted with nonsubstantive changes to conform the section to the agency's current drafting style and plain language preferences.

REASONED JUSTIFICATION. Amendments to §§21.109, 21.701, 21.3003, 21.4003, 21.4502, 21.4703, and 21.5501 are necessary to implement several provisions of legislation.

- From the 89th Legislature:

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

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

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

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

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

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

To implement other provisions of SB 1236, HB 2221, and HB 1620, TDI adopted amendments to 28 TAC Chapters 3, 11, and 26 (*51 TexReg 6944, 7049, and 7057*) in the October 2 and 9, 2026 issues of the *Texas Register*; and adopted 28 TAC Chapter 19, posted for publication in the November 27, 2026 issue of the *Texas Register*.

The adopted amendments are described in the following paragraphs.

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

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

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

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

Amendments to §21.120(d) redesignate this subsection as §21.120(c) and modify the subsection to align with filing rules in 28 TAC Chapter 3, Subchapter A. The term "the

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

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

Section 21.705. The amendments to §21.705 update the types of HIV tests that may be used for underwriting purposes by replacing references to outdated tests with tests recommended by the Centers for Disease Control and Prevention.

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

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

to comments noting that plans sometimes have different group numbers for medical and pharmacy benefits, TDI modifies §21.3003(b)(3)(A) as proposed to clarify that the ID card must include the applicable pharmacy benefits group number.

TDI adopts new §21.3003(e) and (f) to implement SB 1236. New subsection (e) requires that a group number on an identification card that is provided to an enrollee in a plan subject to Insurance Code Chapter 1369, Subchapter D, cannot be assigned to an enrollee in a plan that is not subject to that subchapter. In response to comments, TDI removes a provision proposed in §21.3003(e)(1), which would have required unique group numbers to be assigned for each line of business specified in Insurance Code §1369.151(b), and reorganizes the subsection so that it is no longer divided into paragraphs.

New §21.3003(f) requires a health benefit plan issuer to provide a method to identify--on the basis of the group number provided on the identification card--whether an enrollee is covered by a plan that is subject to Insurance Code Chapter 1369, Subchapter D. For example, the issuer could include an identifier within the group numbering convention, or the issuer could maintain a list of group numbers that are associated with applicable health benefit plans. In response to comments, TDI modifies §21.3003(f) as proposed to specify that the issuer must provide a method for contracted pharmacies and pharmacists to identify, in real time, on the basis of the pharmacy benefits group number, whether an enrollee is in a plan subject to Insurance Code Chapter 1369, Subchapter D. The proposed amendment that would have required the issuer to make the identification method publicly available on its website is not adopted. This change gives issuers additional flexibility in how they make this information available.

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

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

To conform the section to the agency's current drafting style and plain language preferences, TDI modifies §21.4003 as proposed by replacing a comma with a semicolon in §21.4003(a)(3)(A) and (b)(1)(B) and replacing all instances of the word "shall" with "must" in §21.4003(b)(1).

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

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

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

Section 21.5501. Amendments to §21.5501 implement HB 721 by removing former §21.5501(a)(3) and adding new §21.5501(b)(5). These changes clarify that the rules in Subchapter UU no longer apply to a regional or local health care program. To conform to HB 4611, §21.5501(b)(4) is amended to reference Government Code Chapter 540 instead of Government Code Chapter 533. In addition, §21.5501(c) - (e), which address the initial implementation deadlines, are removed because they are no longer relevant.

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

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

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

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

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

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

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

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

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

- The "billing_code_type_version" definition is updated to specify instructions if there is no version available for the "billing_code_type." This change is made

in the In-Network and Contained Billing Code Objects of the In-Network File Schema and the Out-Of-Network Object of the Out-Of-Network Allowed Amount File Schema.

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

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

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

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

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

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

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

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal. The comment period ended on August 31, 2026.

Commenters: TDI received comments from two commenters, and one of the commenters spoke at a public hearing on the proposal held on August 25, 2026. The commenters in support of the proposal with changes were the Texas Association of Health Plans and Texas Pharmacy Association.

Comments on §21.3003(e) and (f)

Comment. One commenter raises concerns with provisions in §21.3003(e)(1), specifying that a unique group number must be assigned for each line of business in Insurance Code §1369.151(b). The commenter states that this imposes substantive requirements on issuers that were not included in the bill as negotiated and requests TDI withdraw §21.3003(e)(1) in its entirety. A second commenter supports §21.3003(e) as proposed, noting that requiring group numbers to distinguish between lines of business appropriately advances the objective of SB 1236 to enable pharmacists and patients to

determine whether a particular health plan is subject to Texas insurance law and TDI jurisdiction.

Agency Response. As TDI noted in the proposal, Insurance Code §1369.151(b) includes employer plans for state employees, teachers, and university employees, as well as Medicaid and CHIP. These plans are exempt from many of the requirements in Insurance Code Chapter 1369, so it could create confusion if they used the same group numbers as other plans that are subject to Insurance Code Chapter 1369, Subchapter D. However, this concern is mitigated because the state agencies overseeing these plans may require unique group numbers by contract. In response to the concerns raised by the first commenter, TDI modifies the rule as proposed by removing §21.3003(e)(1).

Comment. One commenter raises concerns that as proposed, §21.3003(e) and (f) are not sufficiently specific to ensure that the ID card includes the group number used to administer prescription drug benefits. The commenter notes that in some arrangements, the issuer's pharmacy benefit manager (PBM) assigns a pharmacy group number for processing prescription drug claims that is different from the group number the issuer uses to process other medical claims. The commenter recommends that the final rule expressly state that the group number subject to §21.3003(e) and (f) is the group number used for the enrollee's prescription or pharmacy benefits. Another commenter states that Insurance Code §1369.153(e) as added by SB 1236 speaks exclusively to group numbers and should only prohibit their reuse. The commenter states that structuring the rule around a different operational identifier would require issuers to reengineer card and claims data to serve a mandate the Legislature never enacted.

Agency Response. TDI agrees with the first commenter and modifies §21.3003(b)(3)(A), (e) and (f) as proposed to clarify that the group number governed by the rule is the group number applicable to pharmacy benefits. With respect to the second commenter, it is not clear whether the commenter opposes using pharmacy benefit group numbers, or opposes requiring some alternative identifier. TDI believes that clarifying that the rule applies to the pharmacy group number is consistent with Insurance Code §1369.153(e). Insurance Code Chapter 1369, Subchapter D, concerning Pharmacy Benefit Cards, has long required that the pharmacy ID card include the group number applicable to the enrollee. As the first commenter noted, in some arrangements health benefit plan issuers use group numbers on pharmacy ID cards that are different from those for other health benefits, and TDI has never taken the position that such issuers are out of compliance. If TDI were to instead mandate that pharmacy ID cards use the same group numbers as are used for administering other health benefits, that would require issuers to modify ID card and claims systems.

Comment. One commenter recommends that TDI modify §21.3003(f) by establishing a functional standard as follows: using the group number shown on an enrollee's identification card, a member of the public should be able to determine whether the group number corresponds to a health benefit plan subject to Insurance Code Chapter 1369, Subchapter D. The commenter states that a pharmacist should not be required to take multiple steps to understand whether Texas pharmacy benefit protections apply. The commenter also recommends that the rule require that:

- the identification method be publicly available without registration or authentication, and not require any information beyond the ID card;

- using the pharmacy group number, the user should be able to identify the payor or issuer, the relevant plan or line of business, and whether the plan is subject to Insurance Code Chapter 1369, Subchapter D; and

- issuers promptly update the information when group numbers, payor relationships, pharmacy benefit manager arrangements, or plan classifications change.

A second commenter asserts that §21.3003(f) as proposed exceeds the statute by creating a new public-disclosure obligation. The commenter states that nothing in SB 1236 or Insurance Code §1369.153 requires an issuer to publish anything, build a group-number lookup tool, or make its group-number architecture publicly accessible. The commenter raises concerns that this new obligation would have operational, vendor, and information-security implications that were not contemplated in the bill text and would be operationally ineffective.

Agency Response. With respect to the first commenter's suggestions, TDI disagrees that §21.3003(f) should be expanded to provide information beyond whether a group number is subject to Insurance Code Chapter 1369, Subchapter D. Such changes would exceed the scope of the rule as proposed. With respect to the concerns raised by the second commenter, TDI disagrees that §21.3003(f) is inconsistent with the statute. SB 1236 includes a provision requiring a network contract to state that it is subject to Insurance Code Chapter 1369, in addition to requiring issuers to differentiate the pharmacy group numbers used on ID cards, depending on whether the plan is subject to Insurance Code Chapter 1369, Subchapter D. Both provisions aim to ensure that pharmacies and pharmacists can identify plans that fall under TDI's jurisdiction and that TDI can effectively address complaints. Issuers cannot comply with the statute if they do not develop a method for differentiation. The rule as proposed simply requires the issuer to be

transparent about the method for differentiating group numbers. Issuers are already required to maintain websites with information needed by providers to verify coverage. For example, Insurance Code §1223.002 and §1661.002 require issuers to maintain electronic systems that provide real-time information at the point of care about the enrollee's coverage and financial responsibility. In response to the commenter's operational and information-security concerns, TDI modifies §21.3003(f) as adopted to narrow the requirement to contracted pharmacies and pharmacists and remove the requirement for the identification method to be on a publicly accessible website. This gives issuers broader flexibility to provide the method either on a public website or within a secure provider portal.

Comment. One commenter suggests that each issuer should be required to submit a standardized group-number crosswalk to TDI for publication, identifying the group number, payer or issuer, plan type or line of business, PBM (if applicable), and whether the plan is subject to Insurance Code Chapter 1369, Subchapter D. The commenter encourages TDI to make the issuer-submitted crosswalk available through a centralized and readily discoverable TDI webpage and to require issuers and any delegated PBMs to provide a direct link to the applicable lookup or crosswalk information from their own webpages. A second commenter opposes the first commenter's request that TDI collect and publish group number data, noting that this was not contemplated by the statute and would impose real and ongoing burdens for issuers. The second commenter states that SB 1236 does not authorize TDI to compel issuers to submit group-number information to the agency, build and maintain a centralized lookup database, or publish issuers' group-number architecture.

Agency Response. TDI agrees with the second commenter and declines to make the changes suggested by the first commenter. Introducing a new data collection requirement would exceed the scope of the statute.

Comment. One commenter notes that for many plans, the PBM is the entity best positioned to maintain and communicate pharmacy processing information. Therefore, the rule should permit an issuer to delegate the requirement in §21.3003(f) to the PBM; however, the issuer should maintain ultimate responsibility for compliance.

Agency Response. TDI agrees with the commenter that when issuers choose to delegate administrative responsibilities to a third party, such as a PBM, the issuer maintains the ultimate responsibility for compliance. However, TDI disagrees that any change is needed to the rule. In addition to Insurance Code §1369.153 clearly applying to health benefit plan issuers, Insurance Code §4151.1042 makes it clear that issuers that use third-party administrators bear the ultimate responsibility for those covered benefits. As stated in 28 TAC §7.1613(c), insurers' contracts with third-party administrators "may not be construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder."

Subchapter B. Advertising, Certain Trade Practices, and Solicitation
28 TAC §21.109 and §21.120

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

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

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

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

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

TEXT.

§21.109. Unlawful Inducement.

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

(1) This subsection does not prohibit, in connection with an accident and health insurance policy or health maintenance organization contract, the provision of loss-control or value-added products or services, or the disclosure in advertising of the

availability of such additional services and information, to prospective policy or certificate holders, or prospective enrollees or contract holders. If there is a separate charge required to access such additional services or information, an advertisement referencing the services or information must disclose that fact.

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

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

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

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

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

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

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

§21.120. Insurance Advertising.

(a) Any advertisement required to be submitted or submitted voluntarily by an insurer licensed to do business in Texas must be submitted to TDI consistent with filing procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). The filing must contain the following information:

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

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

(3) the form number of each approved policy or rider advertised;

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

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

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

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

(c) An advertisement subject to requirements regarding filing of the advertisement with the department for review under the Insurance Code or this title that is an exact copy or substantially similar to an advertisement previously reviewed and accepted by the

department, is not required to be filed for review. For the purposes of this subsection, "exact copy" and "substantially similar" have the meanings assigned in §3.2 of this title (relating to Definitions). A person or entity wishing to introduce a "substantially similar" advertisement must submit an informational filing in SERFF that includes a signed certification for a substantially similar filing consistent with the requirements in Chapter 3, Subchapter A, of this title. The filing must identify or illustrate the changes to be introduced, and list each previously reviewed and accepted form in which those changes would appear, including the form and the SERFF filing number those forms were previously reviewed and accepted under.

(d) The following rules require that advertisements be filed with the department for review at or before use:

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

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

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

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

Subchapter H. Unfair Discrimination
28 TAC §21.701 and §21.705

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

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

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

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

TEXT.

§21.701. Purpose.

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

§21.705. Nondiscriminatory Testing for Human Immunodeficiency Virus.

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

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

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

(A) the proposed insured is tested to determine the existence of HIV antibodies or antigens in the blood using a test that is included in the current Centers for Disease Control and Prevention (CDC) recommended laboratory HIV testing algorithm for serum or plasma specimens; and

(B) the test is considered positive only if testing results meet the most current CDC recommended HIV testing algorithm or a more reliable confirmatory test or test protocol; and

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

Subchapter V. Pharmacy Benefits
28 TAC §21.3003

STATUTORY AUTHORITY. TDI adopts amendments to §21.3003 under Insurance Code §1369.154 and §36.001.

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

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

TEXT.

§21.3003. Standard Identification Cards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) as applicable:

(A) for a group health benefit plan, the applicable pharmacy benefits group number, subject to the requirements in subsection (e) of this section; or

(B) for an individual health benefit plan, the applicable policy number or evidence of coverage number;

(4) the effective date of coverage;

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

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

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

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

(d) Nothing in this section prohibits the issuer of a health benefit plan, or an administrator or pharmacy benefit manager, from issuing a standard identification card

containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required by subsections (b) and (c) of this section is printed on the card.

(e) Consistent with Insurance Code §1369.153, concerning Information Required on Identification Card, a pharmacy benefits group number on an identification card provided to an enrollee in a health benefit plan subject to Insurance Code Chapter 1369, Subchapter D, concerning Pharmacy Benefit Cards, may not be assigned to an enrollee in a health benefit plan that is not subject to that subchapter.

(f) An issuer of a health benefit plan must provide a method for contracted pharmacies and pharmacists to identify, in real time, based on the pharmacy benefits group number provided on the identification card, whether an enrollee is covered by a health benefit plan that is subject to Insurance Code Chapter 1369, Subchapter D.

Subchapter FF. Obligation to Continue Premium Payment Coverage After Notice of Lost Group Eligibility
28 TAC §21.4003

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

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

Insurance Code §1301.007 provides that the commissioner adopt rules as necessary to implement Insurance Code Chapter 1301 and to ensure reasonable

accessibility and availability of preferred provider benefits and basic level of benefits to residents of this state.

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

TEXT.

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

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

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

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

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

(2) If a health carrier agrees that a group policyholder or group contract holder may tender the notice referenced in paragraph (1)(A) of this subsection by mail, the date the group policyholder or group contract holder tenders the notice to the postal

service is the date the group policyholder or group contract holder notifies the health carrier. Evidence of written notifications may be maintained in a mail log to provide proof of submission and establish date of receipt.

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

(A) agreed on by the group policyholder or group contract holder and the carrier; and

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

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

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

(6) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section under coverage a health carrier extends to an individual in compliance with 29 USC §1161 et seq. (COBRA), the Insurance

Code Chapter 1251 Subchapter F, concerning Continuation or Conversion Privilege on Termination of Coverage Under Group Policy, or any other federal or state continuation of coverage requirement that allows an individual insured or enrollee, upon termination of eligibility from a group, to pay premium and extend the period of group health benefit plan coverage after the individual has left employment or otherwise no longer qualifies as a member of the group.

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

(8) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section in the event of the individual insured's or enrollee's death after the later of the date of the individual insured's or enrollee's:

(A) death; or

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

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

(1) A health carrier that enters into or renews a health benefit plan contract with a group policyholder or group contract holder must provide written notice to the group policyholder or group contract holder that the group policyholder or group contract holder is liable for premiums for an individual who is no longer part of the group

until the health carrier receives notification of termination of the individual's eligibility for coverage as follows:

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

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

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

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

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

Subchapter KK. Health Care Reimbursement Rate Information
28 TAC §21.4502

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

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

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

TEXT.

§21.4502. Applicability.

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

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; and

(6) a health maintenance organization (HMO).

(b) As provided in Insurance Code §38.353(b), and notwithstanding any provision in Insurance Code Chapters 1551, concerning Texas Employees Group Benefits Act; 1575, concerning Texas Public School Employees Group Benefits Program; 1579, concerning Texas School Employees Uniform Group Health Coverage; or 1601, concerning Uniform

Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M System or any other law, this subchapter applies to:

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

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

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

(4) basic coverage under Insurance Code Chapter 1601.

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

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

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

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

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

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

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

(d) Notwithstanding subsection (c)(1) of this section, an applicable health benefit plan issuer is not prohibited from electively including data concerning reimbursement rates for standard health benefit plans provided under Insurance Code Chapter 1507 in its submission of the report required in §21.4506 of this title (relating to Submission of

Report) for purposes of administrative convenience. Data from all other plans identified in subsection (c) of this section must be excluded from the report.

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

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

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

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

Subchapter MM. Wellness Programs
28 TAC §21.4703

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

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

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

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

TEXT.

§21.4703. Wellness Programs Exception.

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

(b) Notwithstanding the provisions of Insurance Code §1702.102 and §544.052, an insurer issuing an accident and health insurance policy may vary the amount of premium or contribution it requires similarly situated individuals or individuals of the same class

and of essentially the same hazard to pay, or vary benefits, or both, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title.

Subchapter UU. Machine Readable Files
28 TAC §21.5501 and §21.5503

STATUTORY AUTHORITY. TDI adopts amendments to §21.5501 and §21.5503 under Insurance Code §1662.004 and §36.001. Insurance Code §1662.004 authorizes the commissioner to adopt rules necessary to implement Insurance Code Chapter 1662.

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

TEXT.

§21.5501. Applicability and Effective Date.

(a) Except as provided in subsections (b) and (c) of this section, this subchapter applies to issuers of health benefit plans as specified in Insurance Code §1662.003, concerning Applicability of Chapter, that provide major medical coverage for which federal reporting requirements under 26 CFR Part 54, concerning Pension Excise Taxes; 29 CFR Part 2590, concerning Rules and Regulations for Group Health Plans; 45 CFR Part 147, concerning Health Insurance Reform Requirements for the Group and Individual Health

Insurance Markets; and 45 CFR Part 158, concerning Issuer Use of Premium Revenue: Reporting and Rebate Requirements, do not apply, including:

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

(2) issuers providing grandfathered health plan coverage, as defined in 45 CFR §147.140, concerning Preservation of Right to Maintain Existing Coverage.

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

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

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

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

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

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

§21.5503. Data Schemas.

(a) In-network negotiated rate file schema. For the "in-network-rates" file published under this subchapter, an issuer must include data elements consistent with the In-

Network File Schema contained in Machine-Readable Files: Data Schemas (version 2.0), published on the department's website.

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

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

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

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

Issued at Austin, Texas, on November 19, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§21.109, 21.120, 21.701, 21.705, 21.3003, 21.4003, 21.4502, 21.4703, 21.5501, and 21.5503 are adopted.

Signed by:
Amanda Crawford
FE10434BC41A470...

Amanda Crawford
Commissioner of Insurance

Commissioner's Order No. 2026-10244