SUBCHAPTER F. PROFESSIONAL EMPLOYER ORGANIZATIONS SPONSORING SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLANS

28 TAC §§13.510-13.513, 13.520-13.524, 13.530-13.534, 13.540-13.545, 13.550-13.557, 13.560-13.568, 13.570-13.573, and 13.580-13.583

INTRODUCTION. The Texas Department of Insurance adopts new 28 TAC Subchapter F, §§13.510-13.513, 13.520-13.524, 13.530-13.534, 13.540-13.545, 13.550-13.557, 13.560-13.568, 13.570-13.573, and 13.580-13.583 concerning the regulation of self-funded employee health benefit plans (plans) sponsored by professional employer organizations (PEOs) under Labor Code Chapter 91, concerning Professional Employer Associations. The commissioner also adopts by reference the Statutory Deposit Transaction Form, Form No. FIN407; the Declaration of Trust Form, Form No. FIN453; the Texas PEO Annual Report, Form No. FIN410, and the Texas PEO Quarterly Report, Form No. FIN409, including all instructions and requirements included on those forms. These new sections are adopted with changes to the proposed text published in the December 25, 2015, issue of the *Texas Register* (40 TexReg 52). The changes from the proposal are nonsubstantive and reflect the TDI style guidelines.

A nonsubstantive change is made to §13.523 removing subsection (a)(4) which references Insurance Code Chapter 38, Subchapter C, concerning Data Collection and Reporting Relating to HIV and AIDS. This statute was repealed by SB 784, 84th Leg., Regular Session (2015), Effective September 1, 2015. All subsections from §13.523(a)(4) to §13.523(a)(107) were renumbered to reflect the removal of the provision citing the repealed statute.

Nonsubstantive changes are made to §§13.523(a)(38); 13.523(a)(83); 13.523(a)(101); 13.524(a), and (a)(8), (21), and (43); 13.534(f); 13.561; 13.572; 13.573(b); 13.580(d); and §13.582(a) and (c) as adopted to correct errors in the headings of statutes and rules that are cited in these provisions. A nonsubstantive edit is made to §13.552(a) to update the new title of the TDI section responsible for a plan amendment filing.

A nonsubstantive change is made to §13.532(a)(10) to add a parenthetical reference to the heading of a section the provision cites, and another nonsubstantive edit is made to §13.532(b)(1) to clarify that a reference in the paragraph is to Division 6 of 28 TAC Chapter 13, Subchapter F.

Nonsubstantive changes are made to §13.542 and §13.582(e) to correct punctuation.

A nonsubstantive change is made to §13.553(d) to correct the use of section symbols in a citation.

REASONED JUSTIFICATION. The adopted sections are necessary to augment and implement the regulation of plans that are not fully insured and are sponsored by PEOs licensed by the Texas Department of Licensing and Regulation (TDLR), as required by Labor Code §91.0411, enacted under Senate Bill 1286, 83rd Legislature, Regular Session (2013), effective September 1, 2013.

Division 1 - Purpose and Definitions

This division addresses the purpose and application of the rule and provides definitions.

Section 13.510 states that the purpose of the new subchapter is to augment and implement the regulation of a PEO-sponsored self-funded employee health benefit plan, in compliance with Labor Code Chapter 91.

Section 13.511 identifies the PEO's sponsoring benefit plans that are and are not subject to the subchapter, and specifies that a PEO subject to the subchapter must be licensed by both TDLR and the department before offering a self-funded employee health benefit plan.

Section 13.512 states that the subchapter applies to a PEO and its plan and trust to the extent permitted by ERISA, and the section includes a severability provision.

Section 13.513 defines terms relevant to the subchapter. Where appropriate, definitions are drawn from Labor Code Chapter 91, from the Insurance Code, and from ERISA.

Division 2 – Applicability of Insurance Code and Administrative Code Provisions

This division provides a list of Insurance Code and Administrative Code provisions regulating a self-funded PEO-sponsored plan.

Section 13.521 establishes that the department will consider an approved PEO to be a large employer and will regulate its plan as a large employer health benefit plan for purposes of applying the Insurance and Administrative Codes.

Section 13.522 authorizes an approved PEO to delegate by contract to other entities regulated by the department (such as a third party administrator (TPA)) the

performance of the PEO's or trust's statutory and regulatory requirements. The PEO or trust and the contracting regulated entity may be held jointly and severally liable by the department for noncompliance with respect to the delegated responsibilities. A PEO or trust must give the department notice of its intent to enter into, terminate, or replace a delegated contract. Notice must include pertinent information about the proposed contracting regulated entity, or other relevant information, such as whether on contract termination the functions performed under that contract will be performed by the PEO or trust, or by another contracted regulated entity. The section also includes procedures to be followed when a contracting regulated entity is terminated for cause. Day-to-day operations of the plan and trust must be performed by a TPA.

The balance of Division 2, §13.522 and §13.523, lists the sections of the Insurance Code and Administrative Code with which an approved PEO must comply. These are provisions which apply, almost without exception, to a fully insured large employer health benefit plan regulated by the department. Section 13.522 and §13.523 each include subsections to clarify whether the approved PEO is considered an issuer or an employer for purposes of applicable Insurance Code and Administrative Code provisions where both entities are referenced.

Division 3 – Certificate of Approval

Division 3 sets out the certificate of approval requirements.

Section 13.530 requires a PEO to receive a certificate of approval from the department before sponsoring a plan in Texas. A PEO sponsoring a plan without approval will be considered an unauthorized insurer. This requirement, and the balance

of the application requirements, are similar to those applied to risk-bearing entities seeking to do the business of health insurance in Texas.

Section 13.531 establishes that a PEO must apply for a certificate of approval by providing the information required by the division and must include an application fee of $5,050.

Section 13.532 lists the information to be provided by an applicant seeking a certificate of approval.

Section 13.533 requires that an applicant include an independent actuarial opinion that describes the extent to which projected plan contributions are:

- not excessive or discriminatory;
- adequate to pay all plan benefits and expenses; and
- sufficient to maintain adequate plan reserves and surplus.

The independent actuarial opinion will also show the expected allocation of client employers' contributions to fund the plan's administrative expenses, reserves, and other expenses.

Section 13.534 provides for the commissioner's review and approval or denial of a PEO’s application for a certificate of approval, and the process to appeal a denial.

Division 4 – Conduct of Approved PEO

Division 4 sets out the requirements for management of the PEO and administration of the plan and trust.

Section 13.540 addresses the qualifications of the individuals responsible for the management of the PEO and the administration of the plan and trust. The section permits the PEO to maintain its books and records outside the state as permitted by Insurance Code Chapter 803, concerning Location of Books, Records, Accounts, and Offices Outside of This State.

Section 13.541 requires an approved PEO plan sponsor to contract for stop-loss insurance covering the plan and trust until a board of trustees has been established to manage the plan and trust.

Section 13.542 requires an approved PEO to maintain a fidelity bond or a zero-deductible crime policy to cover all individuals responsible for handling or administering plan funds or servicing the plan. This requirement remains in effect even after a board of trustees has been established to administer the plan and trust, because the PEO will be responsible for collecting and remitting contributions to the trust.

Section 13.543 regulates the approved PEO's conduct with respect to the plan and trust, including the establishment of plan contribution amounts, payments to the trust from PEO assets and accounts, and reimbursement to the PEO from plan assets for its costs to establish and initially administer the plan and to comply with the subchapter's requirements. The section prohibits PEO transactions affecting the plan and trust and its assets that would violate state or federal law.

Section 13.544 regulates an approved PEO's marketing materials and offers of enrollment, and it requires guaranteed renewability in compliance with applicable state

and federal law. Only employees of the PEO's clients and their dependents are eligible to enroll in an approved PEO's plan.

Section 13.545 governs an approved PEO's representations to clients and plan participants about pricing, billing, and notices of increased contributions. The section also requires the PEO to accept sole responsibility, without obligating its clients, for funding any asset amount needed to equal the liabilities owed by the plan should there be a shortfall in trust assets, and it renders unenforceable any client services agreement provision in conflict with the subchapter. Finally, the section prescribes certain language to be included in the summary plan description provided to plan participants.

Division 5 – Formation, Governance and Operation of Plan and Trust

Division 5 addresses the administration of an approved PEO's plan and trust.

Section 13.550 requires an approved PEO's plan to be established in compliance with ERISA and to contain specified provisions. The section authorizes an approved PEO to amend its plan without approval by the plan's trustees. All plan amendments must be submitted to the department for review and approval by the commissioner as described by §13.552 before becoming effective.

Section 13.551 requires an approved PEO's plan trust, in which all funds used to administer and pay claims are to be held, be established in compliance with the Trust Code and with ERISA. The trust must be governed by a board of trustees under a trust agreement, terms of which are set out in the subchapter. The trustees are authorized to amend the trust agreement without the approval of the approved PEO. All trust

amendments must be submitted to the department for review and approval by the commissioner as described by §13.552 before becoming effective.

Section 13.552 specifies that the approved PEO must submit for approval by the commissioner to designated TDI offices all amendments to the documents of both the plan and the trust. The approved PEO must certify that the approved PEO and the plan will remain in compliance with the subchapter and with ERISA if a proposed plan amendment is approved and adopted. The trustees must certify that the trust will remain in compliance with the subchapter and with ERISA if a proposed trust amendment is approved and adopted. Transactions between affiliated parties are subject to Insurance Code Chapter 823, Subchapters B and C.

Section 13.553 establishes a plan fiduciary's duty, consistent with a fiduciary's duty under ERISA, and provides that the standard may change if the federal standard is modified. The section provides standards of conduct for a plan fiduciary involved in a transaction involving the plan or trust, and it requires that all plan and trust expenses be paid from plan assets. Finally, the section establishes the requirements for a voluntary trust termination, including a requirement that assets remaining in the trust may not be distributed until the commissioner has cancelled the approved PEO's certificate of approval.

Section 13.554 regulates the appointment and number of plan trustees by the approved PEO, and it specifies that a person who is receiving or has received compensation from the trust is ineligible to serve as a board member.

Section 13.555 establishes the trustees' responsibilities and authority, including the duty of prudence, the responsibility for all operations of the plan, and the safeguarding of plan assets. Within 12 months of the board's formation, the trustees, either directly or through an appointed agent, must contract with a TPA and with a stop-loss carrier. Members of the board serve without compensation.

Section 13.556 requires that the trustees protect the plan's assets by buying fidelity coverage for those responsible for handling or administering plan assets, by buying errors and omissions insurance for the trustees' performance of their duties, and by annually reviewing documentation that the approved PEO has maintained and is maintaining its own fidelity coverage required under this subchapter.

Section 13.557 provides that all claims or other disputes arising under an approved PEO's plan are subject to the Insurance Code and other relevant state law, to the extent the Insurance Code and state law are not inconsistent with ERISA.

Division 6 – Financial Solvency Requirements for PEO Plans

Division 6 provides for financial requirements for approved PEO plans.

Section 13.560 establishes the methodology to be used to calculate claim reserves maintained in the plan's trust.

Section 13.561 requires that the trust invest its assets in compliance with Insurance Code Chapter 425, Subchapter C.

Section 13.562 requires an approved PEO to establish a deposit or letter of credit that represents at least 25 percent of the aggregate limit attachment point in the plan and trust's stop-loss agreement before beginning to enroll participants. The deposit or

letter of credit must be maintained continually, and any deposit or letter of credit must be held for TDI's control.

In §13.562 TDI adopts by reference the Statutory Deposit Transaction Form, Form No. FIN407. This form requires information necessary for the department to record the deposit, substitution, or withdrawal of securities, including: the name and address of the PEO establishing the deposit; whether the transaction establishes, substitutes, or withdraws securities; the authority under which the deposited securities are held; the name of the designated custodian; security specific information, including the identification number, description, interest rate, par value amount, maturity date, and rating information; the total deposit or withdrawal amount for the transaction; a dated signature of an authorized officer of the entity establishing the deposit; and the total deposit, total withdrawal, and net balance after the transaction.

In §13.562 TDI also adopts by reference the Declaration of Trust Form, Form No. FIN453, which affirms that securities are unencumbered assets of the person or entity making a deposit and are pledged to the commissioner by reasons of law. This form requires information necessary to identify: the entity or person making a deposit, its principal place of business, its custodian or bank, and security specific information including the CUSIP number; interest rate; maturity date; and par value amount.

Section 13.563 specifies the form of the required deposit.

Section 13.564 requires that the amount of the deposit be recalculated annually, and it prescribes how changes to the deposit are to be made.

Section 13.565 provides the requirements for a letter of credit that can be used to replace or supplement a deposit to meet financial responsibility standards.

Section 13.566 requires that the amount of the letter of credit be recalculated annually, and discusses the consequences if a letter of credit is replaced, is not renewed, or is suspended.

Section 13.567 addresses the requirements for the stop-loss insurance that the plan trustees, or the approved PEO acting on the trustees' behalf, must maintain in the name of and for the benefit of the trust. The section regulates the issuer's qualifications and directs that certain terms be included in the stop-loss contract. It also establishes the trust's maximum retention of expected claims. The section permits the trustees to request from the commissioner a waiver or reduction in coverage amount. The commissioner will grant a waiver if the commissioner determines that the interests of the PEO's clients and the plan participants are adequately protected.

Section 13.568 provides the requirements for the fidelity bond or crime policy required under §13.542 and §13.556, which direct an approved PEO and a plan's board of trustees to maintain fidelity coverage for each person responsible for handling or administering plan assets. The requirements are consistent with similar requirements included in ERISA.

Division 7 – Quarterly and Annual Filings; Examinations; Hazardous Conditions

Division 7 addresses financial reporting, examination by TDI, and hazardous condition regulation. Section 13.570 describes both the quarterly and annual filings of the plan and trust's financial statement to be submitted by an approved PEO using

generally accepted accounting principles of the United States as modified by the subchapter. The section states that the PEO must submit quarterly a certified unaudited financial statement, and annually both a certified unaudited financial statement for the previous four financial quarters and by June 1 of each year an audited financial statement meeting requirements set out in Insurance Code Chapter 401.

In §13.570 TDI adopts by reference the Texas PEO Annual Report, Form No. FIN410, and the Texas PEO Quarterly Report, Form No. FIN409, which are spreadsheets the PEO will file with information for TDI to assess facts about the PEO's financial condition. These forms may be requested by emailing PEO@tdi.texas.gov, and they are also available for inspection on TDI's website at www.tdi.texas.gov/rules/2015/index.html. The PEO must also file an annual actuarial opinion completed by a qualified actuary which includes a description of the actuarial soundness of the plan, a calculation of reserves as required by §13.560, and a recommendation on the level of specific and aggregate stop-loss insurance the trust should maintain.

Section 13.571 requires the PEO submit a fee with its annual statement filings.

Section 13.572 addresses the commissioner’s examination of the affairs of an approved PEO and the plan and trust to the same extent that the commissioner can examine the affairs of a licensed domestic insurer.

Section 13.573 outlines what will be considered hazardous conditions for the plan and trust, and it identifies the regulatory actions the commissioner will order to correct or address those hazardous conditions.

Division 8 – Market Exit

Division 8 provides the requirements for approved PEO plans to exit the market.

Section 13.580 requires an approved PEO to file a withdrawal plan for review by the commissioner if it wants to voluntarily terminate its plan or is directed by the department to terminate its plan. The section details the contents of a withdrawal plan, and establishes conditions that must be met before the commissioner will approve such a plan. These requirements and conditions are designed to ensure the benefit plan's participants are protected from disruption by its dissolution. The commissioner has authority to modify or deny the withdrawal plan and take actions authorized under the Insurance Code if the approved PEO is unable to meet its contractual and financial obligations. The section also provides for the appeal of a commissioner's denial of a withdrawal plan.

Section 13.581 provides that the commissioner will limit, suspend, or cancel an approved PEO's certificate of approval in response to notice that TDLR has taken action against its license to operate in Texas. An approved PEO must notify the department within 10 days of receiving notice that TDLR is contemplating taking action against its license. While its license is suspended, an approved PEO cannot contract with a new client to allow the enrollment of new plan participants. If TDLR terminates a PEO's license, the PEO must file a withdrawal plan under §13.580 within 30 days; when the PEO has fulfilled its withdrawal plan, the commissioner will cancel the PEO's license. If TDLR reinstates a PEO's license or grants a new license, the PEO may reapply to TDI for a license.

Section 13.582 provides that the commissioner will limit, suspend, or cancel an approved PEO's certificate of approval if the commissioner finds that the approved PEO or its plan or trust do not meet the requirements of applicable Insurance Code provisions or of the subchapter. The section also provides for the appeal of an action by the commissioner.

Section 13.583 requires that an approved PEO must file a withdrawal plan within 30 days of receiving a notice of suspension. If the commissioner determines an approved PEO's certificate should be canceled, the PEO must file a withdrawal plan under §13.580, and upon the plan's completion, the commissioner will cancel the PEO's certificate of approval.

TDI adopts by reference the Statutory Deposit Transaction Form, Form No. FIN407; the Declaration of Trust Form, Form No. FIN453; the Texas PEO Annual Report, Form No. FIN410; and the Texas PEO Quarterly Report, Form No. FIN409, including all instructions and requirements included in those forms. These forms are available on TDI's website.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI received oral comments from two people. TDI did not receive any written comments. Commenters in support of the proposal were: Employer Flexible and the National Association of Professional Employer Organizations. TDI did not receive any comments in opposition to the proposal.

Two commenters provided general comments supportive of the rule and commended TDI staff's efforts on the rule. TDI is appreciative of the supportive comments.

One commenter requested that TDI continue to be willing to work with the industry as unexpected issues can arise out of the most well intentioned rules. TDI acknowledges the request.

STATUTORY AUTHORITY. The new sections are adopted under Labor Code §91.0411 and Insurance Code §36.001.

Labor Code §91.0411 provides for the commissioner of insurance to adopt rules necessary to augment and implement the regulation of benefit plans sponsored by PEOs licensed by TDLR, which include requirements that must be met by the licensed PEO and plan. The rules must include initial and final approval requirements, authority to prescribe forms and items to be submitted to the commissioner by the license holder, a fidelity bond, use of an independent actuary, use of a third-party administrator, authority for the commissioner to examine an application or plan, the minimum number of clients and covered employees covered by the plan, standards for those natural persons managing the plan, the minimum amount of gross contributions, the minimum amount of written commitment, binder, or policy for stop-loss insurance, the minimum amount of reserves, and a fee in the amount reasonable and necessary to defray the costs of administering the section to be deposited to the credit of the operating fund of the Texas Department of Insurance.

Insurance Code §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.

TEXT.

SUBCHAPTER F. PROFESSIONAL EMPLOYER ORGANIZATIONS SPONSORING SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLANS

§§13.510-13.513, 13.520-13.524, 13.530-13.534, 13.540-13.545, 13.550-13.557, 13.560-13.568, 13.570-13.573, and 13.580-13.583

DIVISION 1. PURPOSE AND DEFINITIONS.

§13.510. Purpose. The purpose of this subchapter is to augment and implement the regulation of an employee health benefit plan that is not fully insured and is sponsored by a PEO as permitted by Texas Labor Code Chapter 91, concerning Professional Employer Organizations.

§13.511. Regulated PEOs; Approval Required.

(a) PEOs subject to this subchapter. This subchapter applies to a PEO sponsoring a self-funded employee health benefit plan if:

(1) its primary business location is in this state; or

(2) a majority of the eligible employees of at least one of its clients are employed in this state; or

(3) the primary business location of at least one of its clients is in this state, where no other state contains a majority of that employer's eligible employees.

(b) PEOs not subject to this subchapter. This subchapter does not apply to a PEO sponsoring an employee health benefit plan that consists only of benefits provided through a group insurance policy or evidence of coverage that guarantees the payment of claims for all eligible benefits issued by a carrier authorized to do business in this state.

(c) License and certificate of approval required. A PEO to which this subchapter applies may not offer a self-funded employee health benefit plan unless the PEO is:

(1) licensed and in good standing with TDLR; and

(2) has a certificate of approval from TDI issued under this subchapter.

(d) Insurance Code Chapter 846. Insurance Code Chapter 846, concerning Multiple Employer Welfare Arrangements, does not apply to a plan sponsored by a PEO unless:

(1) a PEO that does not have a certificate of approval to sponsor a PEO plan under this subchapter performs activities that require a certificate of authority under Chapter 846; or

(2) an approved PEO files a withdrawal plan that is approved by the commissioner, and relinquishes its certificate of approval as a PEO plan sponsor under this subchapter.

§13.512. ERISA's Applicability; Severability of Subchapter's Provisions.

(a) This subchapter applies to an approved PEO and its plan and trust to the extent permitted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§1001-1191c.

(b) If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application. To this end, the provisions of this subchapter are severable.

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

(1) Affiliate--A person is defined as an affiliate under §7.202(a)(2) of this title (relating to Definitions).

(2) Approved PEO--A PEO that has received a certificate of approval from TDI to sponsor a plan.

(3) Cash--Currency and demand deposits with banks and other financial institutions.

(4) Client--A person who enters into a professional employer services agreement with a licensed PEO.

(5) Coemployment relationship--A contractual relationship between a client and a PEO that involves the sharing of employment responsibilities with or allocation of employment responsibilities to covered employees in compliance with the

professional employer services agreement and Labor Code Chapter 91, concerning Professional Employment Organizations.

(6) Commissioner--The commissioner of insurance.

(7) Contracting regulated entity--An entity regulated by TDI that has contracted with an approved PEO to accept responsibility for the performance of any requirement of this subchapter.

(8) Controlling person--A person that directly or indirectly and alone or under an agreement with one or more other persons, exercises such a controlling influence over the management or policies of the PEO that it is necessary or appropriate in the public interest or for the protection of the PEO's covered employees that the person be considered to control the PEO. A person is presumed to be a controlling person if:

(A) the person or a person and members of the person's immediate family directly or indirectly, own, control, or hold with the power to vote 10 percent or more of the voting securities or authority of the PEO; or

(B) the person holds proxies representing 10 percent or more of the voting securities or authority of the PEO, but is not a corporate officer or director of the PEO.

(9) Covered employee--An individual having a coemployment relationship with a PEO and a client.

(10) Dependent--A person eligible to enroll in a plan because of the person's relationship to a covered employee.

(11) Fiduciary--To the extent not inconsistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1002, concerning Definitions, a person is a plan fiduciary to the extent that the person:

(A) exercises any discretionary authority or discretionary control with respect to management of the plan, or exercises any authority or control with respect to management or disposition of plan assets; or

(B) has any discretionary authority or discretionary responsibility in the administration of the plan.

(12) Health status-related factor--Health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability, to the extent not inconsistent with ERISA, 29 U.S.C. §1182, concerning Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status.

(13) Organizational documents--With respect to the plan and trust, the contracts, articles, bylaws, agreements, plan documents, trust agreements, or other documents or instruments describing the rights and obligations of:

(A) the PEO, its clients and coemployees; and

(B) the plan sponsor, its plan, plan trustees, administrators, and participants.

(14) Participant--A covered employee or dependent enrolled in a plan, to the extent not inconsistent with ERISA, 29 U.S.C. §1002 and §1144, concerning Other Laws.

(15) Person--An individual, corporation, partnership, association, joint stock company, trust, or unincorporated organization, or a similar entity or a combination of the listed entities acting in concert. The term does not include a securities broker while performing no more than a function that is usual and customary for a securities broker.

(16) Professional employer organization or PEO --A business entity that offers professional employer services, as defined in Labor Code Chapter 91.

(17) Plan--A self-funded employee health benefit plan established under Labor Code Chapter 91.

(18) Qualified financial institution--An institution that:

(A) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state of the United States; and

(B) is regulated, supervised, and examined by a federal or state authority that has regulatory authority over banks and trust companies.

(19) Reserves--A liability representing plan benefit obligations that have been incurred, whether known or unknown.

(20) TDI--The Texas Department of Insurance.

(21) TDLR--The Texas Department of Licensing and Regulation.

(22) Third party administrator--A person that holds a certificate of authority under Insurance Code Chapter 4151, Third Party Administrators.

(23) Trust--A trust established under Texas Property Code Title 9, Subtitle B, and ERISA, 29 U.S.C. §1103, concerning Establishment of Trust.

(24) Trustee--A person defined as a trustee under Texas Property Code Title 9, Subtitle B, to the extent not inconsistent with ERISA as provided in ERISA, 29 U.S.C. §1144, concerning Other Laws.

(25) Ultimate controlling person--A person that is not controlled by another person.

DIVISION 2. APPLICABILITY OF INSURANCE CODE AND ADMINISTRATIVE CODE PROVISIONS.

§13.520. Applicability of Insurance Code Provisions to an Approved PEO, Plan, or Trust. Under Labor Code §91.0411, this division lists Insurance Code and Administrative Code provisions that are necessary to augment and implement the regulation of a plan that is not fully insured.

§13.521. Applicable Insurance Code and Administrative Code Terms. For purposes of this subchapter and for purposes of regulation by TDI:

(1) PEO as large employer. An approved PEO is a large employer as defined in Insurance Code Chapter 1501, concerning the Health Insurance Portability and Availability Act, unless a provision in this subchapter clearly indicates otherwise.

(2) PEO plan as large employer health benefit plan. An approved PEO's plan is a large employer health benefit plan as defined in Insurance Code Chapter 1501 unless a provision in this subchapter clearly indicates otherwise.

(3) Provisions applicable to both small and large employer plans. An Insurance Code or Administrative Code provision that refers to both small and large employer health benefit plans or their issuers applies to an approved PEO as a large employer health benefit plan issuer and to its plan as a large employer health benefit plan unless a provision in this subchapter clearly indicates otherwise.

(4) Plan document is group policy. An approved PEO's plan document is a group policy unless a provision in this subchapter clearly indicates otherwise.

(5) Certificate of coverage is certificate of insurance. An approved PEO's certificate of coverage is a certificate of insurance. An approved PEO's certificate of coverage must comply with ERISA, 29 U.S.C. §1022 (Summary plan description).

§13.522. Delegation of Functions to a Contracting Regulated Entity.

(a) Delegation to regulated entity. An approved PEO or the plan trustees may delegate to a contracting regulated entity the responsibility to perform any requirement of this subchapter that the contracting regulated entity is authorized by law to perform.

(b) Joint and several liability. If an approved PEO or the plan trustees delegate responsibility to perform any requirement of this subchapter, TDI in its sole discretion may hold the PEO, the plan trustees, and the contracting regulated entity jointly or severally liable for noncompliance with respect to the responsibilities delegated.

(c) Notice of contract with regulated entities. An approved PEO or the plan trustees must give the commissioner a written notice of intent to enter into a contract with a regulated entity at least 30 days before the effective date of that contract. A notice of intent must include the information about the contracting regulated entity required by §13.532(b)(6) of this title (relating to Application Requirements).

(d) Notice of termination of contract with regulated entity. Except as provided in subsection (g) of this section, an approved PEO or the plan trustees must give the commissioner a written notice of intent to terminate a contract with a regulated entity at least 30 days before the effective date of that termination.

(e) Third party administrator. An approved PEO or the plan trustees may not terminate under any circumstances a contract with the plan's third party administrator unless they have contracted with a replacement third party administrator to perform the day-to-day operations of the plan with no lapse in administrative services to the plan.

(f) Notice of replacement contracting regulated entity. Except as provided in subsection (h) of this section, if an approved PEO or the plan trustees intend to enter into a contract with a regulated entity to perform the functions for which a terminating contracting regulated entity was responsible, the approved PEO or the plan trustees must provide the commissioner notice that complies with subsection (c) of this section.

(g) Notice of contract termination for cause. If an approved PEO or the plan trustees terminate a contract with a regulated entity for cause as permitted by the terms of that contract, the approved PEO or the plan trustees must give the commissioner written notice of the contract's termination not later than five days after the effective date of that termination, including a statement explaining whether the functions for which the terminating contracting regulated entity is responsible will be performed by the approved PEO or by another contracting regulated entity.

(h) Notice of intent to contract with replacement regulated entity. After a termination under subsection (g) of this section, if the plan and trust functions will be performed by another contracting regulated entity, the approved PEO or the plan trustees must give the commissioner written notice of intent to enter into a contract with that new regulated entity as soon as is practicable, but not later than 10 days after the effective date of that contract. The notice of intent must include the information about the contracting regulated entity required by §13.532(b)(6) of this title.

§13.523. Applicable Insurance Code Provisions.

(a) The following provisions of the Insurance Code are applicable to an approved PEO to the same extent as the provisions apply to any entity TDI regulates under those provisions:

(1) Insurance Code Chapter 36, Subchapter C, concerning General Subpoena Powers; Witnesses and Production of Records;

(2) Insurance Code Chapter 36, Subchapter D, concerning Judicial Review;

(3) Insurance Code §38.001, concerning Inquiries;

(4) Insurance Code Chapter 38, Subchapter F, concerning Data Collecting and Reporting Relating to Mandated Health Benefits and Mandated Offers of Coverage;

(5) Insurance Code Chapter 38, Subchapter H, concerning Health Care Reimbursement Rate Information;

(6) Insurance Code Chapter 40, concerning Duties of State Office of Administrative Hearings and Commissioner in Certain Proceedings; Rate Setting Proceedings;

(7) Insurance Code Chapters 82, concerning Sanctions;

(8) Insurance Code Chapter 83, concerning Emergency Cease and Desist Orders;

(9) Insurance Code Chapter 84, concerning Administrative Penalties;

(10) Insurance Code Chapter 101, concerning Unauthorized Insurance;

(11) Insurance Code Chapter 461, concerning General Provisions;

(12) Insurance Code §521.005, concerning Notice to Accompany Policy;

(13) Insurance Code Chapter 541, Subchapter A, concerning General Provisions;

(14) Insurance Code Chapter 541, Subchapter B, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined;

(15) Insurance Code Chapter 541, Subchapter B-1, concerning Advertising Requirements;

(16) Insurance Code Chapter 542, concerning Processing and Settlement of Claims;

(17) Insurance Code Chapter 543, concerning Prohibited Practices Related to Policy or Certificate of Membership;

(18) Insurance Code Chapter 544, Subchapter A, concerning General Prohibitions Against Discrimination by an Insurer or Health Maintenance Organization;

(19) Insurance Code Chapter 544, Subchapter B, concerning Other General Prohibitions Against Discrimination by Insurers;

(20) Insurance Code Chapter 544, Subchapter C, concerning English Fluency;

(21) Insurance Code Chapter 544, Subchapter D, concerning Family Violence;

(22) Insurance Code Chapter 544, Subchapter E, concerning Fibrocystic Breast Condition;

(23) Insurance Code Chapter 545, concerning HIV Testing;

(24) Insurance Code Chapter 546, concerning Use of Genetic Testing Information;

(25) Insurance Code §550.002, concerning Increase in Certain Premium Payments;

(26) Insurance Code Chapter 558, concerning Refund of Unearned Premium;

(27) Insurance Code Chapter 560, concerning Prohibited Rates;

(28) Insurance Code Chapter 601, concerning Privacy;

(29) Insurance Code Chapter 602, concerning Privacy of Health Information;

(30) Insurance Code Chapter 701, concerning Insurance Fraud Investigations;

(31) Insurance Code Chapter 705, concerning Misrepresentations by Policyholders;

(32) Insurance Code Chapter 801, concerning Certificate of Authority;

(33) Insurance Code Chapter 803, concerning Location of Books, Records, Accounts, and Offices Outside of this State;

(34) Insurance Code Chapter 804, concerning Service of Process;

(35) Insurance Code Chapter 823, Subchapter B, concerning Registration;

(36) Insurance Code Chapter 823, Subchapter C, concerning Transactions of Registered Insurer;

(37) Insurance Code Chapter 823, Subchapter D, concerning Control of Domestic Insurer; Acquisition or Merger;

(38) Insurance Code §1201.013, concerning Programs Promoting Disease Prevention, Wellness, and Health;

(39) Insurance Code §1201.059, concerning Termination of Coverage Based on Age of Child in Individual, Blanket, or Group Policy;

(40) Insurance Code §1201.062, concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program;

(41) Insurance Code §1201.063, concerning Prohibition of Certain Criteria Relating to a Child's Coverage in Individual or Group Policy;

(42) Insurance Code §1201.064, concerning Coverage for Child of Spouse in Individual or Group Policy;

(43) Insurance Code Chapter 1203, concerning Coordination of Benefits Provisions;

(44) Insurance Code Chapter 1204, Subchapter A, concerning Payments to Certain Public Hospitals;

(45) Insurance Code Chapter 1204, Subchapter B, concerning Assignment of Benefit Payments;

(46) Insurance Code Chapter 1204, Subchapter D, concerning Payments for Certain Publicly Provided Services;

(47) Insurance Code Chapter 1204, Subchapter E, concerning Exclusionary Clauses;

(48) Insurance Code Chapter 1204, Subchapter F, concerning Payment of Benefits to Conservator of Minor;

(49) Insurance Code Chapter 1205, concerning Certificate of Creditable Coverage;

(50) Insurance Code Chapter 1206, concerning Denial of Health Benefit Plan Enrollment Based on Existing Coverage Prohibited;

(51) Insurance Code Chapter 1207, concerning Enrollment of Medical Assistance Recipients and Children Eligible for State Child Health Plan;

(52) Insurance Code Chapter 1208, concerning Identity of Available Employee of Health Benefit Plan Issuer;

(53) Insurance Code Chapter 1210, concerning Notice of Certain Policy Provisions;

(54) Insurance Code Chapter 1213, concerning Electronic Health Care Transactions;

(55) Insurance Code Chapter 1214, concerning Advertising for Certain Health Benefits;

(56) Insurance Code Chapter 1215, concerning Reporting of Claims Information;

(57) Insurance Code Chapter 1216, concerning Out-of-Country Coverage Prohibited;

(58) Insurance Code Chapter 1251, Subchapter C, concerning Group Accident and Health Insurance: Required Provisions;

(59) Insurance Code Chapter 1251, Subchapter D, concerning Group Accident and Health Insurance: Coverage for Dependents;

(60) Insurance Code Chapter 1251, Subchapter E, concerning Group Accident and Health Insurance: General Provisions;

(61) Insurance Code Chapter 1251, Subchapter F, concerning Continuation or Conversion Privilege on Termination of Coverage under Group Policy, except that an approved PEO may not offer a conversion policy under Insurance Code §1251.256, concerning Conversion of Group Policy;

(62) Insurance Code Chapter 1251, Subchapter G, concerning Continuation of Group Coverage for Certain Family Members and Dependents;

(63) Insurance Code Chapter 1252, concerning Discontinuation and Replacement of Group and Group-Type Health Benefit Plan Coverage;

(64) Insurance Code Chapter 1274, concerning Electronic Transmission of Eligibility and Payment Status;

(65) Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, except that a small PEO plan is not subject to §1301.009, concerning Annual Report;

(66) Insurance Code Chapter 1351, concerning Home Health Services;

(67) Insurance Code Chapter 1352, concerning Brain Injury;

(68) Insurance Code Chapter 1355, concerning Benefits for Certain Mental Disorders;

(69) Insurance Code Chapter 1356, concerning Low-Dose Mammography;

(70) Insurance Code Chapter 1357, concerning Mastectomy;

(71) Insurance Code Chapter 1358, concerning Diabetes;

(72) Insurance Code Chapter 1359, concerning Formulas for Individuals with Phenylketonuria or Other Heritable Diseases;

(73) Insurance Code Chapter 1360, concerning Diagnosis and Treatment Affecting Temporomandibular Joint;

(74) Insurance Code Chapter 1361, concerning Detection and Prevention of Osteoporosis;

(75) Insurance Code Chapter 1362, concerning Certain Tests for Detection of Prostate Cancer;

(76) Insurance Code Chapter 1363, concerning Certain Tests for Detection of Colorectal Cancer;

(77) Insurance Code Chapter 1364, concerning Coverage Provisions Relating to HIV, Aids, or HIV-Related Illnesses;

(78) Insurance Code Chapter 1365, concerning Loss or Impairment of Speech or Hearing;

(79) Insurance Code Chapter 1366, concerning Benefits Related to Fertility and Childbirth;

(80) Insurance Code Chapter 1367, concerning Coverage of Children;

(81) Insurance Code Chapter 1368, concerning Availability of Chemical Dependency Coverage;

(82) Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services;

(83) Insurance Code Chapter 1370, concerning Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer;

(84) Insurance Code Chapter 1371, concerning Coverage for Certain Prosthetic Devices, Orthotic Devices, and Related Services;

(85) Insurance Code Chapter 1376, concerning Certain Tests for Early Detection of Cardiovascular Disease;

(86) Insurance Code Chapter 1377, concerning Coverage for Certain Amino Acid-Based Elemental Formulas;

(87) Insurance Code Chapter 1379, concerning Coverage for Routine Patient Care Costs for Enrollees Participating in Certain Medical Trials;

(88) Insurance Code Chapter 1451, concerning Access to Certain Practitioners and Facilities;

(89) Insurance Code Chapter 1453, concerning Disclosure of Reimbursement Guidelines under Managed Care Plan;

(90) Insurance Code Chapter 1454, concerning Equal Health Care for Women;

(91) Insurance Code Chapter 1455, concerning Telemedicine and Telehealth;

(92) Insurance Code Chapter 1456, concerning Disclosure of Provider Status;

(93) Insurance Code Chapter 1460, concerning Standards Required Regarding Certain Physician Rankings by Health Benefit Plans;

(94) Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution;

(95) Insurance Code Chapter 1501, Subchapter A, concerning General Provisions;

(96) Insurance Code Chapter 1501, Subchapter C, concerning Provision of Coverage;

(97) Insurance Code Chapter 1501, Subchapter M, concerning Large Employer Health Benefit Plans;

(98) Insurance Code Chapter 1502, concerning Health Benefit Plans for Children;

(99) Insurance Code Chapter 1503, concerning Coverage of Certain Students;

(100) Insurance Code Chapter 1504, concerning Medical Child Support;

(101) Insurance Code Chapter 1507, Subchapter A, concerning Consumer Choice of Benefits Health Insurance Plans;

(102) Insurance Code Chapter 1653, concerning High Deductible Health Plan;

(103) Insurance Code Chapter 1661, concerning Information Technology;

(104) Insurance Code Chapter 1701, concerning Policy Forms;

(105) Insurance Code Chapter 4201, concerning Utilization Review Agents; and

(106) Insurance Code Chapter 4202, concerning Independent Review Organizations.

(b) Approved PEO as insurer; client as policyholder. For purposes of applying provisions addressing refunds of unearned premiums in Insurance Code Chapter 558, an approved PEO is the equivalent of an insurer, and the approved PEO's client is the equivalent of a policyholder.

(c) Client as plan sponsor. For purposes of applying Insurance Code Chapter 1215, a client is the equivalent of a plan sponsor as defined by Insurance Code §1215.001, concerning Definitions.

(d) Approved PEO as insurer and employer. For purposes of applying Insurance Code Chapter 1251, Subchapters E, F, and G, an approved PEO is the equivalent of both an insurer and an employer.

(e) Approved PEO as insurer; client as group policyholder. For purposes of applying Insurance Code §1301.0061, an approved PEO is the equivalent of an insurer, and the approved PEO's client is the equivalent of a group policyholder.

(f) Approved PEO as employer. For purposes of applying provisions addressing required offers of coverage in Insurance Code Title 8, Subtitle E, concerning Benefits Payable under Health Coverages, an approved PEO is the equivalent of an employer entitled to elect or decline an offer of coverage required by the Insurance Code.

(g) Approved PEO as carrier; client as policyholder. For purposes of applying Insurance Code Chapter 1501, Subchapter A, an approved PEO is the equivalent of a health insurance carrier, and the approved PEO's client is the equivalent of a policyholder.

(h) Approved PEO as large employer issuer; client as employer. For purposes of applying Insurance Code Chapter 1501, Subchapter C, an approved PEO is the equivalent of a large employer health benefit plan issuer, and the approved PEO's client is the equivalent of an employer.

(i) Approved PEO as issuer; client as group contract holder. For purposes of applying provisions in Insurance Code Chapter 1365 addressing required offers of coverage, an approved PEO is the equivalent of a group health benefit plan issuer, and the approved PEO's client is the equivalent of a group contract holder.

§13.524. Applicability of Administrative Code Provisions to an Approved PEO, Plan, or Trust.

(a) Applicable Administrative Code provisions. The following provisions of this title are applicable to an approved PEO, or to its plan and trust, as appropriate, to the same extent as the provisions apply to any entity TDI regulates under those provisions:

(1) Chapter 1 of this title (relating to General Administration);

(2) Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings);

(3) Chapter 3, Subchapter E of this title (relating to Group Life, and/or Accident and Health Insurance Policies and Certificates);

(4) Chapter 3, Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies);

(5) Chapter 3, Subchapter M of this title (relating to Discretionary Clauses);

(6) Chapter 3, Subchapter U of this title (relating to Newborn Children Coverage);

(7) Section 3.3601 of this title (relating to Orthodontic Coverages);

(8) Chapter 3, Subchapter V of this title (relating to Coordination of Benefits);

(9) Chapter 3, Subchapter X of this title (relating to Preferred and Exclusive Provider Plans);

(10) Chapter 3, Subchapter BB of this title (relating to Pharmaceutical Services);

(11) Chapter 3, Subchapter HH of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers);

(12) Chapter 7, Subchapter B of this title (relating to Insurance Holding Company Systems);

(13) Chapter 12 of this title (relating to Independent Review Organizations);

(14) Chapter 19, Subchapter R of this title (relating to Utilization Review for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy);

(15) Chapter 21, Subchapter A of this title (relating to Unfair Competition and Unfair Practices of Insurers, and Misrepresentation of Policies);

(16) Chapter 21, Subchapter B of this title (relating to Advertising, Certain Trade Practices, and Solicitation);

(17) Chapter 21, Subchapter C of this title (relating to Unfair Claims Settlement Practices);

(18) Chapter 21, Subchapter E of this title (relating to Unfair Discrimination Based on Sex or Marital Status);

(19) Chapter 21, Subchapter H of this title (relating to Unfair Discrimination);

(20) Chapter 21, Subchapter K of this title (relating to Certification of Creditable Coverage);

(21) Chapter 21, Subchapter L of this title (relating to Medical Child Support, Unfair Practices);

(22) Chapter 21, Subchapter M of this title (relating to Mandatory Benefit Notice Requirements);

(23) Chapter 21, Subchapter P of this title (relating to Mental Health Parity);

(24) Chapter 21, Subchapter Q of this title (relating to Complaint Records to be Maintained);

(25) Chapter 21, Subchapter R of this title (relating to Diabetes);

(26) Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims);

(27) Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits);

(28) Chapter 21, Subchapter W of this title (relating to Coverage for Acquired Brain Injury);

(29) Chapter 21, Subchapter Y of this title (relating to Unfair Discrimination in Compensation for Women's Healthcare);

(30) Chapter 21, Subchapter Z of this title (relating to Data Collecting and Reporting Relating to Mandated Health Benefits and Mandated Offers of Coverage);

(31) Chapter 21, Subchapter AA of this title (relating to Consumer Choice Health Benefit Plans);

(32) Chapter 21, Subchapter BB of this title (relating to Dental Care Benefits);

(33) Chapter 21, Subchapter CC of this title (relating to Electronic Health Care Transactions);

(34) Chapter 21, Subchapter DD of this title (relating to Eligibility Statements);

(35) Chapter 21, Subchapter EE of this title (relating to High Deductible Health Plans);

(36) Chapter 21, Subchapter FF of this title (relating to Obligation to Continue Premium Payment and Coverage After Notice of Lost Group Eligibility);

(37) Chapter 21, Subchapter II of this title (relating to Recognition of National Certifying Organizations for Noninvasive Screening of Cardiovascular Disease);

(38) Chapter 21, Subchapter JJ of this title (relating to Autism Spectrum Disorder Coverage);

(39) Chapter 21, Subchapter KK of this title (relating to Health Care Reimbursement Rate Information);

(40) Chapter 21, Subchapter MM of this title (relating to Wellness Programs);

(41) Chapter 21, Subchapter NN of this title (relating to Noninsurance Benefits and Features);

(42) Chapter 21, Subchapter PP of this title (relating to Out-Of-Network Claim Dispute Resolution);

(43) Chapter 21, Subchapter RR of this title (relating to Standard Proof of Health Insurance for Medical Benefits for Injuries Incurred as a Result of a Motorcycle Accident);

(44) Chapter 21, Subchapter SS of this title (relating to Continuation and Conversion Provisions);

(45) Chapter 22 of this title (relating to Privacy); and

(46) Chapter 26 of this title (relating to Small Employer Health Insurance Regulations).

(b) Plan as large employer plan. For purposes of applying Chapter 21, Subchapter P or W of this title, a plan sponsored by an approved PEO is the equivalent of a large employer health benefit plan, regardless of the size of any of the approved PEO’s clients.

(c) Approved PEO as insurer; client as group policyholder. For purposes of applying Chapter 21, Subchapter FF of this title, an approved PEO is the equivalent of a health insurer, and the approved PEO's client is the equivalent of a group policyholder.

(d) Approved PEO as large employer carrier and large employer. Except as provided in subsection (e) of this section, for purposes of applying Chapter 26 of this title, an approved PEO is the equivalent of both a large employer carrier and a large employer.

(e) Approved PEO as large employer carrier; client as large employer. For purposes of applying §26.303 and §§26.307-26.309 of this title, (relating to Coverage Requirements, Fair Marketing, Renewability of Coverage and Cancellation, and Refusal to Renew and Application to Reenter Large Employer Market), an approved PEO is the equivalent of a large employer carrier, and the approved PEO's client is the equivalent of a large employer.

DIVISION 3. CERTIFICATE OF APPROVAL.

§13.530. Certificate of Approval Required. A PEO may not sponsor a plan in Texas unless the PEO has received a certificate of approval issued under this subchapter and is operating its plan and trust as required by this subchapter. If a PEO receives and maintains a certificate of approval under this subchapter, it will not be considered an unauthorized insurer for purposes of Insurance Code Chapter 101, concerning Unauthorized Insurance.

§13.531. Forms and Fees.

(a) Form of application. A PEO must apply for a certificate of approval by providing the information required by this division.

(b) Application fee. Each application for a certificate of approval must be accompanied by a nonrefundable application fee of $5,050.

§13.532. Application Requirements.

(a) Organizational information. An applicant must provide the following information and documentation about its structure and operations:

(1) its name, federal employer identification number, location, and a means for contacting its representative for purposes of the application;

(2) the physical location of the plan and trust's books and records, and its means of maintaining the books and records;

(3) the name of the applicant's ultimate controlling person or persons;

(4) the documents or instruments describing the rights and obligations between the applicant and its clients, including but not limited to all forms of its professional employer services agreement;

(5) a description of the applicant's basic organizational structure, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant that affect the plan; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(6) disclosure of any suit or judgment filed in a matter involving dishonesty, breach of trust, or a financial dispute within the last 10 years against the applicant, an ultimate controlling person, or any other persons from whom biographical information is provided under paragraph (10) of this subsection;

(7) a copy of its most recent TDLR license;

(8) a financial statement of the applicant covering a period ending not more than 180 days prior to the date of the application, that is prepared using generally accepted accounting principles of the United States and includes:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(9) evidence that the applicant has engaged or will engage a sufficient number of competent persons to:

(A) administer the plan; and

(B) provide claims adjusting and underwriting services to the plan;

(10) evidence of the PEO's fidelity coverage that complies with §13.542 of this title (relating to PEO's Fidelity Coverage); and

(11) for all plans sponsored by the applicant, whether operating in Texas or in any other state, a list of and access to all reports for the last three years created and filed with the United States Department of Labor in compliance with Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§1021(g), concerning

Reporting by Certain Arrangements; 1023, concerning Annual Reports; and 1024, concerning Filing and Furnishing of Information.

(b) Plan and trust information and documentation. An applicant must provide the following information and documentation about its plan and trust:

(1) proof of deposit or letter of credit satisfying the financial solvency requirements of Division 6 of this subchapter;

(2) financial projections of the trust covering three full years of operation that are prepared using generally accepted accounting principles of the United States and include:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(3) a written investment plan in compliance with Insurance Code §425.105, concerning Written Investment Plan;

(4) an actuarial opinion supporting the structure of the plan meeting the requirements of §13.533 of this title (relating to Actuarial Opinion Requirements);

(5) a description of the applicant’s plan to service plan billings, claims, and underwriting;

(6) the name and Texas license number of each contracted regulated entity the trust proposes to engage to service the plan, and a copy of each agreement or proposed agreement with a contracted regulated entity;

(7) each organizational document of the plan and trust, including:

(A) the plan document;

(B) the plan's summary plan description, created in compliance with ERISA, 29 U.S.C. §1022, concerning Summary Plan Description; and

(C) the trust agreement;

(8) the name of the named fiduciary or fiduciaries who jointly or severally will have authority to control and manage the operation and administration of the plan, as required by ERISA, 29 U.S.C. §1102(a), concerning Establishment of Plan;

(9) the name of the administrator designated by the terms of the instrument under which the plan is operated, as defined by ERISA, 29 U.S.C. §1002(16)(A);

(10) biographical information about each person who governs or manages the affairs of the applicant or the plan and trust, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other controlling person, and including disclosure of whether the person is prohibited from serving in any capacity under ERISA, 29 U.S.C. §1111, (concerning Persons Prohibited from Holding Certain Positions). An applicant must provide the required biographical information on TDI form number FIN311, Biographical Affidavit, available on TDI's website, and must list the full name and address of the PEO where the form requires "Full Name and Address of Company/HMO;"

(11) a complete set of fingerprints for the individuals described in paragraph (10) of this subsection using the procedures set out in Chapter 1, Subchapter D of this title (relating to Effect of Criminal Conduct), unless the individual meets the exemption in that subchapter or provides evidence that the individual has successfully completed the fingerprinting process conducted during the applicant's licensing or license renewal process through TDLR;

(12) evidence of the trustees' fidelity coverage and errors and omissions policy that comply with §13.556 of this title (relating to Protection of Plan and Trust Assets); and

(13) an attestation that the plan and trust have been established in compliance with §13.550 and §13.551 of this title (relating to Plan Formation and Trust Formation).

(c) Officers' attestation. An applicant must provide a written attestation signed by two principal officers of the applicant who have submitted biographical affidavits that the information and documentation provided in compliance with subsections (a) and (b) of this section is true and correct and complies with applicable federal and state laws and regulations, including this subchapter, to the best of their knowledge and belief.

(d) Service of Process. An applicant must appoint the commissioner as its resident agent for purposes of service of process as provided in Insurance Code Chapter 804, concerning Service of Process, in the same manner as a domestic company.

§13.533. Actuarial Opinion Requirements. The independent actuarial opinion submitted with the application must:

(1) describe the extent to which projected plan contributions:

(A) are not excessive;

(B) are not unfairly discriminatory;

(C) are adequate to pay all of the plan's:

(i) benefit payments;

(ii) administrative expenses;

(iii) other operational expenses; and

(D) are sufficient to maintain the required reserves and surplus to be held in trust for the plan's participants; and

(2) include a statement allocating the projected plan contributions to be charged to clients for plan coverage for:

(A) the plan's administrative expenses;

(B) plan reserves; and

(C) all other expenses associated with operation of the applicant's plan.

§13.534. Application Review, Approval, and Denial.

(a) Commissioner's review. The commissioner will review the applicant's submission and other pertinent information, including information from TDLR, to ensure the applicant's compliance with applicable statutes and regulations, and:

(1) conduct any investigation that the commissioner considers necessary to determine whether the applicant has obtained an appropriate license or has delegated to contracting regulated entities, adequate facilities, resources, and competent personnel, as determined by the commissioner, to administer the plan and trust;

(2) examine under oath any person interested in or connected with the applicant or its plan or trust; or

(3) perform an examination to confirm compliance with applicable Texas statutes and rules, including funding of the trust.

(b) Application approval. After completing the review, the commissioner will approve an application for a certificate of approval if the commissioner has determined there is no cause for denial as listed in subsection (d) of this section and if the application for certificate of approval meets the requirements of §13.532 of this title (relating to Application Requirements).

(c) Term of certificate of approval. A certificate of approval remains in effect until terminated at the request of the approved PEO or canceled by the commissioner.

(d) Application denial. The commissioner will deny the application in writing in the following circumstances:

(1) if the applicant does not meet the requirements of §13.532 of this title; or

(2) if the applicant, any person representing the applicant, a member of the board of trustees, or any person that has a fiduciary relationship with the trust:

(A) makes a material misstatement or omission in the application for a certificate of approval;

(B) obtains or attempts to obtain at any time a certificate of approval or license for an insurance entity through intentional misrepresentation or fraud;

(C) misappropriates or converts to the person's own use or improperly withholds money under any fiduciary relationship;

(D) is prohibited from serving in any capacity under Employee Retirement Income Security Act of 1974, 29 U.S.C. §1111;

(E) without reasonable cause or excuse, fails to appear in response to a subpoena, examination, or any other order lawfully issued by the commissioner;

(F) has previously been subject to a determination by the commissioner resulting in:

(i) suspension or revocation of a certificate of approval or license; or

(ii) denial of a certificate of approval or license on grounds that would be sufficient for suspension or revocation; or

(G) is not eligible for licensure under Chapter 1, Subchapter D of this title (relating to Effect of Criminal Conduct).

(e) Notice of denial. If the commissioner denies the application, the commissioner will issue a written notice of denial to the applicant. The notice will state the basis for the denial.

(f) Hearing on denial. If, within 30 days of receiving a notice under subsection (e) of this section, the applicant submits a written request for a hearing, the commissioner will file a request to set a hearing at the State Office of Administrative Hearings, at which the applicant will be given an opportunity to show compliance with the related Insurance Code provisions and regulations. Hearings described in this subchapter will be conducted as required by Government Code Chapter 2001, concerning Administrative Procedure; Insurance Code Chapter 40, concerning Duties of State Office of Administrative Hearings and Commissioner in Certain Proceedings; Rate Setting Proceedings; TDI's and State Office of Administrative Hearing's rules of procedure; and any other applicable law and regulations.

DIVISION 4. CONDUCT OF APPROVED PEO.

§13.540. Governance and Operation of Approved PEO.

(a) Management of approved PEO. An approved PEO must be managed by competent and trustworthy individuals. An individual responsible for risk management, financial reporting, underwriting, claims, or investment functions of the plan and trust must be eligible for licensure based on the guidelines established in Chapter 1, Subchapter D of this title (relating to Effect of Criminal Conduct) and hold any necessary licenses as required by the Insurance Code.

(b) Initial plan administration. An approved PEO must contract with a third party administrator to perform the day-to-day operations of the plan until the plan's trustees

have contracted with a third party administrator to perform the day-to-day operations of the plan as provided in §13.555 of this title (relating to Trustees' Responsibility and Authority).

(c) Location of books and records. An approved PEO may request to maintain the plan and trust's books and records outside this state in compliance with Insurance Code Chapter 803.

§13.541. Stop-Loss Insurance. An approved PEO must contract for stop-loss insurance in the name of and on behalf of the plan and trust that complies with §13.567 of this title (relating to Stop-Loss Insurance), until the trustees have contracted for stop-loss insurance as provided in §13.555 of this subchapter.

§13.542. PEO's Fidelity Coverage. An approved PEO must maintain a fidelity bond or a zero-deductible crime policy that complies with the requirements of §13.568 of this title (relating to Standards for Fidelity Coverage). The fidelity bond or zero-deductible crime policy must cover each person responsible for handling or administering plan assets, including: the approved PEO; its directors, officers, and employees; or any other individual responsible for servicing the plan.

§13.543. Approved PEO's Conduct with Respect to the Plan and Trust.

(a) Assessed contributions. Contributions assessed by the approved PEO from clients for coverage for their participants must be sufficient to fund at least 100 percent

of the plan and trust's aggregate stop-loss retention, as provided in Division 6 of this subchapter, plus all other expenses of the plan and trust.

(b) Payments to the trust. An approved PEO must transfer to the trust all payments from clients or participants that represent or that are intended as contributions to the trust as soon as those amounts can reasonably be segregated from the approved PEO's general assets, but no later than 15 days after receipt. These payments are plan assets.

(c) Reimbursement from plan assets. An approved PEO may be reimbursed by the trust for its reasonable expenses incurred to:

(1) establish and initially administer the plan and trust; and

(2) comply with this subchapter, including contracting for stop-loss insurance and fidelity coverage.

(d) Transactions with respect to plan and trust. An approved PEO in its transactions with respect to the plan and trust must not:

(1) deal with plan assets in its own interest or for its own account;

(2) act on behalf of or represent a person whose interests are adverse to the interests of the plan or the interests of its participants; or

(3) receive any consideration from any person dealing with the plan and trust in connection with a transaction involving plan assets.

(e) Conduct with respect to plan and trust. An approved PEO's conduct with respect to the plan and trust must remain in compliance with applicable federal and state laws.

§13.544. Marketing Materials; Offers of Enrollment.

(a) Marketing material. An approved PEO's marketing material discussing the plan and trust must be fair and accurate, and must not represent the plan or a prospective client's projected contributions to be assessed for coverage under the plan in a way that is materially inaccurate or misleading.

(b) Offer of enrollment. An approved PEO must offer enrollment in the plan to the covered employees of any client that agrees to meet the terms and conditions of the PEO's professional employer services agreement and elects to enroll its covered employees in the plan.

(c) Guaranteed renewability. A PEO may not deny a client whose employees are covered under the plan continued access to coverage under the terms of the plan, other than:

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the client;

(3) for noncompliance with material plan provisions;

(4) because the plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the client who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without

regard to the claims experience of clients or any health status-related factor in relation to such individuals or their dependents; or

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

§13.545. Representations to Clients and Participants.

(a) Pricing and billing. An approved PEO must be fair and accurate in its pricing and billings with respect to the plan, and may not make any materially inaccurate, knowingly or recklessly misleading, or fraudulent misrepresentations of the projected contributions to be assessed for plan coverage for a client's covered employees or participants.

(b) Notice of increased contribution. An approved PEO may not increase a client's contribution amount without giving the client at least 60 days' advance notice of the amount of the increase.

(c) PEO solely responsible if trust assets insufficient. An approved PEO's professional employer services agreement must provide that the PEO, and not the client, will be responsible for funding any additional asset amount needed to equal the liabilities owed by the plan. An approved PEO may not contractually obligate its clients to make up any shortfall in trust assets.

(d) Agreement in conflict with this subchapter. An approved PEO's professional employer services agreement is unenforceable to the extent that it conflicts with the requirements of this subchapter.

(e) Summary plan description. An approved PEO must provide each participant an evidence of coverage and a summary plan description specific to the participant's plan. The summary plan description must contain the following statement:
"The benefits and coverages described in this document are provided through a self-funded health benefit plan and trust fund established and funded by your employers, {insert the name of the covered employer and the approved PEO}. The plan and trust are established in compliance with Chapter 91 of the Texas Labor Code and the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001-1191c. This is not an insurance contract, and you are not protected by an insurance guarantee fund or other protective governmental program."

DIVISION 5. FORMATION, GOVERNANCE, AND OPERATION OF PLAN AND TRUST.

§13.550. Plan Formation.

(a) Establishing the plan. A PEO applying for a certificate of approval must establish its plan in compliance with the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1102, concerning Establishment of Plan.

(b) Required plan provisions. The plan:

(1) must be a nonprofit entity;

(2) must hold all plan assets in a trust as established under §13.551 of this title (relating to Trust Formation);

(3) must accept as participants the covered employees or dependents of covered employees of every client that elects to allow its covered employees to participate in the plan; and

(4) may not condition participation on a client's claims history or its covered employees' health status-related factors.

(c) Plan amendment. An approved PEO may amend the terms of its plan without the approval of the plan's trustees; the trustees may not amend the terms of the plan.

(d) Approval of plan amendment. A plan amendment must be submitted to TDI as provided in §13.552 of this title (relating to Required Filings) for review and approval by the commissioner before becoming effective.

§13.551. Trust Formation.

(a) Establishing the trust. A PEO applying for a certificate of approval must establish a trust in compliance with both Texas Property Code Title 9, Subtitle B, concerning Texas Trust Code: Creation, Operation, and Termination of Trusts; and the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1103, concerning Establishment of Trust, in which all funds used to administer and pay claims and expenses arising from the plan must be held.

(b) Powers of the trust. Except as otherwise provided in the trust document, the powers of the trust must be exercised by a board of trustees elected to carry out the purposes established by the organizational documents of the trust.

(c) Trust agreement. The trust agreement or other document establishing the trust must:

(1) include the names of the persons creating the trust and the names and signatures of each of the initial trustees;

(2) state that all plan assets will be kept continuously in a qualified financial institution;

(3) outline the powers and duties of the board of trustees;

(4) provide that board decisions must be made by at least a simple majority;

(5) give the trustees exclusive authority and discretion to manage and control plan assets;

(6) provide that the trustees will not be subject to the direction of a named fiduciary; and

(7) provide that plan assets will never inure to the benefit of any employer and will be held for the exclusive purposes of providing benefits to plan participants and defraying reasonable expenses of administering the plan.

(d) Trust amendment. The trust agreement or other document establishing the trust must provide that:

(1) only the plan's trustees may amend the terms of the trust, and may do so without the approval of the approved PEO;

(2) an amendment to the trust document must be approved by at least a simple majority of the trustees; and

(3) a trust amendment must be submitted to TDI as provided in §13.552 of this title (relating to Required Filings) for review and approval by the commissioner before becoming effective.

§13.552. Required Filings.

(a) Plan amendment. An approved PEO must file each plan amendment with the Life and Health Lines Office of TDI for prior approval by the commissioner. An amendment will not be effective until approved by the commissioner. The approved PEO's filing must include a statement by the approved PEO certifying that, to the best of the signer's knowledge and belief, in adopting the plan amendment, the approved PEO and the plan will remain in compliance with this subchapter and all applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§1001-1191c.

(b) Trust amendment. An approved PEO must file each amendment to the trust agreement or any other organizational document of the trust with the Company Licensing and Registration Office of TDI for prior approval by the commissioner. An amendment will not be effective until approved by the commissioner. The approved PEO's filing must include a statement by the plan's trustees certifying that, to the best of

the trustees' knowledge and belief, in adopting the trust amendment the plan and the trust will remain in compliance with this subchapter and all applicable provisions of ERISA, 29 U.S.C. §§1001-1191c.

(c) Transactions between parties. Agreements and transactions between or among the approved PEO, an affiliate, and the trust are subject to Insurance Code Chapter 823, Subchapters B and C, including the filing requirements of these subchapters. For the purposes of this subchapter, an affiliate and a trust are each considered members of an insurance holding company system as described in Insurance Code §823.006, concerning Description of Insurance Holding Company System.

§13.553. Plan and Trust Governance and Operation.

(a) Fiduciary duty. A fiduciary must discharge his or her duties with respect to a plan solely in the interest of the participants, and:

(1) for the exclusive purposes of:

(A) providing benefits to participants; and

(B) defraying reasonable expenses of administering the plan;

(2) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(3) in compliance with the documents and instruments governing the plan so long as those documents and instruments are consistent with this subchapter and with all other applicable state and federal laws.

(b) Transactions between fiduciary and plan. A fiduciary in its transactions with respect to the plan and trust must not:

(1) deal with plan assets in its own interest or for its own account;

(2) act on behalf of or represent a person whose interests are adverse to the interests of the plan or the interests of its participants; or

(3) receive any consideration from any party dealing with the plan and trust in connection with a transaction involving plan assets.

(c) Plan and trust expenses. All expenses of the plan and trust must be paid from plan assets. Expenses include but are not limited to:

(1) administration of the plan and trust; and

(2) the plan and trust's reasonable expenses incurred to comply with this subchapter, including contracting for stop-loss insurance, fidelity coverage, and errors and omissions insurance.

(d) Voluntary termination of trust. The trust agreement must provide for the distribution of plan assets on dissolution of the trust. The distribution of assets must be consistent with of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1103 and §1104, concerning Fiduciary Duties, and related guidance by the U.S. Department of Labor. The trust's assets may not be distributed until the commissioner

has canceled the approved PEO's certificate of approval under Division 8 of this title (relating to Market Exit).

§13.554. Board of Trustees.

(a) Appointment. An approved PEO may appoint members of the board of trustees.

(b) Number of members. The board of trustees must have no fewer than three members.

(c) Ineligible individuals. An owner, officer, or employee of a third party administrator or contracted regulated entity that provides services to the approved PEO, or any other person that has received compensation from the plan or trust may not serve as a board member.

§13.555. Trustees' Responsibility and Authority.

(a) Responsible for operations and assets. Members of the board of trustees are responsible for all operations of the trust and must take all necessary precautions to safeguard plan assets.

(b) Contract for plan administration. Within 12 months of the establishment of the initial board of trustees, the board of trustees must contract with a third party administrator to perform the day-to-day operations of the plan.

(c) Insure payment of claims. Within 12 months of the establishment of the initial board of trustees, the board of trustees, or an approved PEO acting as their agent, will

contract for, and pay for with plan assets, a stop-loss insurance agreement in the name of and for the benefit of the plan and trust that complies with the requirements of §13.567 of this title (relating to Stop-Loss Insurance) to insure payment of all claims arising under the terms of the plan.

(d) Appointment of agents. The trustees may appoint agents for the trust as necessary to meet the obligations of the plan and trust. Each agent may only exercise the authority and perform the duties required in the management of the trust and the affairs of the plan that is delegated to them by the board of trustees.

(e) Service without compensation. A member of the board of trustees serves without compensation except for actual and necessary expenses.

§13.556. Protection of Plan and Trust Assets.

(a) Trustees' fidelity coverage. The board of trustees must maintain a fidelity bond or a zero-deductible crime policy that complies with the requirements of §13.568 of this title (relating to Standards for Fidelity Coverage). The fidelity bond or zero-deductible crime policy must cover each person responsible for handling or administering plan assets, including the board of trustees, the approved PEO, its directors, officers, agents and employees, or any other individual responsible for servicing the plan.

(b) Errors and omissions insurance. The board of trustees must purchase an errors and omissions policy in the amount of $500,000 to cover the performance of their

duties to the plan and trust. The policy must be purchased from a company that satisfies the requirements of §13.568(a)(2) of this title.

(c) Ensuring existence of PEO's fidelity coverage. The trustees must annually require that the approved PEO provide them with documentation that it has maintained and is maintaining in effect fidelity coverage that complies with §13.542 of this title (relating to PEO's Fidelity Coverage).

§13.557. Disputes Arising Under the Plan or Trust. Benefit claims or other disputes arising under an approved PEO's plan are subject to the Insurance Code, including utilization review and independent review under Insurance Code Title 14, concerning Utilization Review and Independent Review, and to resolution under state law in the same manner as are benefit claims or disputes arising under a large employer health benefit plan issued under Insurance Code Chapter 1501, concerning the Health Insurance Portability and Availability Act, to the extent not inconsistent with the Employee Retirement Income Security Act of 1974 (ERISA) as provided in ERISA, 29 U.S.C. §1144.

DIVISION 6. FINANCIAL SOLVENCY REQUIREMENTS FOR PEO PLANS.

§13.560. Annual and Quarterly Reserves. The financial statements filed by an approved PEO under §13.570 of this title (relating to Financial Filing Requirements) must report the trust's reserves as described below:

(1) the trust's year-end reserves must be calculated as the difference between the trust's total claim distributions and the aggregate limit attachment point of its stop-loss insurance agreement for each plan year;

(2) the total claim distributions number used in paragraph (1) of this section must be the amount of paid claims reduced by any amount either received or recoverable by the trust associated with the specific attachment point included in its stop-loss insurance agreement;

(3) the trust's quarterly reserves must equal the total amount of its known unpaid claims as the end of the respective calendar quarter; and

(4) the known unpaid claims number used in paragraph (3) of this section is the amount of reserve established for a claim when it is received, reduced by any amount recoverable by the trust associated with the specific attachment point included in its stop-loss insurance agreement.

§13.561. Authorized Investments. The trust must invest its assets in compliance with Insurance Code Chapter 425, Subchapter C, concerning Authorized Investments and Transactions for Capital Stock, Life, Health, and Accident Insurers.

§13.562. Deposit or Letter of Credit Required.

(a) Initial deposit or letter of credit. Before receiving a certificate of approval, a PEO applying for a certificate of approval must establish a deposit of at least 25 percent

of the attachment point of the aggregate limit included in the plan's stop-loss insurance agreement or establish a letter of credit for that amount.

(b) Proof of deposit. The commissioner adopts by reference both Statutory Deposit Transaction Form, Form No. FIN407 (rev.1115), and Declaration of Trust Form, Form No. FIN453 (rev.1115). Both forms are available on TDI's website. An applicant must give proof of its deposit on both TDI's Statutory Deposit Transaction Form and TDI's Declaration of Trust Form.

(c) Continuing deposit or letter of credit. An approved PEO sponsoring a plan must maintain a deposit or letter of credit of at least 25 percent of the attachment point of the aggregate limit included in the plan's stop-loss insurance agreement.

(d) Deposit to be held for TDI's control. Any deposit must be held for TDI's control and may not be withdrawn or substituted without the commissioner's approval.

§13.563. Form of Deposit. A deposit must consist of funds in the form of:

(1) money of the United States including certificates of deposit issued by a qualified financial institution, but the amount of total deposits by the approved PEO in the qualified financial institution may not exceed the greater of:

(A) the limits of federal insurance coverage for the deposits; or

(B) ten percent of the issuing qualified financial institution's net worth, provided that its net worth is in excess of $25 million;

(2) bonds of Texas;

(3) bonds or other evidences of indebtedness of the United States that are guaranteed as to principal and interest by the United States government; or

(4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of this state.

§13.564. Annual Recalculation; Changes to Deposit.

(a) Annual recalculation. An approved PEO must recalculate its deposit required every year, not later than 60 days after negotiating the plan's stop-loss insurance agreement for the current plan year, using the formula stated in §13.562(b) of this title (relating to Deposit or Letter of Credit Required).

(b) Changes to deposit.

(1) An approved PEO may request to change its deposit by submitting both the Statutory Deposit Transaction Form, Form No. FIN407 (rev.1115), and the Declaration of Trust Form, Form No. FIN453 (rev.1115), and must submit a safekeeping receipt showing that the securities are pledged to TDI.

(2) If the commissioner approves the release of any portion of a deposit, TDI's bond and securities officer will execute a release of any pledge, and the funds will be returned to the approved PEO.

(3) An approved PEO that requests a release of any part of its deposit because the deposit amount exceeds the amount calculated under §13.562(b) of this title must provide supporting documentation that justifies the release, including:

(A) the reasons for the release; and

(B) evidence satisfactory to the commissioner that its deposit exceeds the amount required in §13.562(b) of this title.

(4) All interest income due on its deposit funds may be paid directly to the approved PEO by the bank.

§13.565. Letter of Credit.

(a) Requirements. Instead of a deposit, an approved PEO may maintain a letter of credit. A letter of credit must comply with the following requirements:

(1) the letter of credit cannot be supported or collateralized by a guaranty;

(2) the letter of credit and all amendments to the letter of credit must be filed with TDI; and

(A) be clean, irrevocable, unconditional, and issued by a qualified financial institution;

(B) contain an issue date;

(C) stipulate that the beneficiary is the commissioner, that the commissioner need only draw a draft under the letter of credit and present it to obtain funds, and that no other document need be presented;

(D) show only one amount on the letter of credit;

(E) state that the letter of credit is not subject to any conditions or qualifications outside of the letter of credit and must not contain reference to any other agreements, documents, or entities;

(F) contain a statement to the effect that the obligation of the qualified financial institution under the letter of credit is in no way contingent on reimbursement; and

(G) state that the letter of credit is subject to and governed by either the laws of this state or the laws of the state in which the issuing qualified financial institution is domiciled, and that all drafts drawn on the letter of credit will be presentable at any office in the United States of the issuing qualified financial institution.

(b) Conditions not permitted. The letter of credit must not:

(1) have a schedule of periodic payments;

(2) name any beneficiary other than the commissioner; and

(3) in aggregate of all letters of credit issued to the approved PEO by one qualified financial institution, exceed 10 percent of the financial institution's total equity capital, as shown in the qualified financial institution's most recent report of condition as filed with the appropriate federal or state financial institution regulatory agency.

(c) Term of letter of credit. The term of the letter of credit must be for at least one year and must contain an evergreen clause that prevents the expiration of the letter of credit without written notice from the issuer. The evergreen clause must provide for a period of no less than 30 days' written notice to the commissioner prior to the expiration date or nonrenewal.

§13.566. Annual Recalculation; Changes to Letter of Credit.

(a) Annual recalculation. An approved PEO must recalculate the required amount of its letter of credit every year, not later than 60 days after negotiating the plan's stop-loss insurance agreement for the current plan year, using the formula stated in §13.562(b) of this title (relating to Deposit or Letter of Credit Required).

(b) Changes to letter of credit.

(1) If a letter of credit is not renewed or replaced, the commissioner must not be prevented from withdrawing the balance of the letter of credit and placing that sum in trust to secure continuing obligations until the commissioner has received a renewal letter of credit or an acceptable substitute.

(2) If a letter of credit is not renewed or replaced, or if it is suspended, the approved PEO and the issuing qualified financial institution must give the commissioner immediate notice of the nonrenewal, replacement, or suspension.

§13.567. Stop-Loss Insurance.

(a) Minimum specific and aggregate coverage. The plan and trust must maintain specific and aggregate stop-loss insurance that is not less than the recommended minimum level included in the annual actuarial opinion required by §13.570(c)(2) of this title (relating to Financial Filing Requirements).

(b) Terms of contract for stop-loss insurance. The trustees, or an approved PEO acting on behalf of the trustees, must contract for stop-loss insurance in the name of and for the benefit of the plan and trust, as evidenced by a written commitment, binder,

or policy for stop-loss insurance issued by an unaffiliated insurer authorized to do business in this state, which must include the following:

(1) no less than 30 days' notice to the commissioner of any amendment, cancellation, or nonrenewal of coverage;

(2) provide both specific and aggregate coverage with an aggregate retention of no more than 125 percent of the amount of expected claims for the subsequent plan year and the specific retention amount as determined by the actuarial opinion required by §13.570(c)(2) of this title;

(3) both the specific and aggregate coverage must require all claims to be submitted within 90 days after the claim is reported; and

(4) a requirement that the stop-loss carrier provide the trustees and the PEO any renewal quote at least 90 days before the expiration of the current policy.

(c) Request for waiver. The trustees, or an approved PEO acting on behalf of the trustees, may request in writing, including supporting documentation, that the commissioner waive or reduce the requirement for aggregate stop-loss insurance. The commissioner, after reviewing the request and documentation, and any additional information requested by and provided to TDI, will approve the request if the commissioner determines that the interests of the clients and participants are adequately protected.

13.568. Standards for Fidelity Coverage.

(a) Fidelity bond or crime policy. A fidelity bond or crime policy required by any section of this rule must be for an amount of at least $500,000. The commissioner will consider information of all interested parties and determine any amount required in excess of $500,000. The bond or policy must:

(1) obligate the surety to pay any loss of money or other property the plan or trust sustains because of an act of fraud or dishonesty by a person covered by the bond or policy, acting alone or in concert with others; and

(2) be issued by an unaffiliated insurer that holds a certificate of authority in this state, and that is a corporate surety company that is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury under 31 U.S. Code Chapter 93. If the commissioner determines, after reviewing information from the approved PEO or the plan and trust's board of trustees, that a fidelity bond or a zero-deductible crime policy is not available from a qualified unaffiliated insurer that holds a certificate of authority in this state, the approved PEO or board of trustees may obtain a fidelity bond or a zero-deductible crime policy from a surplus lines agent in this state in compliance with Insurance Code Chapter 981, concerning Surplus Lines Insurance, or from a corporate surety company which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury under 31 U.S. Code Chapter 93.

(b) Cash deposit. Instead of a fidelity bond or zero-deductible crime policy, the approved PEO or board of trustees may place on deposit with a qualified financial institution securities meeting the requirements of §13.564 of this title (relating to Annual Recalculation; Changes to Deposit) for the benefit of the commissioner. The deposit

must be maintained in the amount and is subject to the same conditions required for fidelity coverage under this section. The deposit must be held for TDI's control and may not be withdrawn or substituted without the commissioner's approval.

DIVISION 7. QUARTERLY AND ANNUAL FILINGS; EXAMINATIONS; HAZARDOUS CONDITIONS.

§13.570. Financial Filing Requirements.

(a) Approved quarterly filing form. TDI adopts by reference PEO Quarterly Report, Form No. FIN409 (rev. 1115). The form is available on TDI's website. An approved PEO must submit its quarterly filings as described in subsection (c) of this section on PEO Quarterly Report, Form No. FIN409, using generally accepted accounting principles of the United States as modified by this subchapter.

(b) Approved annual filing form. TDI adopts by reference PEO Annual Report, Form No. FIN410 (rev. 1115). The form is available on TDI's website. An approved PEO must submit its annual filings as described in subsection (d)(1) of this section on PEO Annual Report, Form No. FIN410, using generally accepted accounting principles of the United States as modified by this subchapter.

(c) Quarterly filings. An approved PEO must file electronically with the commissioner within 45 days of the end of each calendar quarter an unaudited quarterly financial statement of the plan and trust, certified by an appropriate officer or agent of:

(1) the trustees; or

(2) the approved PEO.

(d) Annual filings. An approved PEO must file electronically with the commissioner by March 1 of each year:

(1) an unaudited financial statement of the plan and trust reflecting the financial transactions and results of the four previous quarters, certified by an appropriate officer or agent of:

(A) the trustees; or

(B) the approved PEO; and

(2) an annual actuarial opinion prepared and certified by an actuary who is not an employee of the approved PEO, and who is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary approved by the Joint Board for the Enrollment of Actuaries to perform actuarial services required under ERISA, 29 U.S.C. §§1001-1191c. The annual actuarial opinion must include:

(A) a description of the actuarial soundness of the plan and trust, including any recommended actions that the approved PEO should take to improve the plan and trust's actuarial soundness;

(B) a calculation of reserves as required by §13.560 of this title (relating to Annual and Quarterly Reserves); and

(C) a recommended minimum level of specific and aggregate stop-loss insurance the plan and trust should maintain.

(3) Audited financial statements for the plan and trust must be filed annually by June 1 of each year and meet the requirements of Insurance Code Chapter

401, Subchapter A, concerning Independent Audit of Financial Statements, and §7.88 of this title (relating to Independent Audits of Insurer and HMO Financial Statements and Insurer and HMO Internal Control Over Financial Reporting) using generally accepted accounting principles of the United States as modified by this subchapter.

§13.571. Annual Fee. With its annual filings an approved PEO must pay to TDI an annual statement filing fee of $500. This fee does not include the form filing fees required under §13.521 of this title (relating to Applicable Insurance Code and Administrative Code Terms).

§13.572. Examination of Approved PEO, Plan, and Trust. The commissioner or any person appointed by the commissioner has the power to examine the affairs of the approved PEO and the plan and trust as set forth in Insurance Code Chapter 401, concerning Audits and Examinations and §7.83 and §7.84 of this title (relating to Appeal of Examination Reports and Examination Frequency), as those provisions apply to domestic insurers licensed to transact the business of insurance in this state.

§13.573. Hazardous Condition; Violations of Statute.

(a) Hazardous conditions. An approved PEO's plan and trust are considered to be in hazardous condition if any of the following conditions exist with respect to the plan and trust:

(1) assets to liability ratio less than 1:1;

(2) negative financial position;

(3) negative net income combined with negative retained earnings;

(4) negative cash flow;

(5) failing to maintain minimum reserves;

(6) the trust failing to receive all monthly contributions paid by clients to the approved PEO;

(7) transfers of funds between the trust and the approved PEO not authorized under the trust agreement; or

(8) mismanagement by the third party administrator, trustees, or approved PEO that endanger the solvency or operations of the plan and trust.

(b) Regulation of solvency. An approved PEO and its plan and trust are subject to Insurance Code Chapters 404, concerning Financial Condition; 406, concerning Special Deposits Required Under Potentially Hazardous Conditions; 441, concerning Supervision and Conservatorship; and 443, concerning the Insurer Receivership Act.

(c) Order of actuarial review. On finding of good cause, the commissioner will order an actuarial review of an approved PEO in addition to the actuarial opinion. The approved PEO must pay the cost of any additional actuarial review ordered by the commissioner.

(d) Order to correct deficiencies. If the commissioner determines that the approved PEO’s plan and trust do not comply with this section or are found to be in hazardous condition, the commissioner will order the approved PEO to correct the deficiencies. The commissioner will take action authorized by the Insurance Code and

other applicable laws against the approved PEO and its plan and trust if the approved PEO does not initiate immediate corrective action.

DIVISION 8. MARKET EXIT.

§13.580. Withdrawal from Market.

(a) Withdrawal plan. An approved PEO that undertakes of its own initiative or is required by §13.581 or §13.582 of this title (relating to Limitation, Suspension, or Cancellation of Certificate of Approval in Response to TDLR Action and Limitation, Suspension, or Cancellation of Certificate of Approval in Response to TDI Action) to terminate its health benefit plan must file a withdrawal plan for review by the commissioner prior to terminating the plan. The withdrawal plan must include:

(1) the approved PEO's reasons for the withdrawal;

(2) a timeline for withdrawal, including the date on which the approved PEO intends to complete the withdrawal process;

(3) a copy of the proposed notice to be sent to client employers and plan participants giving them at least 180 days' notice of the plan's termination;

(4) the number and names of clients and the number of plan participants affected by the proposed withdrawal;

(5) a procedure for handling plan participants' claims for benefits;

(6) a procedure for identifying plan participants with special circumstances, as defined in Insurance Code §1301.153, concerning Continuity of Care;

(7) provisions for meeting all contractual obligations of the approved PEO;

(8) provisions for meeting any applicable statutory obligations; and

(9) verification of reserves to complete a solvent resolution of the plan's obligations.

(b) Novation and resolution of plan claim obligations. The commissioner will not grant the request of an approved PEO to cancel its certificate of approval unless the approved PEO novates its remaining plan obligations with an unaffiliated authorized insurer or satisfies its remaining plan obligations under an agreement filed with and approved in writing by the commissioner. For purposes of this subsection, those obligations are:

(1) known claims and expenses associated with those claims; and

(2) incurred but not reported claims and expenses associated with those claims.

(c) Approval of withdrawal plan. Except as provided by subsection (d) of this section, the commissioner will approve a withdrawal plan that satisfies the requirements of subsections (a) and (b) of this section.

(d) Modification or denial of withdrawal plan. If the approved PEO is unable to meet its contractual and financial obligations in a solvent and compliant manner, the commissioner will modify or deny an approved PEO's filed withdrawal plan, and take action authorized under Insurance Code Chapters 404, Financial Condition; 406, concerning Special Deposits Required Under Potentially Hazardous Conditions; 441,

concerning Supervision and Conservatorship; 443, concerning the Insurer Receivership Act; or all other applicable law.

(e) Notice of modification. The commissioner will issue a written notice to an approved PEO stating the basis for a modification under subsection (d) of this section. If within 30 days of receiving a notice of modification the approved PEO submits a written request for review by the commissioner and submits additional information that its withdrawal plan satisfies the requirements of subsections (a) and (b) of this section, the commissioner will reconsider the modification and give the PEO written notice of his decision.

(f) Notice of denial; State Office of Administrative Hearings hearing request. The commissioner will issue a written notice of denial to an approved PEO stating the basis for a denial under subsection (d) of this section. If within 30 days of receiving the commissioner's notice the approved PEO submits a written request for a hearing on denial of withdrawal plan, the commissioner will file a request to set a hearing at the State Office of Administrative Hearings under Government Code Chapter 2001, concerning Administrative Procedure; and Insurance Code Chapter 40, concerning Duties of State Office of Administrative Hearings and Commissioner in Certain Proceedings; Rate Setting Proceedings. At the hearing the approved PEO will be given an opportunity to show compliance with this section.

§13.581. Limitation, Suspension, or Cancellation of Certificate of Approval in Response to TDLR Action.

(a) Notice of TDLR action against approved PEO's license. The commissioner will limit, suspend, or cancel an approved PEO's certificate of approval in response to an action by TDLR against the approved PEO's license.

(b) Notice of TDLR's contemplated action. An approved PEO must notify the commissioner through TDI's licensing section within 10 business days of first receiving notice that TDLR is contemplating taking action against its license. The approved PEO's notice to the commissioner must include a copy of TDLR's notice.

(c) Limitation or suspension of certificate of approval. If the commissioner receives notice that TDLR is contemplating taking action against an approved PEO's license, at the commissioner's discretion the approved PEO's certificate of approval may be limited or suspended. While an approved PEO's certificate of approval is suspended, the approved PEO cannot contract with a new client to allow enrollment of new plan participants. When the commissioner receives satisfactory notice that all outstanding issues between TDLR and the approved PEO are resolved to TDLR's satisfaction, TDI will remove the limitation or suspension of the approved PEO's certificate of approval.

(d) Notice of TDLR action terminating license. If TDLR revokes an approved PEO's license, the approved PEO must terminate its health benefit plan in compliance with §13.580 of this title (relating to Withdrawal from Market). An approved PEO must notify the commissioner through TDI's licensing section within 10 business days of

receiving notice that TDLR has revoked its license. The approved PEO's notice to the commissioner must include:

(1) a copy of TDLR's notice of termination; and

(2) confirmation that the approved PEO will file its withdrawal plan within 30 days.

(e) Cancellation. When an approved PEO has fulfilled all requirements of its withdrawal plan, the commissioner will cancel the approved PEO's certificate of approval.

(f) Reapplication. If TDLR later reinstates the PEO's license or grants the PEO a new license in good standing, the PEO may reapply to TDI for a certificate of approval in order to sponsor another plan under this subchapter.

§13.582. Limitation, Suspension, or Cancellation of Certificate of Approval in Response to TDI Action.

(a) Commissioner's authority. Nothing in this section limits the commissioner's authority under Insurance Code Chapters 404, Financial Condition; 406, Special Deposits Required Under Potentially Hazardous Conditions; 441, Supervision and Conservatorship; or 443, the Insurer Receivership Act.

(b) Limitation, suspension, or cancellation of certificate. The commissioner will limit, suspend, or cancel an approved PEO's certificate of approval if the commissioner

finds that the approved PEO or its plan or trust do not meet the requirements of applicable Insurance Code provisions or this subchapter.

(c) Notice of limitation; commissioner's hearing. The commissioner will issue a written notice to an approved PEO stating the basis for a limitation under subsection (b) of this section. If within 30 days of receiving a notice of limitation the approved PEO submits a written request for review by the commissioner, the commissioner will schedule a hearing under Insurance Code Chapter 40, at which the approved PEO will be given an opportunity to show compliance with this subchapter. Hearings described in this subchapter will be conducted as required by Government Code Chapter 2001, concerning Administrative Procedure; Insurance Code Chapter 40, concerning Duties of State Office of Administrative Hearings and Commissioner in Certain Proceedings; Rate Setting Proceedings; TDI's and State Office of Administrative Hearing's rules of procedure; and any other applicable law and regulations.

(d) Notice of suspension or cancellation. The commissioner will issue a written notice of suspension or of intent to cancel to an approved PEO stating the basis for the suspension or cancellation under subsection (b) of this section.

(e) Hearing request in contested case. An approved PEO may submit a written request to the commissioner for a hearing at the State Office of Administrative Hearings under Government Code Chapter 2001, Administrative Procedure, within 30 days of receiving notice that its certificate of approval:

(1) remains limited after a commissioner's hearing under subsection (c) of this section,

(2) is suspended under subsection (d) of this section, or

(3) will be canceled under subsection (d) of this section.

(f) At that hearing the approved PEO will be given an opportunity to show compliance with this subchapter.

§13.583. Cancellation of Certificate of Approval.

(a) Plan termination. If the commissioner determines that an approved PEO's certificate of approval should be canceled, the approved PEO must terminate its health benefit plan in compliance with §13.580 of this title (relating to Withdrawal from Market). The approved PEO must file its withdrawal plan within 30 days of receiving the commissioner's written notice of suspension.

(b) Cancellation of certificate of approval. When an approved PEO has fulfilled all requirements of its approved withdrawal plan, the commissioner will cancel the approved PEO's certificate of approval.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on April 21, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC Subchapter F, §§13.510-13.513, 13.520-13.524, 13.530-13.534, 13.540-13.545, 13.550-13.557, 13.560-13.568, 13.570-13.573, and 13.580-13.583.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **4410**